

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Developing Outpatient Therapy Payment Alternatives (DOTPA)-  
Data Collection Update  
Thursday, August 19, 2010  
2:00 pm to 3:30 PM ET  
Conference Call Only

CMS invites all providers of Medicare Part B outpatient rehabilitation therapy to participate in a Special Open Door Forum (ODF) about the research project known as DOTPA, for "Developing Outpatient Therapy Payment Alternatives." CMS and its data collection contractor, RTI International, will explain the critical role of providers in this research. Medicare is now actively seeking providers to participate as data collection sites.

This Special ODF is intended for all institutional and noninstitutional providers of outpatient physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) who are reimbursed under Medicare Part B. It may also be of interest to physicians who refer beneficiaries for outpatient therapy.

After explaining the goals of the research and updating the provider community on the DOTPA data collection forms, speakers will describe the provider enrollment and setup process, the training resources available for participants, and data collection operations at a typical site. Also, CMS will answer any questions you may have about what is involved in participating in this project.

DOTPA intends to enroll providers as data collection sites continuously through the remainder of this year. Data collection involves Medicare Part B patients only, and is expected to take up to six months at each participating provider. CMS encourages interested facilities, practices and individual providers to consider enrolling. By participating, providers gain an opportunity to contribute to ground-breaking research in case mix measurement and payment methodology for therapy services paid under Part B. More information about the project can be found at <http://optherapy.rti.org>.

We look forward to your participation.

Open Door Forum Instructions:

*\*\*Capacity is limited so dial in early. You may begin dialing into this forum as early as 1:45 PM ET.\*\**

Dial: 1-800-837-1935 Reference Conference ID 92977603

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording and transcript of this Special ODF will be posted to the Special ODF website at [http://www.cms.hhs.gov/OpenDoorForums/05\\_ODF\\_SpecialODF.asp](http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp) and

will be accessible for downloading on or around Monday August 30, 2010 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: <http://www.cms.hhs.gov/OpenDoorForums/>

Thank you.

Audio file for this transcript: <http://media.cms.hhs.gov/audio/DOTPA081810.mp3>

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Developing Outpatient Therapy Payment Alternatives (DOTPA)-  
Data Collection Update  
Moderator: Natalie Highsmith  
August 19, 2010  
2:00 p.m. ET

Operator: Good afternoon, my name is Chrissy and I will be your conference facilitator today.

At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Special Open Door Forum on Developing Outpatient Therapy Payment Alternatives.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question-and-answer session. If you would like to ask question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, Chris, and welcome everyone to today's Special Open Door Forum on Developing Outpatient Therapy Payment Alternatives - Data Collection Update. This call will be (inaudible) of Medicare Part B outpatient therapy rehab, outpatient rehabilitation therapy. And this call will discuss the goals of the research and give updates on the adopted data collection forms, describe provider enrollment and setup process, the training resources available for participants, and data collection operations at a typical site.

This call will also be transcribed and the audio file will be posted on the CMS Special Open Door Forum Web page beginning on or around Monday, August 30<sup>th</sup> and will be available for about 30 days. And also, you all should have received a notice about the presentation materials that have been posted on the Web site [optherapy.rti.org](http://optherapy.rti.org) and you can follow along for those materials.

I will now turn the call to Miss Ann Meadow who is the Project Officer in our Office of Research, Development, and Information.

Ann Meadow: Hello, everyone. Good afternoon, and I want to thank you for coming. I just want to provide a little bit more information about the slides. If you have an opportunity, you can follow along with the slides and the exact URL is <http://optherapy.rti.org>.

This is an important study that begins to consider refinements of outpatient therapy payments that recognize the range of populations you treat under the Medicare Part B covered sector of services. And it brings the opportunity to better recognize those differences in your payments.

In other words, we want to see with this research if Medicare can incorporate some recognition of case mix differences among patients to improve upon the current cap and exceptions process.

Your role is critical in allowing us to conduct this research. We're entering the recruitment phase now and that's why we set up this Special Open Door Forum, and in the course of this we'll be covering various types of information you need to know.

I'm on slide two now. I want to introduce you to the team that we have working on this project. It's led by Research Triangle International and three speakers here today that are leading the project are Barbara Gage, Ed Drozd, and Judy Abbate. They'll be speaking later in the program.

They also have support from several institutions including the Rehab Institute of Chicago, Boston University, University of Southern California, and there are consultants to the project from the National Rehabilitation Hospital, the University of Pennsylvania and FOTO.

I want to move to slide three now and just give you an outline of what we're going to cover.

First of all, we are going to explain in a little more detail the purpose of the research. We'll update you on the data collection instruments, their origin, the format, and content. We'll explain how providers can participate, what types, when. We'll describe the data collection process and provider roles and responsibilities. We'll describe the range of training and other supports to participants that will be provided by the various members of the project team I just described. And I want to explain what's in it for you, why you should consider participating.

I'm on slide four now. So, just to give you the big picture of the project, CMS awarded RTI a contract in the beginning of 2008 to help us develop alternatives to the current Medicare payment cap and exception processes.

The three main phases were to develop a patient assessment tool for research purposes for measuring severity and outcomes, to collect those assessment data from a robust provider sample that is representative of where Part B therapy takes place, and then to use the sample data merged with administrative data—claims—to study alternative payment models for outpatient therapy, building upon the main elements of the payment system.

I am moving to slide five now. So, I want to emphasize that all settings where Part B therapy takes place are being sought for inclusion in the study. That includes independently, privately practicing therapists, outpatient rehab facilities, comprehensive outpatient rehabilitation facilities, and outpatient

rehabilitation facilities, hospital OPDs, day rehabilitation programs, and Part B stay patients in nursing facilities.

It's important that we have the full range of Part B therapy providers represented so that we can represent all the types of patients that are being paid for under the Part B therapy benefit.

So, before I turn it over to the next speaker, I want to thank you for participating and listening to us to explain the – what we intend to do and why we encourage you to participate.

The next speaker is going to be Ed Drozd and he's going to update you on the data collection instruments. So, we are on slide six.

Ed Drozd: Hi, this is Ed Drozd from RTI. And so, I am going to spend a few minutes just to go over with you who may not be familiar, some of the general principles and the approach to developing the assessment instruments for the DOTPA initiative. And then I will turn it over to Barb Gage and Judy Abbate, also of RTI, to describe the assessment instruments and data collection processes and recruitment in some detail.

So, turning to slide seven. The general principles (inaudible) to collect data to measure case mix and outcomes and the feasibility of using (inaudible) data in the payment system. Assessment instruments as many of you presumably even use in your own practices, can be useful for care planning. This one could be, but the purpose is not for care planning. The purpose is only for focusing on (inaudible) identifying and measuring patient complexity and outcomes, not on care planning.

And so, the focus here is on applying the case mix adjusters and outcomes to various alternative payment models, payment approaches based on the Medicare fee schedule that you are currently very familiar with. Alternatives that can generally fit within the existing system, retaining all of the features of the Relative Value Units (RVUs), the CPT or Current Procedural Terminology code and (inaudible) healthcare procedure coding system codes that you currently use.

We, other than staying within the framework, generally, of Medicare fee schedule, we're not preordaining the use of various alternatives and we anticipate that the data collection, excuse me, will be flexible enough to support a wide the range of alternatives, again, not preordaining any particular one.

The assessment items and therefore the case (inaudible) and outcomes that we measure should be appropriate the various ambulatory payment populations. So, just to recap, those are the general principles that we used in order to think about developing assessment instruments for data collection for this initiative.

Turning to slide eight, more specifically from the approach to developing these assessment instruments, we felt that it was very important to build on

current measurement approaches used among the various therapy disciplines. We examined a variety of current therapy measurement systems. We took into consideration very strongly the administrative feasibility and we – that requires a common set of items to be used for measuring case mix and outcomes, rather than using a variety of assessment items, and sets of items.

And the other approaches that we featured, what can be called a core and supplemental approach where there is a subset of items which all patients would be assessed on. And there will be other subsets where only if certain conditions are met would there be greater detail to go into a particular area of functional limitation impairments, et cetera.

Now, there, the approach in this project is to use paper-based tools and we understand that many of you currently collect data electronically. However, electronic options will be considered at individual sites if the particular items that are used in the – data collection instruments are used and we can discuss that further later in this presentation and also during recruitment with individual providers.

Turning to slide nine, we created within the large set of items two separate items sets for ambulatory populations and those receiving Part B covered therapy, excuse me, in nursing facilities or day rehabilitation programs. The reason we did this is to reflect differences associated and associated complications that need to be considered, different types of settings have different types of patients and we wanted to ensure that the sets of items that individual providers would use was not overly long, but we did want to make sure that the items, the specific items used by particular settings were specific to their particular patient population. And we did pilot test these items in several settings to address some particular practical issues.

Now, again, that was only in several different settings and was not comprehensive collection of data in the wide variety of settings, in the wide variety of patients who are receiving Part B therapy and that is a principal purpose of the data – of this data collection phase that we are entering into now.

So, I'm going to turn this presentation over to Barbara Gage of RTI, with whom many of you are probably familiar, and she will describe in more detail the assessment instruments themselves.

So, slide 11 would be the next slide.

Barbara Gage: Thank you, Ed.

The – as Ann mentioned and Ed have mentioned throughout, there, this is a tough area to be developing standardized items. And since we don't yet have consensus of all of the different fields in terms of how to best measure an ambulatory therapy population.

So, this work has had a lot of stakeholder input, trying to understand the best measures from each of the different points of view of the different therapies in

the community. So, as Ann had mentioned, our team includes people that have different measurement approaches in their background, the AM-PAC approach, the FOTO approach, the (inaudible) approach, and that was a starting point.

The team turned to the stakeholder world and asked for extensive input from the members of the Professional Practice Associations, particularly those representing the different types of clinicians as well as those representing the settings in which the different clinicians practice. We had a technical expert panel in the summer of 2008 which some of you may be familiar with. That panel was asked to recommend a standard set of items to identify what types of concepts should be measured and the best measurement approach for those items.

We then had additional advisory panel meetings to refine those (inaudible) recommendations and to create a working set that could result in separate, but complementary items sets for both the ambulatory and the more impaired population.

As Ed mentioned, this effort recognizes the difference in the complexity of a patient seen in an ambulatory setting, versus the other patients also covered by Part B, but in the more inpatient setting such as the nursing facilities and the day rehab.

So, on slide 12, we give a bit of an overview of the CARE-C tool which is the community-based tool for all of you working in ambulatory therapy settings, including the hospital outpatient department, the different clinicians' offices, of course, the (inaudible).

This tool has two key sections. Those of which are very short, the patient's self-report section includes function – self-report function items, participation items, and they're very, they're a subset of what is currently contained in the AM-PAC and the PM-PAC item tools.

We also have a set of self-report items on cognition and communication, which were recommended by the speech and language pathology community and the complete tool is out on our Web site for those of you who hadn't pulled it down yet, that Web site being the [optherapy.rti.org](http://optherapy.rti.org) Web site.

So, there's a patient's self-report section which should only take a patient about five minutes to complete. But given the differences in the elderly population and the impairments of the disabled population, it could take up to 15 minutes to complete. But it's a pretty straightforward set of check-offs.

Then there's a second section on the CARE-C tools that the clinician responds to. So, these are the PTs, OTs, and speech pathologists in the room. It's a small set of items. We're asking the clinician to identify the reason for therapy, the duration of the problem, the complication, such as pain, or active illnesses associated with that which you're treating. And then there are a set of seven screening items getting the issues of different impairments, communication and cognition.

So, if a patient has a problem with one of those screening items, there are a couple of follow-up items to understand the problem. And that shouldn't take over 10 minutes to complete. It's all designed as a very easy check-off. But together, it gives us information from the patient's point of view on the functional levels and the types of problems that they perceive themselves having, as well as the clinician assessed information on the types of problems you're treating.

On page 13, we described the tool that's used in the nursing facilities and the day rehab programs. This is based on the items that are, that were tested in the PAC payment reform demonstration on populations in inpatient settings such as hospitals, skilled nursing facilities and the home health population. It does have additional cognition and communication items, again, recommended by the speech language community and it probably takes up to 35 minutes per patient, again, depending on the patient complexity. It could be as quick as 10 or 15 minutes. But it is designed to deal with that more impaired population.

The key attribute of this effort, as noted on slide 14, is the standardized language. So, as we've been working with the different stakeholders and talking to people across the country, there aren't really any items on here that you're not already using in your practices to identify who you're treating that day, but you're all using different language. So, the items on these care item set standardize that language.

Both tools have that screening item approach, so you're only asking a handful of items per patient with additional items where appropriate. And they both have the easy check-off format.

Our goals on slide 17 are to test ...

Ann Meadow: Fifteen.

Barbara Gage: ... 15, thank you Ann – is to test these items in the therapy settings because we want to make sure, we want to identify what items work with what populations or in what settings given practice workflows, et cetera. And a really key role in participating is giving CMS feedback on these items as they apply to your populations to measure severity and outcome.

So, we have a data collection process. It's outlined on slide 16. We're going to talk a little about the provider selection and recruitment. And then I'm going to turn it over to Judy Abbate to talk about the participant roles and responsibilities and the support that's available in participating.

So, the provider's selection, as Ann mentioned, it's important to have a full range of providers and patients that receive Part B covered therapy. We're (inaudible) we would like to enroll 30 to 50 providers in each of the following groups. So, this isn't a very large initiative. We're only looking for 30 to 50

hospital outpatient departments, 30 to 50 CORFs or 30 to 50 PT private practices, et cetera.

We will be trying to – our sample will include providers from all the different regions of the country, as noted on slide 18. We're also looking for providers that are treating those urban, rural and suburban populations. And those of you that might be specializing in certain populations, perhaps you have all strokes or all neuros, you have some specialty, we'd like to include that type of provider, as well as the more general list.

And, so far, we've had quite a bit of interest. More than 50 providers have e-mailed or called to participate in a demonstration. The reason – the project – the reason we're having this Open Door Forum today is to formally kick that off and get moving in terms of starting that enrollment.

But on slide 19, you'll see how you can get involved. So, if you are interested in participating or if you just want to look at the CARE-C or CARE-F and give us comments, please go to the Web site, you'll see all the information about the initiative or you can e-mail us at [optherapy@rti.org](mailto:optherapy@rti.org) or you can call Dr. Abbate at the number that's listed on slide 19, which is 781-434-1793.

The timeline, as I mentioned, we're starting up enrollment. So from now through November, we'll be initiating enrollments with different practices. We'll be continuing all the way through spring. But, if you were hoping to get into the initiative and we have not called you, please do send an e-mail earlier, rather than later, as we do have a limited number of slots and we want to make sure they represent our different groups that we we're looking for.

The data collection will begin, for those that – the first group will be beginning probably in late September and we'll keep starting new organizations off, all the way through the spring of 2011.

The participation is outlined on slide 20. The participation involves assessing a new Medicare Part B patient when they come into your office, or into your site. You'd want to assess them on the first or second visit and you'd want to assess them again at the end of the services in the last or near last visit, so that we can see the change in the function associated with the treatment with the pain or whatever is the primary reason for treatment.

We're looking for 20 to 30 new Medicare Part B patients per month and we can work with you to identify one of several systematic approaches for identifying those. You might want the first 20 patients of the month, you might want the first on different days, et cetera. We'll work with you individually to select one of several systematic approaches.

Data collection goes on for up to six months, so you'll have 20 patients on whom you're doing an assessment per month for up to about six months. And we're looking for up to 150 patients per site. We throw that number out there loosely recognizing that some of you are small or have smaller practices and some have larger and we don't want to overburden anyone.

So, we have a – so, I will turn it over to Judy Abbate to talk a little bit about the data collection approach.

Judy Abbate: Thank you. This is Judy Abbate.

I'm on slide 21. And we do use the team approach in collecting this data. What we do is, OK, we're using a team approach and we're targeting these providers to work together as project administrators and clinicians heading this data collection and divide into a couple of roles there.

First would be the project administrator's role. One of the roles is for the project administrator to identify eligible study patients in your clinic or outpatient department or within the skilled nursing facility, and be able to identify those patients that are at your site and track those patients enrolled in this initiative and manage the forms. As Ed mentioned, we have paper forms, for the most part, including giving the patient the self-report form in the clinical area using CARE-C and clinicians, the clinical form on the clinical side.

So, the administrator would collect the forms and ensure that the patient's privacy is maintained and basically make sure that the process is moving forward. We try to take into account your individual practice and the range of clinicians that you will have involved in this initiative and your administrative practices, your workflow.

So, we work very closely with you on this to identify how things are processed and how your individual sites work. And then we seek to help to you, guide you in this data collection.

So, the forms themselves are returned to RTI on weekly basis, I'm sorry, a bi-weekly basis, in envelopes that we provide and with address labels that make it easy for you.

In terms of the clinician side, the clinician's role is to obviously complete the appropriate sections of the assessment instrument and depending upon your practice, more than one type of therapist may complete items on the form. We have individualized data collection process that's going to take into account your type of patient, the range of clinicians, and your administrative practice.

So, again, depending upon your practice, we work with you to tailor the best data collection process, the most efficient.

The data collection itself, if I can give you an example for the ambulatory sites, the patient is given the self-report items when they come into their first visit as part of their admitting paper work. And you might use a clipboard or other means to transfer and get the patient started. And then the clinician reviews this with them after the patient is brought to the clinician and completes the clinician's section at the end of the visit, making sure that everything is completed.

This is a time when it may be useful for patient therapy communication to review the form that the patient has completed in the self-report section.

The project administrator collects the assessment and mails batches to RTI every couple of weeks and then the process is repeated in the last or second to the last visit.

So, the data collection in the nursing facility and the day rehab unit, the clinician will use the CARE-F form in that situation to assess the patient on the first to second visit. There aren't any self-report items on CARE-F.

The project administrator collects the assessments and mails them back in a batch to RTI every two weeks and then the process is repeated in the last or second to the last therapy visit.

On slide 23, this outlines how we are recruiting you to participate. Invitations will be mailed out starting in the beginning of September and continuing on through the spring. We have invitation packages that are going to include a project overview, which you might want to share with your colleagues. And then for those who are definitely interested in participating, please contact us to make sure that you're included if you have not received an initial mailing. We have the e-mail listing here [optherapy@rti.org](mailto:optherapy@rti.org). And we'll be happy to talk to you about the feasibility of setting this initiative up in your clinic or in your facility.

In slide 24, we do have individualized training support. We make arrangements with you based on your own circumstances. We have an interactive webinar for the site coordinator team and the participating clinicians and we do have individualized data collection procedures that we established with you prior to starting the assessment data collection. And then we have ongoing support throughout the process and we really do provide you with refresher webinars if needed. We have training materials that we provide. We make them available on our Web site and we also have a very active helpdesk that's available by toll-free telephone, e-mail, and also querying through our Web site.

We also provide monthly provider check-in calls to make sure that everything is going smoothly and we also have coordinator calls, monthly coordinator's calls where you can get involved and receive updates and discuss the data collection process. And we share tips, ways to ease data collection for you.

We have, when you enroll, approximately three weeks after you enroll, we will set up your webinar training for you and, again, we will have a lot of available support.

And now, we're up to slide 25. So, our monthly group calls are scheduled to provide you ongoing assistance and we really are looking for your input on individual items used with the population that you're serving.

This is critical to us and there are three ways for you to give us feedback. One is every form asks – on every form at the end of the form, there is an

item called feedback on the last page and this is the time for you to just tell us what is working on the form and to give us feedback on particular items. And then within the monthly calls that I just described, we have a team, RTI and RIC that is comprised of clinicians and helpdesk people and we invite you to these monthly calls. And, as I mentioned, we have the Web site where you can contact us and also invite your colleagues to review and to submit any comments that they might have.

The date of submission involves the use of the paper forms that will be provided to each of you and mailing materials so that you will have the pre-addressed labeled and mailers and we're using a secure mailing procedure that will allow us to have – you mail in the forms directly and they are trackable and tamper proof and we have a procedure for that.

So, from – I will turn this over to Ann, who will talk about ...

Ann Meadow: Thanks a lot, Judy .

Judy Abbate: ... benefits.

Ann Meadow: So, now that you've gotten the description of how we see this working, you can see that we have tried to incorporate a lot of what we perceive that you would perceive as attractive features. The way the forms are done, to be efficient, the way they are structured, the kinds of support, and particularly the individualized support, the enrollment that we will conduct on a rolling basis so that you can start collecting data when you feel you could add that function to your office operation.

And, as we stated earlier, and I'm on slide 27 – I will just orient you to that – where I want to reinforce that it's important that we have a range so that we have a (inaudible) representative sample. And the way to get that is to get all the settings involved as data collection sites so that the – every type of patient is represented in our study dataset. We want to make sure that we test the items on the full range of Medicare Part B therapy patients.

The other thing that we mentioned which, this is an opportunity to directly provide your point of view and give voice to your experiences with this kind of data collection process in your office. Also your experiences with individual items and how workable they are, what you think the utility is, what you think the limitations might be. So, it's on the data collection instruments itself. So, if it comes up there. You can just capture it right then and have it sent back to RTI via the group conference calls that Judy discussed. If you're online with the helpdesk, they will be prepared to accept this kind of feedback – this kind of feedback also.

So, in summary, we have tried to structure this to ease your participation in this study.

Finally, we have been working with our Office of Financial Management to defer possible documentation requests under the MAC and RAC programs, while you are collecting data under the DOTPA project. And we have staff

here. I'm going to turn it over to staff here from OFM who are going to speak a couple of minutes about that.

First. Connie Leonard.

Connie Leonard: Thank you, Ann. Just quickly, we've done (inaudible) one other time in a demonstration because we realize the extra work staff providers are doing when they collect this data and we are trying to fine-tune the process. We ran into a couple of issues with the last go-round. I like the word they were using this time, called "deferral." I think that is the good word.

Basically, there are four points to remember about the deferral. It is only during the time that you are participating in this demonstration. So, if it's six months or whatever the data collection period is, that is what your deferral is. And it's only for, if you won't have any additional documentation requests or medical record requests from a RAC contractor during that time. Once you complete claims process before, during or after the demonstration period, are all available for possible RAC review.

So, there is no exemption of RAC claims to review, just (inaudible) deferral some review because we realized the additional steps you're taking to provide to send it to us.

And then, as I, reviews by (inaudible) may continue depending on, you know what the (inaudible) are looking at a particular period in time.

And the last big point is, if things are already in process, if you already have requests from a recovery audit contractor, at the time you entered into the program, this will continue. We're not going to stop anything midstream. It's just that you shouldn't get any additional documentation requests after you enter into the program.

And if there is an issue, in the letter that you'll get we will tell you to contact me, my name is Connie Leonard. I might give you my e-mail address and we can tell the RAC and they will very quickly take you off the list.

Again, this is something that we have done in the past, and we don't mind doing because of it's a temporary thing. And hopefully this data will be very important (inaudible) down the road.

Any questions I'd be happy to take, but I think it's a fairly straightforward process to help you guys (inaudible) the benefits.

Ann Meadow: Thanks a lot, Connie. And we also have Debbie Skinner from the MAC side.

Debbie Skinner: I'm Debbie Skinner and I work in the Division of Medical Review and Education. And I need to echo a lot of what Connie said. We will, upon receipt of the list of providers participating in the demo, we will send instructions out to our contractors to not look at your claims for the six-months period that you are participating in the demo. But as Connie said, if you are in a review now, that activity will continue and we will continue automated

pre-pay review because that does not require asking for any additional documentation.

And then after the six-month period, the contractors will resume their normal medical review activity which could include looking back on those (inaudible) database.

Ann Meadow: Thanks a lot.

So, I think we're ready to move to our question-and-answer period. And I first would like to entertain questions about the topic we just covered, the deferrals, because the OFM staff have to leave in a few minutes.

Can we get those questions – questioners who have any questions about the deferral to the front of the line please?

Natalie Highsmith: OK, Chris, if you could just remind the folks on how they can get into queue to ask their question. And everyone please remember when it is your turn to restate your name, give what state you're calling from and what provider or organization you're representing today. And also please be reminded that we are just taking questions right now at this time for the deferral topic. And we will have open Q & A for the rest of the demonstration – for the rest of the presentation. But right now we just want to focus on the deferral topic.

Chris?

Operator: Again, I would like to remind everyone to please press star one on your telephone keypad. And we'll just pause for a second to see if anyone has current questions.

Your first question comes from Jennifer Fintz from Ohio. Your line is now open.

Jennifer Fintz: Hi, my question is about the deferral. Is this for all product lines by the providers or just the PT/OT/speech, the RAC deferral?

Connie Leonard: It would be from a RAC perspective, it would be everything for that particular provider NPI.

Jennifer Fintz: Thank you.

Operator: Your next question comes from Patricia from California. Your line is now open.

Patricia: Hi, that last call cut out. I have the same question. In regards to the RAC deferral, if a hospital, for example, participating would be RAC deferral would be limited to claims relating to outpatient therapy services or would it include all other services from that provider?

Connie Leonard: It will include services for that provider, based on its NPI.

Patricia: OK, thank you.

Operator: Your next question comes from line of Debbie Nemcheck from Connecticut. Your line is now open.

Debbie Nemcheck: Sorry, I really didn't have a question. I thought were supposed to press that star one just to be able to hear everyone else's question, I apologize, I do not have specific question about deferrals.

Operator: Your next question comes from the line of Stephanie Ruiz from New York. Your line is now open.

Stephanie Ruiz: Hi, I'm sorry. I actually pressed it by accident. So, I thought we were suppose to do it.

Operator: Your next question comes from Jeanette Cunill from Florida. Your line is now open.

Jeanette Cunill, your line is now open.

Your next question comes from Melinda Rodriguez from Texas. Your line is now open.

Melinda Rodriguez: We also have a home health agency and we also are an ORF. So, kind of under the same thing as the other question. So the RAC, will that also affect our home health agency protection from the RAC?

Connie Leonard: Only if you use the same NPI. So, if you use one NPI for all of your facilities, then the deferral would be for all of them. But if you have separate NPI, they may only be for the – that one NPI. So we're basing if off NPI.

Melinda Rodriguez: OK. Another question is would this include like billing hold-ups, I guess, so that will facilitate our billing delays if we participate?

Connie Leonard: If there's been something that has been demanded previously prior to you entering in, that will continue. It's – as we've said that anything in process will continue. So, if you have something that's already been demanded and is in the (inaudible) process, that will continue. Obviously because there are no new additional documentation requests, you should not have – unless it came from a pre-payment or automated perspective any new recoupment while you're in the deferral period, but anything in process will continue to be processed.

Melinda Rodriguez: OK, thank you.

Operator: Again, if you'd like to ask question about the deferral, please press star one on your telephone keypad.

And your next question comes from Tresa Blem. Your line is now open.

Tresa Blem: I'm interested in, when we say that we have interest, how are you going to know whether we are a day hospital or free-standing provider or a skilled-nursing facility? How are you going to gather that information?

Barbara Gage: Thank you for that question. On the Web site, we asked you to identify the type of organization, the type of practice that you are, and then as we are following up with the – and we can tell from your ID numbers which are also asked for on the Web site. So, we then have a follow-up call with you during the recruitment process. If you've received a letter, we will be calling to really talk through with you about the types of patients that you're treating and about your process in your organization just to make sure that we have the type of organization that we think we have. But definitely when you submit interest through the Web site, when you go out to [optherapy.rti.org](http://optherapy.rti.org) and you go to the top of the Web site and you click on "Contact Us," you should give us all of that information.

Female: Thank you.

Operator: Your next question comes from Brenda McCloud from Tennessee. Your line is now open.

Brenda McCloud: Yes. We are currently a FOTO, we use the FOTO outcomes measuring survey tool now. We've used it for years and I was wondering if there's anyway that incorporate that if that would make easier for us, if we were participating or if there's – somehow that can complement what we would been doing?

Barbara Gage: It will definitely complement what you have been doing. We've had interest from several of the electronic systems asking about incorporating these items into their systems, that those of you that are using them are using. So, it's something we can discuss further and, yes, it probably would make data collection very easy for you.

Brenda McCloud: OK, thank you.

Barbara Gage: You're welcome.

Operator: Your next question comes from Jennifer Hughes from Texas. Your line is now open.

Jennifer Hughes: We had two questions. The first one is how do one-time Medicare evaluations fit into this process?

Barbara Gage: Could you be more specific as to which evaluations you're referring to?

Jennifer Hughes: For example, like lymphedema patients? Maybe patients we begin to evaluate one time for equipment or just a one-time gate assessment, would we be (inaudible) the intake questionnaire when we know we won't have a discharge follow-up?

Barbara Gage: No, you wouldn't.

Jennifer Hughes: OK. The other question is, have you have institutions that submit part 1 on paper and part 2 by electronic medical record?

Barbara Gage: We have not started this process yet. As we mentioned, we are just beginning enrollment now. If we can talk further about how to arrange data collection procedures that fit within your practices.

Jennifer Hughes: Thank you.

Barbara Gage: You're welcome.

Natalie Highsmith: OK. I think we are moving more into the general Q&A. So, if there are no more questions about deferrals, we'll go ahead and move into the general Q&A for today's topic.

Ann Meadow: But you could always write to the contact points that we mentioned or call the numbers that are in the slides and we can answer further questions after this call about the deferral.

Operator: Your next question comes from the line of Jane Park from New York. Your line is now open.

Jane Park: Hi, how are you. I have a question on just OMB, the form for admission intake and discharge intake questionnaire form, is this something you can answer on this conference call?

Ann Meadow: Sure.

Jane Park: I downloaded (inaudible) and this is going to you know just spend a lot of time for filling out and it's very complicated for you know in terms of my knowledge in the patient population. It's going to cause us a lot of overhead in terms of you know spending time with them one on one, help them out, and there is like a – (if this) and go this and that. I mean, even for me, it took a while to understand, I'm still trying to understand. I don't know what – is this form is going to be the actual form in the near future are we going to be dealing with or this is just for research purpose?

Ann Meadow: This is Ann Meadow, to speak to the second part of your question, this is a research project and we have spent quite a bit of time, evaluating items and assembling them into a research tool for purposes of this study. We want to test these items, see which subsets are useful for recognizing case mix differences in outpatient rehab therapy payment and consider alternatives for improving on the current cap and exceptions process.

So, we cannot speak to any proposals at this point that CMS might make, there is a lot of contingencies that will be coming down the pike as we go through the research process.

Jane Park: Yes.

Ann Meadow: For the first part of your question, I'm going to turn the mic over to Barbara Gage.

Jane Park: OK, great.

Barbara Gage: Thank you, Jane. Are you with an ambulatory provider or ...

Jane Park: No, we are (inaudible) on the, you know physician's office. We do physical therapy and the outpatients. And so, this question, just (inaudible) and discharge intake form is going to tremendously impact how we practice. For example, at the bottom of this intake questionnaire, it says it'll take, on average, 20 minutes per person to review and answer this one. That's really ballpark general guidelines. But I think a lot of them, it will take 30 minutes. We even to hire one person just to sit down and go over this form.

And I have a lot of questions generating this – from this questionnaire. For you example, how do you decide how many – what if the discharge patient says, oh, I didn't get any benefit from this entire treatment and are you going to – I mean, take the reimbursement back? How are you going to do that?

Barbara Gage: Thank you for asking. I'm sure others are also wondering that, Jane. So, let me speak to your issues briefly.

Jane Park: Thank you.

Barbara Gage: Yes. I'm going to walk people quickly through the forms, so that those of you that have not seen it before, haven't downloaded it for this call, know what we're talking about. The intake questionnaire for the ambulatory population has the basic (face) sheet information and then it has several pages of patient self-report items and they're asking the patient things like if it's a primary condition, how long they've been treated, what other medical conditions they have, whether they have pain, if so, where is it. And then a set of basic mobility, everyday activity and light skill items from the AM-PAC which are little check-offs asking whether they need help with opening the car door, opening small containers, things of that sort.

So, in the studies that have used this under the AM-PAC, those that use the AM-PAC system currently, it probably takes the patient five to 15, could be up to 20 minutes, depending upon you know sometimes the elderly population moves a little bit slower or they want to talk back and forth with you about the items. The "you," in that case, is typically the administrative person, your office manager, your receptionist.

We see the self-report section being handed out as your new patients coming in, they're coming for the visit, you hand them the forms to complete for insurance purposes and they answer this little questionnaire.

Then, when you get back to page – to section three, we start on the information that we're asking the clinician to complete and this is a little check-off. It looks lengthy because we've had to list all the different types of conditions that you may be seeing in a patient. But you're probably just

checking off one or two, the body function, the body structure, the activities and participation, and then primary and secondary medical diagnosis.

Typically, this comes out during the visit with the patient. So, in the pilot test that we have had, the clinicians will just keep the form as part of the paperwork that you have in the office and you're talking to the patient, identifying what the conditions are, what are the other medical conditions are, and you just check off on the form.

The supplemental items under the provider information are series of screening questions asking whether the patient has any vision impairment, any hearing impairment, any signs or symptoms of a possible swallowing disorder, any problems with memory, attention, problem solving, et cetera, any signs or symptoms of a possible communication impairment, one or more unhealed pressure ulcers at stage two or any impairments with bladder or bowel.

If the patient you're seeing has none of those, you have just check off no, no, no, no, no, and you are done. Except, if you want to give us comments on the items and on their usefulness in thinking about the severity of the patients that you're treating.

So, it's really – it looks very long because we've laid out all of the options as a check, check, check, check, but it shouldn't take you very long to complete. It shouldn't be over five additional minutes during your visit because these are items that I imagine your clinical team is already looking into.

Jane Park: May I interrupt on one second, please.

Barbara Gage: Yes, please.

Jane Park: OK. So, I just want to know – just let the other know that, this is 17 pages long form and also 17-pages long for the admission and it's – the total 34 pages that patient we have to be filling out. And then, you have provider barcode. So, do you want us to submit electronic health record or we keep in our file? Or I'm sure, you want to see this form submit to you, right?

And then my second question is that this form is for SLP, occupational therapy and physical therapy all included. So I'd like to see is this for the physical therapy, I want to have a simplified form for each specialty, because not – we're not doing everything. We only focusing on physical therapy. We don't do speech language, we don't do also occupational therapy, so I wanted to (inaudible) if you guys are thinking about the – you know the making into a simplified form for each (inaudible) specialty?

Barbara Gage: We can work with you, as we've done in the other initiatives to have the paperwork as simple as possible for you. In thinking about the form, though, what you're – really ask whether you have to bother with the other items that are outside of your scope of practice and the answer is no, because there is question that asks does this affect your treatment. You check off, no, and

that's it. So you still have that page there, but it doesn't affect your time in completing it.

Jane Park: OK. And then when do you want us to submit this form to scan this into your system? I guess you need to scan this, because there is a barcode in each page.

Barbara Gage: No, we will be scanning the forms. I'll turn it over to Judy to speak briefly about the submission process.

Judy Abbate: Thank you. So when the form is completed, we will – you will batch them and every two weeks or depending upon, again, how we arrange things with you, you would simply put them in a mailer that we provide with a label and mail those off. We do ask that you keep a copy. But it's a pretty simple process as far as – an in terms of providing what the PT needs, OT, we work with you individually and make sure that the tool that you're filling out meets your needs.

Jane Park: Right. And then you need this form filled out every two weeks, is that what I hear?

Judy Abbate: Every two weeks, you batch up what you have and put them in a mailer and drop them in the mail.

Jane Park: But you only ...

Judy Abbate: And then ...

Female: At the start of their services and at the end of their services.

Jane Park: So you only need it – the admission and you only need it for discharge, so in between, you have any new patients, you want to just keep submitting for new patients, not for the one patient (inaudible) just for every new patient?

Judy Abbate: Correct.

Jane Park: Is that what – OK, I understand.

Judy Abbate: ...Medicare patient.

Jane Park: And I have a ...

Natalie Highsmith: I'm sorry, Jane, we have to move on to other callers in the queue. If you have more questions, you can submit them through the e-mail address.

Ann Meadow: And let us know how to contact you, Jane, please.

And the answer to the question about if a patient reports that they didn't realize any improvement, does this affect payment, the answer is no.

Natalie Highsmith: OK. Chrissy next question, please.

Operator: Your next question comes from Tina Dodson from Arizona. Your line is now open.

Tina Dodson: They already answered my question. Thank you.

Operator: If you would like to withdraw your question, please press the pound key. And your next question comes from Jon Morren from Maine, your line is now open.

Jon Morren: Hi. I'm Jon Morren. I'm from Maine Coast Memorial Hospital. And my question deals with proxies. I know at the last conference call, the last one you did back in 2008, there was some question about that. How have you planned on dealing with the issue of proxies on the patient information?

Ed Drozd: With respect to planning on them – first of all, on the front page of (inaudible) which has – which is the instrument that has the patient reported items, we have a small process by which we help the practice determine whether or not it is advisable to have an assistant or a proxy to complete the form with the patient. And so, we have a small battery by – why does the – why might the patient need an assistant. We anticipate that patients who are in great need of assistance, many of them will have someone who has come with them and will be able to assist them.

With regard to proxies who – that you may have to provide to the patient is there and no other person is able to assist them, when we set up your site for participation, we will work with you to help determine who might be – you may be able to use as a proxy. This could include people who already in your practice, may have to assist patients with information gathering prior to the clinician seeing them.

Jon Morren: I see. Now, I do see at the bottom of page one where it lists the different types of proxies, what it doesn't list here might be a paid caregiver, you list companion, not family, and I just wanted to clarify, if I could, other types of caregivers who are not necessarily just a friend be a proxy based on what you've have looked at already.

Ed Drozd: Yes.

Jon Morren: OK, good. Just want to clarify that.

Ed Drozd: OK.

Operator: Your next question comes from Danielle Haggerty from Maine. Your line is now open.

Danielle Haggerty: Hello. It is Daniel from Dragonfly Therapy. I was wondering with regards – and you touch upon this just earlier. If the assessment tool from initial evaluation and to discharge does not show an improvement, let say we used a standardized outcome measure which we do in our practice and that does

show improvement, is there any problem (inaudible) as far as reimbursement goes?

Ed Drozd: This does not affect reimbursement. And if you feel that there are issues between the items here to identify function and you feel that there is a change in function and that you've identified using some other instrument that there has been an improvement and for some reason, you feel that these instruments do not identify an improvement in function, then there is at the very end of the assessment (inaudible) useful information or the feedback section, please let us know that you have other tools and please identify the tool that had indicated the there has been improvement. And, so it would help us understand what might be limitations in this particular instrument so that we can advise CMS on modifications and improvements.

Danielle Haggerty: Great. And I do have one other question following up on that. If we use the tool instead of a tool that we're currently using, should we be audited or anything like that if we asked for additional information, can we submit this tool as the additional information?

Barbara Gage: Well, (inaudible) any requirements that you have from your insurers, well, that is a Medicare thing, so there are none.

Danielle Haggerty: Yes.

Ann Meadow: We will take that question down and talk to the – our colleagues here at CMS about it. And we will post information about it on the Web site.

Danielle Haggerty: Thank you.

Operator: Your next question comes from Genine Kolman from Virginia. Your line is now open.

Genine Kolman: Hi, this is Genine Kolman from Fair Oaks Hospital in Virginia. My question is, are there going to be any exceptions to the volume requirement?

Ann Meadow: What kinds of exceptions are you speaking about?

Genine Kolman: My concern is that, I do have one of those specialty clinics, we see neurological patients only, often when somebody has a head injury or a stroke you know they're on caseload for three months. So we're not doing as many new evaluations as maybe a clinic that's doing acute back pain or post-operative rotator cuff repair. So, we would be excluded based on the fact that we wouldn't have 20 to 30 new evaluations per month.

Barbara Gage: Yes, as we mentioned earlier, the estimated enrollments will vary as we speak with individual providers, given your populations and your practice sizes, so, that's not hard and fast ...

Genine Kolman: Yes. So, that's not a requirement?

Barbara Gage: No.

Genine Kolman: OK.

Ann Meadow: The reason that we mentioned those figures is to you know there is some effort on each site's part to participate. There is involvement in training and the other activities we talked about, and if you are willing despite the low number to make those, to put time aside to participate and (inaudible) the assessments and go through the training and administer the research as we train, then we certainly welcome your participation.

Ed Drozd: Yes, we do not want to let those particular targets – and we use the word target specifically – to prevent their being as full representation of the full range of patients receiving outpatient – receiving therapy covered by Part B.

Genine Kolman: OK. Thank you.

Operator: Your next question comes from Ken Mailly from New Jersey. Your line is now open.

Ken Mailly: Thank you. You just addressed one question that I had and I would just add the comment that I'm glad to hear that you're looking to make sure you have a good accurate representation because that volume requirement could certainly screen out the small provider that doesn't see anywhere close to 20 new (inaudible) patients per month. So I would just add that comment.

And I just wanted to ask what discussions or conclusions you've had regarding this form then becoming part of the patient record, thus requiring the provider to maintain the original of this record that apparently you would want to have sent back to you?

Barbara Gage: Yes. This does not become part of the patient record. It is – it does have patient identifiable information and needs to be treated the same way as any other patient information that you treat around your office. But does not go into the record for long term. We will ask you to keep a copy for probably a two-month window, just to make sure that the data that we received, that there aren't any questions that we need to ask you about it.

Ken Mailly: Well, I guess my concern is more related to state requirements that might exist as to whether or not this would constitute patient related information because the patient is completing information, as is the clinician. I understand it's for research purposes. But because of the fact that you know there is patient information here, I think actually where my concern is coming from is at the state level.

Barbara Gage: We can look into this further, but these same questions applied to other work that we've done in this area. And it is not – the data that are collected under Medicare research initiatives, they're not considered part of the patient's medical record typically.

Ann Meadow: But because they are personally identifiable private information, they would be subject to the same precautions you take under HIPPA and your state's requirements.

Ken Mailly: OK. And just lastly, very quickly, I know you've said that invitations will be sent. What will be used as the database for sending those invitations?

Ed Drozd: The – first we will use the list compiled with providers who have expressed interest and hopefully as a result of this call, that list will increase. Secondly, we use Medicare administrative claims data. It is – it will be slightly stale. I mean, it cannot be totally current, but we will use that plus other administrative data on providers who participate in the Medicare program to identify a potential set of providers who we will recruit. However, we first and foremost, will follow up with providers who have expressed interest.

Ken Mailly: OK. Thank you.

Ann Meadow: And I also want to add to that that the list, again, for efficiency sake, we are – (inaudible) the list depends on the throughput of patients. Again, purely, for efficiency sake, but we're not meaning to discourage smaller practices – far from it. We just made that decision to develop our list of providers who in history have a modicum of patient throughput so that we can be efficient.

Natalie Highsmith: Chris, next question please?

Operator: Your next question comes from Debbie Park from Florida. Your line is now open.

Male: Hi. We have just two questions. One has to do with if we've identified a patient that we've targeted for this and the patient declines to participate, does this create a problem? And is there is any need for the patient to sign a release before we can submit the information to you?

Barbara Gage: Thank you for asking that. The patient who declines to participate, you would not want to use that patient. You wouldn't have admission. You wouldn't have a start of care and end of care information, so you would set them aside.

In terms of needing the patient's consent you were basically asking, they are a Medicare covered by definition of the – being involved. So, a patient consent is not required. Probably out of politeness, you would be asking them if they would be willing to complete this form as part of a CMS research initiative.

Male: That's great. Now I have the second question and that is, in our particular situation, we operate multiple clinics and under three NPI, but we would like to be treated as an aggregate one participant. Would that be possible?

Barbara gage: You have three providers?

Male: Yes, we have provider numbers and thus, we have three NPIs. But we would like to be identified or work as a single – not have to be doing – be seven participants.

Barbara Gage: Yes. We can talk to you further about that. Obviously, each NPI would need to be submitted for RAC exclusion, et cetera.

Male: Right.

Barbara Gage: In terms of the training and all, we would want to work through the numbers.

Male: Yes, that would be all coordinated.

Barbara Gage: Yes, yes.

Male: Yes. OK, that answers my question. Thank you.

Operator: Your next question comes from Patrick O'Donnell from New Hampshire. Your line is now open.

Patrick O'Donnell: Hi, I just got a question. I'm on a Web site and I'm looking at the questionnaires essentially at assessment and discharge and obviously this is all self-reported, both assessment and results. Am I right in seeing that there's really little to no objective functional data that comes from the physical therapists themselves when it comes to this?

Ed Drozd: With regard to function for the ambulatory or community-based patient, the – by and large, the issues of the detail on functions are patient reported as opposed to clinician reported. We do ask for the primary reason for therapy which is based on the international classification of function, medical condition and there are set of – a variety of items related to certain impairments that may affect the need for therapy, in the utilization for therapy – excuse me – that are supplemental.

But, based on feedback that we had received in a variety of venues, there was a great deal of interest by the independent practice community for having the patient reported items for a reduction of burden on the clinician.

Patrick O'Donnell: OK. It's just, from my understanding, I know there's a lot of questions in terms of the payers and you know with the diagnosis of, let say it's just generalized lumbago in why one patient could be potentially get better in three visits and another not get better in 16 visits. And a lot of times there is a lot of objective background that answers that question which I see, you may get some of that with the comorbidity information here. But – and again this is for another day, but I think at some point a study that reflects some of the objective data in measurable you know physical data may help out with this whole goal as well.

Ed Drozd: And for those who do participate and feel that there are – is a great deal of difference between how a patient is rating themselves with regard to function and how the clinicians might be, first and foremost, that we want to

understand that in the feedback and other useful information that you can provide and say, this patient looks like X on this set of assessment instruments that – but that the patient is just reporting something that looks very different.

That is something that we would want to understand and something that we would want the clinicians to be able to provide to us.

Ann Meadow: Yes, thank you for that question.

Ed Drozd: And Barb, did you have anything that you wanted to ...

Barbara Gage: Yes.

Ed Drozd: ... add?

Barbara Gage: And this was one of the key differences between the nursing facilities, the more impaired level form, the CARE-F form and the CARE-C form where the CARE-F form uses these clinical – the clinician's assessment of function based on the underlying (inaudible) and all of that which has worked into the CARE tool.

The CARE-C does rely on the patient's self-report and this is based on research which has shown that self-report and clinical assessments on the ambulatory population is statistically equivalent.

So, we are interested, Patrick, in continuing this discussion if you like. CMS's goal is to have the best set of items for this population.

Patrick O'Donnell: OK, thank you.

Barbara Gage: Thank you.

Operator: Your next question comes from Claudia Owen from Washington. Your line is now open.

Claudia Owen: Yes, it's actually Janet Rickey. I'm the physical therapist. And I'm in a rural setting. And I'm just wondering for patients that I don't typically follow with a phone call because they're doing just fine on their own, that I've maybe only seen twice or maybe three times, is there going to be a way to send them their discharge paperwork in the mail that they can then, I don't know, mail back to me and then I mail it to you or they can just mail it directly to you?

Judy Abbate: I think in terms of how we set this up, if they can – we certainly would want that information from the patients. And if we can work with you, but I think that mailing to – back to your agency might be the best way to keep track of these patients who have those self-care assessments. But that's a very good question. And I think that we can work with you on that and yes, we do need that information from the patient.

Claudia Own: That was one of the reasons I couldn't do FOTO because they didn't really have – the patient had to come back in, but it's just too many miles, and they're doing fine. They need to come back in, so.

Barbara Gage: Yes. And that's part of what we are trying to get around with this effort. The rural populations are as important as all the others, so thank you for asking.

Ann Meadow: And this is Ann Meadow, I just want to mention that for sending batches in order to provide for data security, the U.S. Postal Service has trackable methods of mailing, mainly certified mail, so what we're envisioning is that every time you send a batch, it would be by certified mail and in tamper-evident mailing envelopes so that we can protect the privacy of the data.

Ed Drozd: And one last remark is that with regard to population such like yours, and there could be other situations that it might not be possible for us to fully appreciate prior to attempting this data collection, we want – one of the important pieces of information that we want to be able to get out of this study is the feasibility of a variety of different modes of data collection, the information being – as well as the information being collected. So all of this is important for analysis and for (inaudible) understanding of what are feasible features of alternatives to the current payment methods.

Natalie Highsmith: OK, Chris, next questions, please.

Operator: Your next question comes from Herbert Silver from Georgia. Your line is now open.

Herbert Silver: Yes, can you hear me?

Natalie Highsmith: Yes, we can.

Herbert Silver: Yes, I was looking at the form and you have for diagnosis, it has like a primary and secondary. And a lot of times the problem with (inaudible) that I see is (inaudible) their back hurts, they have an arthritic knee, their feet are messed up and their shoulder is messed up. It doesn't really allow – you're missing the complexity of the diagnosis there.

Ed Drozd: Well, there are some responses to that concern. First of all, with both the primary reason for therapy as well as the medical diagnoses, we do instruct to check all that apply. And a part of that complexity if you feel the (different) multiple primary, and we – again, we do ask for all that apply, the combination of the primary reason for therapy which – part of which is body structure, as well as the other component of that functional measure, as well as the primary medical condition, that both of those we will put together to try to understand whether that level of coding can support identifying the complexity that you described.

Barbara Gage: That's a good point for noting that you can check off for more than one primary condition. We would not expect that in the majority of cases, but that patient that you're describing, that's perfectly fine.

Herbert Silver: Thanks a lot.

Operator: Your next question comes from Carol Hofbauer from Ohio. Your line is now open.

Carol Hofbauer: Hi, good afternoon. I am actually in a long-term care setting and I guess it might be a slightly politically incorrect question to ask, but I'm going to ask it anyway. This project sounds wonderful. I'm wondering if what kind of communication there is with Congress, the (exception) process, the current one expires at the end of this year and this project goes well beyond that? And I am wondering if there's any kind of communication to try to coordinate the final project with keeping the exception process going so that we can continue to work with our patients you know without the constraints of the caps right now since this is, was to be the alternate – an alternative approach to the caps.

Ann Meadow: This project was conceived several years ago and was conceived as a five-year project.

Carol Hofbauer: And I remember that from (inaudible).

Ann Meadow: Yes, so a research project and it's – that's what it is. It's research. We're not meaning to affect policy in anyway at this point. We want to collect data and understand the case mix or the severity differences and whether this could be useful in improving the payment system eventually.

Male: OK.

Natalie Highsmith: OK. Chris, we have reached out 3:30 hour here on the East Coast. And I'll turn the call over to Ann Meadow for closing remarks.

Ann Meadow: I want to thank everyone for their interest and their good questions. We – the staff is available for any and all types of questions and we will (attempt) to update – keep the Web site updated with answers. Please feel free to contact the project via the e-mail address [Optherapy@rti.org](mailto:Optherapy@rti.org) . There's also a way to send an e-mail directly from this site which again is the project Web site which is <http://optherapy.rti.org> . And again, thank you very much. We look forward to working with you.

Natalie Highsmith: OK. Chris, can you tell us how many people joined us on the call today?

Operator: We had 735 participants.

Natalie Highsmith: Wonderful. Thank you, everyone.

Operator: This concludes today's conference call. You may now disconnect.

End