Special Open Door Forum:
Medicare Documentation Requirement Lookup Service
June 25, 2020
2:00 pm ET

Coordinator: Welcome, everyone, to today's conference call. At this time, your lines have been placed on listen-only for today's conference until the question and answer portion of our call, at which time you will be prompted to press star 1 on your touch-tone phones. Please ensure that your line is unmuted, and please record your name when prompted, so that I may introduce you to ask your question. Our conference is being recorded, and if you have any objections, you may disconnect at this time. I will now turn the conference over to our host, Ms. Jill Darling. Ma'am, you may proceed.

Jill Darling: Great, thank you so much, (Jill). Hi, everyone. This is Jill Darling, in the CMS Office of Communications, and welcome to today's Special Open Door Forum. Before I hand the call off, just one brief announcement. This Special Open Door Forum is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call.

If you do have any inquiries, please contact CMS at Press@CMS.HHS.gov. And now, I will hand the call off to Ashley Stedding.

(Ashley Stedding): Thank you very much, Jill. Good afternoon, everyone. I want to thank you for joining us today, and welcome you to our fifth Special Open Door Forum on the Medicare Documentation Requirement Lookup Service. Before we get started today, I just want to make participants aware that there is a slide presentation for today's forum, that is posted on our CMS webpage, for those that wish to pull up the slides and follow along.

The link to the webpage is included in the calendar invite and the announcement for today's forum, and it is go.cms.gov/MedicareRequirementsLookup, and the M in Medicare, the R in Requirements, and the L in Lookup must all be capitalized. So again, that's go.cms.gov/MedicareRequirementsLookup.

Moving on to introductions, my name is Ashley Stedding and I'm a Management Analyst in the Provider Compliance Group at the Center for Medicare and Medicaid Services. I'm also the Government Task Lead for the Medicare Fee for Service Documentation Requirement Lookup Service project, and I'll be helping to facilitate today's session.

Also on the line with me today is (Connie Leonard), who is the Acting Director of the Provider Compliance Group at CMS, along with a couple of members of the MITRE CAMH team, including (Larry Decelles), who is the project technical lead, (Bob Dieterle), who's the project technical advisor, and (Nalini Ambrose), who's the project lead.

In this session, we are going to start by providing a quick overview of the Documentation Requirement Lookup Service, or what we refer to as DRLS for short, for those who may not have attended any of our previous forums.

We will cover this current state of the DRLS prototype development and pilot testing, we'll provide a summary of the DRLS activities that have been occurring to advance awareness and buy-in amongst stakeholders, we'll look into the future as we anticipate next steps, and also identify ways that folks can stay informed or get involved in this initiative, and finally, we'll open the floor up for questions from participants at the end of today's session.

So to kick today off, I'm going to spend just a couple minutes doing some background on why CMS is interested in this initiative and give a quick overview of the Documentation Requirement Lookup Service. And for those of you who might be following along with the slides, we're now moving on to slide five.

So why is CMS interested in DRLS? Through a number of provider listening sessions, CMS has been hearing feedback from providers who are saying that documentation requirements are too hard to find.

And as part of this provider listening session, CMS has also heard repeated suggestions that payers should, one, publicly disclose their requirements in a searchable electronic format, and two, clearly communicate to the prescribing and ordering providers what supporting documentation is needed for coverage.

Moving on to slide six and in continuation of the previous slide, this maze attempt to graphically depict the current environment or experience for providers of trying to find and accurately comply with Medicare requirements.

The Medicare requirements appear in various locations, which is typically true for most other payers as well, and this causes burden on providers who must navigate the various Web sites to find requirements for coverage, including things like documentation and prior authorization requirements.

So as a result of this feedback, CMS launched the DRLS initiative, which is one of the critical steps that CMS is taking towards displaying our Medicare Fee for Service rules in an electronic format that will be easily accessible to providers from within their clinical workflow.

Moving on to slide seven, what is the DRLS and precisely what will it do? So the Medicare Fee for Service Documentation Requirement Lookup Service prototype is a software or electronic data exchange service that makes it easier for providers to find Medicare Fee for Service prior auth and documentation requirements right at the time of service, and right from within their electronic health record or integrated practice management system.

DRLS is an important piece of a larger workflow in the clinician's practice, and can also be a precursor to other important activities, such as prior authorization and electronic prescribing for durable medical equipment and other services. However, it is a standalone software, focusing on identifying the need for, locating and contributing to electronically completing coverage documentation.

DRLS essentially introduces automation into what is currently a largely manual process, by streamlining workflow access to coverage requirements, and we strongly believe that this automation will provide significant time efficiencies to the process of discovering prior authorization and documentation requirements, right at the time of service, thereby helping to reduce provider burden, reduce improper payments and appeals, and ultimately improve the exchange of information between providers and payers.

And with this, I'm going to turn it over to (Bob Dieterle), who's going to pick up on slide eight, and talk a little bit about the HL7 Da Vinci project, and how CMS is leveraging industry efforts. (Bob)?

(Bob Dieterle): (Ashley), thank you very much. This is Bob Dieterle. I'd like to talk a little bit about the history of the Da Vinci project. It started a little over two years ago and involves most of the significant players in the healthcare. In particular, on

the provider side, the EHR side, and some major health plans.

The goal of DaVinci is to establish an industry-led effort that can start to address the issues related to exchanging information in value-based care by making the exchange easier to do and uniform across the multiple stakeholders. The goal is to reduce the number of unique solutions that an individual organization, whether it's a payer, provider or an EHR vendor, needs to support to make those exchanges possible.

Our focus is on creating standards that are valid and published by HL7. To create reference implementations that can demonstrate these capabilities and be used as example code for those organizations that are trying to develop this capability of exchange, using these standards.

Da Vinci membership currently includes roughly 46 different organizations, 16 EHR or HIT vendors, 15 payers, 12 provider organizations, and three industry associates, such as HIMMS and NCQA. Da Vinci currently has 16 active and planned use cases. Thirteen of those have actually been kicked off and have produced implementation guides or are in the process of producing them.

Many of them have gone through balloting and are in the process of resolving the ballot comments, and ultimately publishing.

Next slide, please.

Slide number nine depicts the individual use cases grouped together according to the domain they're trying to address, such as quality improvement, coverage or burden reduction, member access, process improvement, and clinical data exchange.

This slide also shows the status of each of these. Those that have gone through ballot are in the burnt orange. Those are that have recently gone to ballot or are in the process of going through ballot are either the white, light grey, or lighter blue. Those that are in the planning process are in the darker blue.

What we're going to talk about today are three of the use cases that are focused on coverage burden reduction. In particular, we'll focus on two of them: coverage requirements discovery, which is where a provider, as they're planning a treatment or intervention for a patient is able to ask the responsible payer, "Is there anything I need to know or do?" Such as collect specific documentation to show medical necessity, or to collect documentation to support prior authorization to proceed with full documentation requirements.

Documentation templates and rules are where we take the rules for those things that require collection of information, bring (the rules) to an application executing in the context of the provider's EHR. This application has the ability to extract information from the medical record for the particular patient using the FHIR APIs that are part of the ONC final rule requirement, and make them available within a construct that looks like a template, but is called a FHIR questionnaire.

Where information is missing, that FHIR questionnaire has the ability to prompt the provider, and by provider, we mean anyone in the provider's organization that's appropriate. It could be the provider that is interacting with the patient, it could be someone in a back office, or it could be somebody at the front desk.

The goal is to collect the missing information and make it available, either discrete data or as a document in the medical record. In addition, the resulting

information would be exchanged to support prior authorization or to support the ability to order a post-acute service.

We'll explore these two implementation guides further. CMS has called the combination of the two guides DRLS or Documentation Requirements Lookup Service. At this point, I'd like to hand it over to Larry Decelles, who is going to walk us through some of the details of the project from the point of view of the Mitre Corporation, who has been tasked with creating DRLS.

(Larry Decelles): Thanks, (Bob). Presenting how DRLS operates within the clinician's normal workflow, and from within their EHR, let's look more closely at what DRLS will look like with a clinician. These four boxes capture the scope of DRLS in the clinician's workflow. They show a scenario where the clinician is helping Medicare Fee for Service patients.

He or she needs to know whether and what documentation Medicare Fee For Service requires for the item or service he or she would like to request. Starting with the first box, the clinicians or staff initiate the DRLS inquiry for a Medicare Fee For Service, when a service is planned or ordered. The CRD part of DRLS will begin by having the EHR as Medicare Fee For Service, ask whether there are coverage requirements, including documentation or prior authorization requirements.

In this scenario, the Medicare Fee For Service DRLS responds by saying no, prior authorization is not required. But yes, there are documentation requirements. The clinician and/or staff will click a web link. This is the DTR part, to initiate the second request - a second request asking for specific documentation requirements.

DRLS will return a questionnaire and rules electronically, and a SMART app

will repopulate these fields with any existing applicable FHIR based data from the EHR. So, the clinician and/or staff doesn't have to manually enter it. DRLS also will identify unpopulated fields, which the clinician and/or staff can and would manually enter to complete the questionnaire.

Once complete, an electronic copy is stored within the EHR. After DRLS finishes in near real-time, the clinician and/or staff can perform necessary actions to ensure compliance with the Medicare Fee For Service rules. These are core functions of the DRLS.

How it works in practice, the look and feel or user interface will be determined by each EHR vendor. Next slide, please. So now we're going to get into some of DRLS's current status. So, next slide. Now you should be on slide 12, for those of you following along.

So, we continue to update the implementation guides and reference implementations to ensure alignment and accuracy. By using open source coding, we are able to encourage other organizations to test, evaluate, and integrate DRLS code into their systems. The implementation guides undergo HL7 validating, which essentially means that industry participants review the content, make comments, and then as a group resolve discrepancies.

The links here are also included at the resource slide, at the end of this slide deck. You're welcome to visit them, to see where DRLS is now, and try it out in your own environment. Next slide, please. So, pilot testing of DRLS and DRLS's reference limitations began last year and is continuing in 2020.

Let's visit the graphic illustrating the DRLS information exchange between the provider and the payer, using the two Da Vinci use cases, CRD and DTR, that (Bob) described earlier. As shown in the top two arrows, CRD, if any

documentation or prior authorization requirements are needed. The second pair of arrows, DTR, then retrieve documentation requirements and rules and populates them with EHR data.

We tested this exchange last year, using the next two types of testing. The first being point to point testing, which tests the transaction and the interchange between a single provider and a single payer. In our case, CMS Medicaid Fee For Service. Multipayer involves a single provider with multiple payers.

We have been able to successfully test the endpoint transaction with several other commercial payers. The third form of testing is provider acceptance testing, where clinicians will test DRLS in their clinical workflow, and make an assessment as to whether DRLS sits within their workflow, whether it reduces their burden, and gives feedback.

We have been conducting ongoing pilot testing, at HL7 connectathons with continued testing through August and possibly beyond. Next slide, please. The project team maintains steady engagement with Rush Medical University, and its instance of Epic throughout the beginning of the year.

The COVID-19 pandemic changed priorities for many providers, with whom the team had been discussing further pilot testing. We have been able to pilot test and demonstrate with the reference implementation.

One of the important elements to making DRLS relevant is their ongoing collaboration with clinicians, vendors, and other payers. So far, we've demonstrated successful data exchange in test environments with CRD and are continuing to improve the DTR exchange through our pilot process.

The project team has demonstrated its ability to exchange data between payer

systems and providers - in the provider's EHR, using both current and older versions of key technologies, but increased pilot testing is critical to move this forward.

Let's talk a little bit more about the requirements for pilot testing for healthcare providers and EHR vendors. Next slide, please. For folks following along, I'm on slide 15. While many are interested in DRLS, the technology for many EHR vendors is not yet capable of handling it. Specifically, DRLS with FHIR R4 (version 4.0.1).

But many EHR vendors use earlier versions of FHIR. Also, FHIR has not been fully adapted within all EHR environments. Next slide, please. We often hear questions from interested healthcare providers and vendors about pilot testing. We are interested in testing DRLS with a variety of practice settings and situations.

We thought it would be helpful to lay out the key roles and responsibilities to participate in pilot testing. We'd like to work with providers who order items and services for Medicare Fee For Service patients. EHRs need to have sufficient technical capability, mainly CDS hooks and FHIR capabilities.

As we mentioned earlier, not having these capabilities presents challenges. But the recent ONC rule that specifies the use of FHIR R4 should help here. To test DRLS, your healthcare provider will be asked to simulate orders and will require dedicated IT staff to work on an integration of the DRLS with their EHR.

As this is part of CMS, the expectation would be that experiences would be shared with CMS and the Da Vinci project, with which CMS is aligned. This helps us shape DRLS to be more valuable for users. Okay, next slide is slide

17. As we mentioned earlier, DRLS can be an important for the many requests clinicians may have for their patients.

Where do we start? The Medicare Fee For Service DRLS reference implementation is being developed and tested with a number of rulesets. What do we mean by rulesets? Let's look at home oxygen therapy, as an example. Typically, this is initially called a topic. The ruleset is the combination of rules and questionnaires.

It combines to make up what we call rulesets for a topic. Rulesets are related to ordering specific items or services. These will be part of the DRLS pilot testing. Currently, we're building ten different rulesets, which are listed on this slide. These rulesets are in various stages of development. The ruleset collection is based on improper payment rates and other factors.

Completed rulesets will be provided in the reference implementation DRLS repositories; such as CDS Connect. And with that, I'm going to hand it over to (Natalie Ambrose).

(Nalini Ambrose): Thanks, (Larry). Good afternoon, everyone. I'd like to give you an overview, starting on slide 18, on our pilot testing activities this year. For those of you who've attended previous DRLS open door forums, you may recall that we started pilot testing last year, with the Rush Medical Center out of Chicago, and their EHR system, Epic.

And this year, we've continued pilot testing with Rush and Epic; we've successfully tested both CRD and DTR use cases for home oxygen therapy orders, as (Larry) mentioned. We also participated in four Connect-a-thons, starting from September of last year through May of this year.

Three of those have been HL7 Connect-a-thons, with one Connect-a-thon being a CMS Connect-a-thon held in January of this year. These Connect-a-thons were very successful where we engaged with the EHR vendors and other health IT vendors, payers, industry stakeholders and Da Vinci members, to test DRLS, and we've made ongoing refinements and updates to the implementation guides and reference implementations for DRLS.

We've also developed a pilot testing demonstration, a video which was prepared for the HIMSS Da Vinci interoperability showcase, which of course later became a virtual forum. We've continued to explore newer versions of tools, such as CDS Hooks and other tools, as (Larry) pointed out, to help us continue to improve DRLS as we progress through this year.

And outside of these Connect-a-thons and other forums, we've also engaged with several provider systems and EHR vendors to continue assessing these systems' readiness and functionality for continued DRLS testing in the upcoming year.

So with that, moving on to slide 19, for those of you who are following, we've also continued convening the industry stakeholder leadership group that we started in June of 2018, which has over 50 members from diverse groups, with representation from the government, commercial payers, healthcare providers and clinicians, EHR vendors, et cetera.

And this group has been extremely engaged and active. We have very engaged co-chairs who facilitate the workgroup from industry, including a physician, and a payer representative, in identifying some of the challenges related to DRLS. This group has provided multiple strong recommendations for successful development, implementation, and adoption of DRLS in the future.

There is also a smaller workgroup that has focused its efforts on some targeted priority areas for discussion this year, which I'll review quickly on slide 20. So there are three major priorities that were identified by the DRLS stakeholder leadership group this year. One is to raise DRLS awareness and improve buy-in and adoption, using stakeholder outreach and education activities, as well as the consideration of incentives to move DRLS forward.

Two is structuring and standardizing not just payer requirements across the board, but also the data elements, and third, addressing clinical workflow challenges and how DRLS might be able to be implemented seamlessly into a clinician's workflow, and any user experiences that might be related to DRLS.

We're working on compiling the workgroup recommendations now. We're in the final stages of fine-honing them, and we plan to share the workgroup recommendations with industry stakeholders later this summer.

Moving to slide 21, in addition to some of our stakeholder engagement activities that I just talked about, we participated in multiple forums, such as the AMIA Symposium in DC last year, the ONC annual meeting, and the CMS Quality Conference earlier this year, where we shared information about the DRLS initiative and have also engaged with potential pilot testing participants, to be able to explore their willingness and readiness for pilot testing.

And we also presented on DRLS at the HIMSS virtual forum. Moving to next steps for DRLS, moving on to slide 23, we see four major activities that would be important to continue in relation to DRLS; the first being - continued standards development for both the CRD and DTR use cases, which are anticipated to go through to the end of 2021, as of now.

Secondly, continued development of the electronic rule sets that (Larry) mentioned, and additional rule sets for a variety of topics, such as durable medical equipment, home health, et cetera. And thirdly, both the CRD and DTR cases need to have continued pilot testing in industry to carry them through to maturity.

So, if there are any listeners who are interested in providing assistance and any EHR vendors who are interested in continued pilot testing, please feel free to reach out to us after the call. And last but not least, early and ongoing stakeholder engagements with industry experts is very critical to continued success of DRLS. And with that, I will hand it over back to you, (Ashley), to wrap up.

(Ashley Stedding): Thanks, (Nalini). So, before we wrap up on our presentation for today, we wanted to highlight some of the primary ways for folks to stay informed about the work that's involved in this initiative. So to keep up with current DRLS-related activities, we encourage you to visit the Web site listed here, on slide 25, and email us at the address provided with any questions.

And then for those who might be interested in learning more about any of the other related topics discussed in these presentations, we have also listed additional relevant links and resources here on slide 26 of the presentation. And that brings us to the end of the presentation portion of today's session, so at this point, Jill, we are ready to open it up for questions from participants.

Coordinator: Thank you. At this time, if you would like to ask a question, please press star 1 on your touch-tone phone. Please ensure that your line is unmuted and please record your name when prompted, to be introduced. Once again, it is star 1 at this time. We have a question from (Morgan Ford). Your line is open.

(Morgan Ford): Great, thank you. How does CMS plan to connect the API data of other payers? Will the payers need to build their externalized APIs?

(Larry Decelles): Hi, this is (Larry). Can you repeat the first part of your question for me?

(Morgan Ford): Sure. How does CMS plan to connect the API gateway to other payers?

(Larry Decelles): CMS is acting currently as a payer. So, every payer is implementing a common API. So, a provider's EHR would have endpoints or URLs to each individual payer/API environment.

So, for example, the SMART app runs client side within a browser. That would have a list of payers that you could reach out to and ask the two questions. Is documentation required? If it is, then a follow-on request would be sent to retrieve rules and templates.

So, essentially we would probably enumerate a list of endpoints. I will say there's some work going on with this. It's not so much a DRLS project right now, but there are folks that are looking at an interface to manage the list of endpoints of all the payer endpoints, a payer directory as opposed to a provider directory. Does that answer your question?

(Morgan Ford): Yes, thank you. Will payers externalize APIs for that?

(Larry Decelles): I'm sorry, can you repeat that one more time?

(Morgan Ford): Will payers need to externalize APIs for that. I know you mentioned having like a direct...

((Crosstalk))

(Larry Decelles): Yes.

(Morgan Ford): Okay.

(Larry Decelles): Yes. That would need to be exposed on the internet. Yes. There is security...

(Morgan Ford): Thank you.

(Larry Decelles): ...involved, so it's not like it's wide open on the internet. So, but yes, it would have to be out on the internet.

(Morgan Ford): Thank you.

(Larry Decelles): You're welcome.

Coordinator: Once again, if you would like to ask a question, please press star 1 and record your name at this time. You have a question from (Greg Lotz). Your line is open.

(Greg Lotz): Thank you. From a standpoint (unintelligible) testing representing an EHR vendor myself in a post-acute environment rather than hospital, looking at the list of current participants, those EHRs listed are (unintelligible) which are predominantly hospital-based. Would you be interested in supporting testing from an EHR that would be mostly in the home healthcare market versus those supporting some of the predominantly hospital-based listed?

(Larry Decelles): Sure. This is (Larry Decelles). Yes. I'm sure we would be interested in. If you saw the slide deck one of our rules (test) is for home health services. And so,

we would definitely - it's not just hospital-based environments, it could be any clinical environment - a small practice if you will.

(Greg Lotz): All right. So, I will forward that up to upper management because we are able to support the (FHIR) version 4 with our software platform. And reach out as they choose to respond.

(Larry Decelles): Okay. Thank you.

Coordinator: We have a follow-up from (Morgan Ford). Your line is reopened, ma'am. (Morgan), your line is open. If you're on mute, we are unable to hear you. As a reminder, if you would like to ask a question please press star 1 and record your name when prompted. We have a question from (David Johnson). Your line is open.

(David Johnson): Yes. I was curious if you guys could talk a little bit more about the FHIR-based questionnaires. I'm familiar with the questionnaire methodology, but just kind of how that's working and how you see it working across multiple payers and multiple entities.

(Larry Decelles): Yes. This is (Larry) again. Yes, we get that question a lot. It sounds like a two-part question. I'll talk a little bit about the questionnaires and then get into the second part of your question. We're using the LHC tool set. I don't know if you're familiar with that, at this site you can actually build questionnaires. It's been quite helpful.

(David Johnson): What is that site?

(Larry Decelles): https://lhcformbuilder.nlm.nih.gov/

(David Johnson): Okay.

(Larry Decelles): I'll work with CMS to include this link. You can actually import things like (lung) panels and they have a whole way to develop questionnaires. I think to answer your first question, I'll describe what we're doing there.

And then we have CQL that will run client side to run rules. That's what's accessing our FHIR based data when we're doing the pre-population. The second part of your question was about how - I think you were asking how our payers are going to share these or utilize these.

(David Johnson): I'm just curious. Yes. Across the industry when you have multiple payers and different entities, how you kind of envision that.

(Larry Decelles): Yes, right now DRLS uses two use cases as (Bob) mentioned. Those two use cases are architected so they are really not concerned where the rules come from.

So, it could be a common repository or you could work out a mechanism to retreive them from multiple repositories. The issue might be whether or not payers are going to share common rules - that's something that, could be done but we haven't really crossed that point yet. I don't know if that answers your question.

(David Johnson): It does. Is it okay if I ask one more - steal the ball and ask one more little follow-up question? So, with the questionnaire specifically, like you have sometimes let's say you have 15 questions, are they - are the questionnaires you're doing dynamic? So for example, sometimes if you know the answer to

the third question is no, you don't need to ask the rest of the questions, or is it the kind of thing where you have to go through all of the questions every time?

(Larry Decelles): Yes, to the first part. For example, if we find out your gender is male, we're not going to ask, mammography type questions.

(David Johnson): Sure.

(Larry Decelles): We call it short-circuiting. So yes, that's definitely a big part of our questionnaires.

(David Johnson): Excellent.

Coordinator: Once again, please press star 0 - I'm sorry, star 1 if you wish to ask a question. Once again, it is star 1. Please record your name when prompted, to ask your question. At this time we show no further questions.

Woman: (Ashley), do you have any closing remarks?

(Ashley Stedding): Sure. I just want to thank everyone so much, for joining today and expressing your interest in this important initiative. And please feel free to reach out to our mailbox if you have any questions. And thanks again.

Coordinator: This does conclude today's conference call. We thank you all for participating. You may now disconnect and have a great rest of your day.

End