Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: April 16, 2020

Moderator: Michael Hanna
Time: 1:00 p.m. CST

Condition of Payment Prior Authorization for Lower Limb Prostheses

Good afternoon and welcome to this CGS Administrators DME MAC Jurisdiction B and Jurisdiction C collaborative "Ask the Contractor Teleconference." These ACT calls are hosted by the DME Provider Outreach and Education team. Joining POE staff on the call this afternoon are subject matter experts from CGS Medical Review. For this particular ACT call, you are welcome to ask questions related to Condition of Payment Prior Authorization for Lower Limb Prostheses.

CMS added the following six HCPCS codes for Lower Limb Prosthetics (LLP) to the Required Prior Authorization list:

- L5856
- L5857
- L5858
- L5973
- L5980
- L5987

Prior authorization for these codes has been delayed by CMS over concerns for the safety and health of our supplier community and Medicare beneficiaries due to the current COVID-19 crisis. While the DME MACs do not yet have a specific date for the program to begin, we still want to provide program information so you can begin preparation for the prior authorization process in the future.

Until the delay was announced, prior authorization for these codes was set to be implemented in two phases. Phase 1 limited the prior authorization requirement to four states, one state per DME MAC jurisdiction, while Phase 2 was set to expand the program nationally. For Phase 1, CMS established the four states as California, Michigan, Pennsylvania, and Texas. At present, the DME MACs have no indication these states will change when the prior authorization goes "live" for the applicable HCPCS codes.

Certain claim types are excluded from prior authorization programs described in the Operational Guide, which is available on our website. The following claim types are not applicable for prior authorization submissions to the DME MAC:

- Veterans Affairs
- Medicare Advantage Plans
- Part A and Part B Demonstrations
- Indian Health Services
- Representative Payees are excluded from any prior authorization that is not implemented on a national level. Thus, any Representative Payee situations are not applicable for prior authorization in any Phase 1 states until the program is expanded nationally.

I want everyone to be aware that no LCD or K level requirements are changing with prior authorization. Please review the LCD for Lower Limb Prostheses (LLP) (L33787), the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations, and Policy Article A55426, Standard Documentation Requirements for All Claims Submitted to the DME MACs to review the coverage criteria or documentation requirements.

When prior authorization begins, suppliers of prosthetic limbs should send the Condition of Payment Prior Authorization (PA) Program Request Form, a completed standard written order and medical records that support the need for the HCPCS code in question to the DME MACs. The medical records should include information in the beneficiary's medical record from an encounter with the treating practitioner and may include information from an encounter with the prosthetist. Prosthetist's records can be used to support the need for the item and used in conjunction with the treating/ordering practitioner's records.

- **Jurisdiction B Request Form:** https://www.cgsmedicare.com/jb/mr/pdf/condition_of_payment_prior_auth.pdf
- **Jurisdiction C Request Form:** https://www.cgsmedicare.com/jc/mr/pdf/condition_of_payment_prior_auth.pdf

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as documentation created by an orthotist or prosthetist, become part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support medical necessity of an ordered DMEPOS item. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

When submitting a prior authorization request package to CGS, the request can be submitted via the myCGS Web portal, Electronic Submission of Medical Documentation System (esMD), fax, or U.S. mail.

For initial submissions of documentation, the DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within ten business days (excluding federal holidays and weekends) of receipt of documentation for the initial prior authorization request.

If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within two business days of receipt of the expedited PA request. Suppliers may request an expedited review on the request form, but the validity of the expedited request will be determined by the DME MAC.

If the documentation in the Prior Authorization Request packet is valid and the DME MAC feels coverage criteria are met, the request will be deemed "affirmed" and the supplier will receive a letter with a Unique Tracking Number (UTN).

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They are then ready to move forward with preparing the prosthesis and submitting the claim.

If the documentation is lacking in some manner, the supplier will receive a non-affirmation letter detailing the reason(s) why there were problems/issues with the documents. After making corrections or acquiring new documents, the supplier can resubmit documents to the DME MAC and will receive a decision within ten business days. For any resubmission of documentation, the DME MAC will also communicate a written decision to the requester/submitter within ten business days.

Suppliers will receive a decision letter of the affirmation or non-affirmation with the UTN. The claim must be submitted with the UTN.

For submission of a prior authorization request using the CMS-1500 Claim Form, the UTN is submitted in the first 14 positions in Item 23. All other data submitted in Item 23 must begin in position 15.

For submission of electronic claims, the UTN is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

For esMD, be sure to use the document/content type "8.4".

There are numerous resources on the Jurisdiction B and Jurisdiction C websites within the Condition of Payment Prior Authorization Program via the Medical Review section of each website. Our Lower Limb Prosthetic Required Prior Authorization web pages have links to the Operational Guide on the CMS website, links to the Lower Limb Prostheses LCD and links to the PDF from a recent CMS Open Door Forum. There are also a number of pertinent resources to help you with preparing for Prior Authorization; What Suppliers Need to Know, a Dear Physician letter, the Documentation Checklist and more. The links to both web pages on the Jurisdiction B and Jurisdiction C websites will be added to the final transcript.

- **Jurisdiction B website:** https://www.cgsmedicare.com/jb/mr/llp_prior_auth.html
- **Jurisdiction C website:** https://www.cgsmedicare.com/jc/mr/llp_prior_auth.html

Just to reiterate one more time – prior authorization for the selected six lower limb prostheses HCPCS codes has been delayed by CMS. Please continue to monitor our ListServs, News web pages and the Lower Limb Prostheses Prior Authorization web pages for updates.

As we prepare to queue your questions, please note that we will only take questions over the telephone as this call is being recorded for transcription purposes. To raise your hand, simply click on the icon of the hand. Then, I will announce you and unmute your individual line so that you can ask a question. Also remember that no specific claim information or Medicare beneficiary's private health information should be verbalized. I will now give you just a moment to prepare your questions…

Michael: The first question comes from **Joe:** Go ahead, Joe, that line is open.

Joe: Michael, can you hear me okay?

Michael: Yes, I can. Go ahead, please.

Joe: Two questions, if you don't mind. One – do you guys have any direction from CMS on whether there will still be the same gap between prior authorization in the four states versus the national? Before the delay, there was a five-month margin there?

The second question – when you state that clinical reviewers will be reviewing prior authorization documents, does that include nurse reviewers? Does that include any other staff such as a certified prosthetist? Does it include both? I think you have a certified prosthestist at CGS now. Will they be involved in the reviews?

Michael: Very good questions, Joe; I will answer them in order. For your first question, we don't have any information from CMS on what they plan to do once the delay ends. Once they decide on the point in time to resume the prior authorization process and re-release the target, or "go live" dates, we will notify the O & P supplier community. As for the reviews, we will utilize our staff available, which are our registered nurses and our certified prosthetist and orthotist.

Joe: Okay, thank you. Very helpful.

Michael: Thank you, Joe, for your questions. We appreciate you dialing in today. The next question comes from Laurie. Go ahead, Laurie, that line is open.

Laurie: I just have a quick question. Once we have taken a claim through the prior authorization process and gotten an affirmation, does it guarantee that these will not be audited after the fact by CERT, RAC, or ZPIC?

Michael: The RAC contractor should not audit these claims as we send a report to them of all claims we have conducted prior authorizations on – just as we do with other prior authorization projects and claims we review on the front end. Thus, they should be aware of what we looked at via the prior authorization process. From a CERT standpoint, everything they choose to review is at random, so they always have the ability to take a claim that has been reviewed by another contractor. They don't take into account whether a claim has been reviewed or not – everything is chosen at random on a claim by claim basis that was submitted and paid by the DME MAC.

Laurie: Okay, thank you.

Michael: You are welcome; we appreciate it, Laurie. Curt's hand just went up. Go ahead, Curt.

Curt: Are they any discussions about expanding prior authorization in the O & P universe?

Michael: Not at this time. If you recall, a number of HCPCS codes were added to the Federal Registry. Since that time, CMS has - for lack of a better term – been parceling out some HCPCS codes as they delver further into the prior authorization arena. These six lower limb prostheses HCPCS are the first foray into the O & P. From a discussion standpoint, I don't know what they plan to do in the future. These six codes were part of the Federal Registry list, though. I know the O & P industry has been wanting this for a while. This is based on information I have gleaned from sources at events and webinars.

Curt: Okay, thank you.

Michael: Thank you. Travis, that line is open. Go ahead, please.

Travis: A question that might be off topic, but I wonder if you can help me. Our business address is located in North Carolina, but we have patients in South Carolina. Do we need to do anything additional in order to treat these Medicare patients on both sides of the state line of North and South Carolina?

Michael: From a prior authorization standpoint or overall?

Travis: Both.

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Michael: Once the prior authorization program goes nationwide for these six HCPCS codes, you will be able to treat beneficiaries who live in both North and South Carolina. I would not be able to speak about the requirements from a state perspective, however. You would need to reach out to the individual states for that. For example, some states have a "brick and mortar" law where you must have a physical presence. I have seen this from the DME side, so you want to make sure you are following all appropriate rules. For Medicare, you will file any prior authorizations and claims to CGS as both states are in Jurisdiction C. Outside of that, I am unable to provide guidance.

Travis: Okay, I appreciate it. Thank you.

Michael: Thank you, sir. While we are waiting for that next hand to come up, review those six HCPCS codes. Go out to our website and take a look at our Condition of Payment Prior Authorization section and the web page dedicated specifically to Lower Limb Prior Authorization. Make sure you are comfortable with the information found therein. Feel free to review the Prior Authorization Request Form so when the process goes live, you will be ready to submit documentation packets.

Judie: This is Judie with CGS. Just a quick follow-up on the question about additional codes being subject to prior authorization in the future. There is a Master List of codes, but all do not require prior authorization. If chosen, the codes are put on the Required List of prior authorization. That list is available in the Federal Registry. These are HCPCS codes that are subject to prior authorization, but they are not at this time. Just a bit of clarification for everyone. Thank you, Michael.

Michael: Thank you, Judie. We can add that URL to our transcript so it's available for everyone. I appreciate you providing that today. Erin, your line is open. Go ahead with your question, please.

Note added after the call: Here is the URL for the Federal Registry notification and list of HCPCS codes: https://www.cms.gov/files/document/esrd-qip-final-rule-2019-24063.pdf-0

Erin: Hi. My question is more of a process question regarding prior authorization and how it's submitted. Prior to this, a colleague had mentioned that the prior authorization should be submitted by the referring physician and not the O &P provider. I wanted to verify this.

Michael: It is best if the O & P supplier submits the documentation. You can request, however, for CGS to send the response to the referring physician. On the request form, you would have to note the name and address of the physician you wanted to receive a copy of the response. Since you are providing the items to the Medicare beneficiary, I think it is best for you to submit the prior authorization to CGS.

Erin: Okay, wonderful. Thank you so much.

Michael: You are welcome. Any other questions for you, Erin?

Erin: No, thank you.

Michael: Susan, that line is open. Go ahead, please, Susan?

Susan: I know we have these six codes, but when we submit a claim, we usually have other codes with it. Will this be separate from those codes or will we need to submit claims separately for the other codes? For example, socks, liners, things like that.

Michael: That's a wonderful question, Susan. When you file your claim, we are aware there will likely be other L-codes with the HCPCS code that has gone through prior authorization. You are more than welcome to file the entire claim that includes everything – every applicable L-code – you provided to that Medicare beneficiary. Be sure, though, you have an affirmed prior authorization for the L-code that requires it. Also be sure your UTN is on the claim. Angie or Judie, did either one of you want to add something to my response?

Judie: This is Judie again. Thank you, Michael. You can submit all applicable codes [for the claim] with the prior authorization request, but we will only review the L-code that is required for prior authorization. We will not be able to affirm any of the other HCPCS codes on the request or subsequent claim.

Susan: Thank you very much, I appreciate it.

Michael: Thank you for your input, Judie, I appreciate it. Maria, that line is open. Maria, you might need to unmute your personal line; I can't hear you.

Maria: Can you hear me now?

Michael: Yes, I can.

Maria: For the codes that do not require prior authorization – does that hold up any process for us? Do you recommend leaving them off and only submitting prior authorization for the codes that need it?

Michael: It's really up to, Maria. Our clinicians aren't going to spend time reviewing those codes that are not part of prior authorization. The codes that are included in prior authorization should be on your screen now. The one important thing to file all L-codes when you submit the claim. Make sure the UTN tracking number is on that claim, you have all of the necessary codes and their respective modifiers when you file the claim to Medicare.

Maria: Okay, thank you.

Michael: Thank you, Maria. Karen that line is open, go ahead, please.

Karen: Hi, good afternoon. Thank you. I was just wondering if we failed to get prior authorization will be able to appeal that for medical necessity or how would that work?

Michael: You would get a denial from CGS on the front end when the claim processes and you do have appeal rights. You would then file a Redetermination case.

Judie: That would be after your claim is submitted. If you didn't go through prior authorization or the prior authorization was not affirmed, you would submit the claim. Then, the denied claim would go through the appeals process.

Karen: Thank you so much, I appreciate it.

Michael: You are welcome, Karen. Anything else for us today? The next line open with a question is from Jane. Go ahead, Jane.

Jane: Hey, Michael. My question is when we are submitting these claims to Medicare, would be it be better to have the L-codes that require prior authorization listed first on the claim? Then, list all of the other codes after that so it stands out. Or, does it make no difference where that L-code is listed in order on the claim?

Michael: It shouldn't matter. Speaking from a historical perspective, we have been doing prior authorization for power wheelchair bases and these are similar to the lower limb prostheses where there is going to be more than one HCPCS code on the claim. The main code for the base goes through prior authorization and the supplier then includes all of the appropriate wheelchair accessories with the approved base on the claim. Your lower limb prostheses claims will follow the same

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process where the L-code is affirmed in prior authorization and you file a claim with that approved code as well as other codes on the claim. Some suppliers will put the power wheelchair base HCPCS code as the first line on the claim and you are more than welcome to that, too, with your lower limb prostheses codes.

Jane: Okay, thank you.

Michael: You are welcome. Was that it; did you have any other questions for us today?

Jane: No, sir.

Michael: Joe, I saw your hand come back up. Did you have another question for us?

Joe: One of the things we get a lot of questions about is whether or not the prior authorization provides any protection to other codes that are part of these claims from additional audits, so I wanted to ask it this afternoon.

Michael: From a CGS Medical Review perspective, we will not be looking at other codes associated with that claim. As I stated earlier with the other caller, other contractors, such as the CERT, do post-pay reviews and might choose one of these codes. For some contractors, like the UPICs, it will depend on what they are looking for and that might play a role in claims or specific codes on claims being chosen for review. Of course, I can only speak to CGS Medical Review, there shouldn't be any other pre-pay reviews from CGS once you have the prior authorization for one of the six applicable L-codes.

Joe: But they could do a post-payment review on codes that do not require the prior authorization? Not the microprocessor knee code that was affirmed in prior authorization, but others? I am sorry to get "in the weeds" on this, but it is a question I get asked often.

Michael: The only reviews the DME MACs can do at this time are Targeted Probe and Educate. I can't give you a complete answer because we don't know what CMS will do in the future or what other auditing entities are doing or will do. At the present time, all of our reviews are TPE and those are pre-pay reviews. They are supplier-specific and we are looking at specific HCPCS codes. From a Jurisdiction B and C perspective in recent months, there have been no TPE reviews on wheelchair accessories, wheelchair seating or wheelchair back systems associated with the power wheelchair bases that require prior authorization. I can only surmise the same will hold true for all of the L-code associated with the six HCPCS codes for lower limb prostheses that will require prior authorization. Does that help at all, Joe?

Joe: It does. Let me ask it another way, and I am not trying to confuse you at all. One of the things we get asked is this – if the "base" code is covered are you going to review the other L-codes that will be on the claim with the approved prior authorization code? Will you spend time reviewing any of these additional codes as they will be necessary for the full functioning of the prosthesis? Does your process include a general determination of the whole package so when the prior authorization is approved, you will not do any additional reviews? Some folks are concerned they are going to get a prior authorization for one of the six L-codes, like a microprocessor knee, but on the back end, will another contractor feel some of those other codes are not medically necessary?

Ed: Michael, this is Ed from Medical Review. Joe, our prior authorization is specific to those six codes and we will review those based on reasonable and necessary guidelines per the LCD. I think that in terms of "does it protect other codes on the claim" it really depends on that individual contractor and how they approach that claim. From a prior authorization process at CGS, we are going to specifically review those L-codes that have been selected for prior authorization. Of course, we will take into consideration thing such as functional level, etc. which could go along with the other codes listed on that individual claim. Our prior authorization review is directed towards those six HCPS codes.

Joe: That's fair enough, and I appreciate it. I am not trying to be difficult; I am just trying to get some answers based on a lot of questions we get at AOPA about this process.

Ed: We can appreciate that, too. I know there is typically a number of HCPCS codes on these claims and I can understand some of the confusion about this. I think we need to be clear that the prior authorization process is just for those six L-codes that have been chosen and listed for prior authorization.

Joe: Thank you, very much. I appreciate it.

Michael: Thank you, Joe. Good questions and good commentary on a process that is new for the O & P suppliers. Thank you for your input, Ed. I see the hand came up for Karen. Did you have another question?

Karen: Yes, I did. My team lead and I were discussing my previous questions and we were wondering if we did get a prior authorization and for whatever reason that prior authorization was denied, could we appeal the prior authorization? Should we go for a second prior authorization and provide additional documents or what?

Michael: If you received a prior authorization and it was non-approved, we will let you now the reason or reasons why we were unable to affirm it. You are more than welcome to make any corrections to documents or get additional documentation and resubmit. For example, maybe the standard written order was not signed by the physician and you missed it. You can send it back to the physician and have them sign it, then resubmit the entire packet to us. Once we get the second submission, we will review the entire documentation packet on its own, so be sure to send the entire documentation packet to us. Once we get that resubmission, we review the documentation and provide a response back to you. It's not an "appeal" of the original information, you are simply providing additional documentation or correcting the errors from the original submission.

Karen: Thank you, I appreciate it.

Tonnette: Michael, this is Tonnette, a Medical Review manager. For prior authorization, we have unlimited resubmissions, so if you don't get it right the first time, send it in a second time. We will reach out to you after the second submission and let you know what the problem is with the documentation.

Susan: Okay, perfect. That really helps, thank you so much. I do appreciate that.

Michael: Thank you, Tonnette. Thank you Karen, very good question. Amy, I am going to try an unmute your line. Amy, that line is now open; can you hear me okay?

Amy: Hi. Can you hear me?

Michael: Yes, I can.

Amy: I was just wondering if there is a time frame on the prior authorization. How long is it from the beginning to the end?

Michael: When the process begins until you have to provide the prosthetic or the time it takes us to review the documentation you submit?

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Amy: To review the documents. Is there a time limit on when you make a decision based on what we send in?

Michael: We have been instructed by CMS to make that decision within 10 business days. That is for the initial submission as well as any resubmissions – we have 10 business days to review your documentation and provide a response to you.

Amy: Okay, thank you.

Michael: You are welcome. Susan that line is open; go ahead, please.

Susan: What if we wind up changing the coding on our end. For example, we start with an L5856 and end up changing that to an L5858. Would we then submit a new case or would that be considered a resubmission within that 10-day period presuming we receive a non-affirmation from the original submission?

Michael: For any resubmission, you want to send in the entire documentation packet back to us. Tonnette, would you like to add anything?

Tonnette: Yes, if they change the code, then it would be considered a new initial case. If you submit with the same code with additional documentation, that's considered a resubmission. If you change the code and submit, we would consider it an initial submission. Does that answer your question?

Susan: Yes, it does. Thank you.

Michael: Jane, I saw that hand come up again. Do you have another question for us?

Jane: I do. Based on the question prior to this, when we are talking about an approval given for a prior authorization and we receive it, is there a time limit on the prior authorization? Medicare Advantage Plans, for example, approve something for three months or six months. Are there any timeline dates on prior authorizations from CGS?

Michael: I want to make sure I understand the question. Once you receive the affirmed response from CGS Medical Review with a UTN tracking number, are you asking how long you have to submit the claim to CGS? That's my understanding, is that correct?

Jane: For the most part, yes. Is there a window of time that we have to deliver the prosthesis to make sure it doesn't "time out" during the process?

Michael: I don't think we have that information. Tonnette, do you happen to know?

Tonnette: We haven't received that information quite yet from CMS. I am sure when we get direction, we will let the supplier community know, but we just don't have that information on the timeliness of delivering the prosthetic. That information will come from CMS.

Jane: Alright, thank you so much.

Tonnette: Thank you.

Michael: Thank you, Tonnette and Jane. Good questions. If we have this information by the time we publish transcript, we will add a note in the section of the transcript where your question is, okay?

Jane: Okay, thank you.

Note added after the call: CGS did not receive any additional information by the time the transcript was uploaded to the CGS websites

Michael: Susan, did you have a question?

Susan: Yes, will this determine whether or not the patient will get a microprocessor knee? In other words, will you look at other underlying problems, like COPD, for example. Will this determine whether or not the patient can get the prosthetic?

Michael: First of all, the Lower Limb Prostheses LCD is not diagnosis driven. But, we will consider the totality of the medical records submitted. We will determine if the K-level is accurate and is it medically necessary for that particular beneficiary. Is that what you are asking?

Susan: Yes, that's exactly it. That's a much better way of putting it. That's what I was trying to get across with their underlying health and whether or not they can utilize the microprocessor knee.

Michael: Our clinicians will definitely take a look at the HCPCS code submitted for prior authorization, the medical records from the treating practitioner, the medical records from you, the CPO, to ascertain if it makes sense medically to provide that particular prosthesis for that patient.

Susan: Very good, thank you very much.

Michael: Monica, that line is open. Go ahead, please.

Monica: If we receive a denial, say, on flex foot, and the patient demands having it anyway. Is a signed ABN valid on that, even though it was denied?

Michael: I want to make sure I understand… You requested a prior authorization for a beneficiary and we provided a non-affirmation back to you because medical necessity was not met. But, the patient wants the prosthesis anyhow?

Monica: Correct.

Michael: You can get a valid ABN and submit a claim to CGS.

Monica: That ABN would be enforceable to bill the patient for the item?

Michael: That is correct. You will have information on the front end via the prior authorization non-affirmation that the prosthesis is not medically necessary due to whatever reason. The reason(s) will be the response letter from CGS. As such, you can use those specific reason(s) on the ABN you provide to the beneficiary. As a reminder, make sure you append the appropriate GA modifier to those claim lines.

Monica: Oh, of course. Thanks.

Michael: Good question, Monica. Any other questions today? I will give everyone one more moment to raise their hands… The next question comes from Susan. Go ahead, Susan, that line is open.

Susan: Okay, I wanted to know if these Medicare Advantage Plans going to follow along with this as well?

Michael: I can only speak for CGS as the DME MAC contractor for Jurisdictions B and C. You would have to reach out to those advantage plan health insurance companies to find out if they are going to do any prior authorizations on the same HCPCS codes. It is my understanding from different conversations with O & P companies, a number of advantage plans are already involved in prior authorizations on a number of HCPCS codes, both DME as well as O & P. We, however, are unable to answer for them and you must reach out to the individual companies.

Susan: Second question. Are we going to get CEUs today?

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Michael: CGS does not offer CEUs for our education. I did provide the PDF version of the presentation I used today. I also provided a certificate of attendance for this afternoon's ACT call. You are welcome to take both documents, and the transcript when it becomes available, to your accrediting organization as they may provide you with some sort of credit for today's educational event. The decision will be on their part, though. The documents I mentioned were sent to all registrants via email earlier today and they are in the Handouts section of your GoToWebinar dashboard. You can download them from GoToWebinar until I conclude the webinar end it today.

Susan: Thank you, I appreciate it.

Michael: You are welcome. Any other questions for us today? I want to give you one more opportunity to raise your hand. Thank you, again, to our O & P suppliers for taking time from your schedule to attend this afternoon's call. Thank you, also, for continuing to assist our Medicare beneficiary population during this COVID-19 pandemic. I am sure they appreciate you being available for your client population during this time.

Michael: I will conclude today's call. Please monitor our ListServ and ACT web page for notification for the transcript publication.

Call ended.

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