

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Certificate of Medical Necessity (CMN) and Durable Medical Equipment (DME)
Information Form (DIF) Elimination Discussion
Wednesday, May 27, 2015
Moderator: Jill Darling

OPERATOR: Good afternoon. My name is (Mike) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services' Certificate of Medical Necessity and Durable Medical Equipment Information Forum Elimination Discussion Special Open Door (Forum).

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

Mr. Dan Schwartz, you may begin your conference.

Dan Schwartz: Thank you, (Mike), and hello everyone. Thank you very much for joining us. My name is Dan Schwartz. And I am from the CMS, CMS' Provider Compliance Group.

And today, we're going to talk about the Certificate of Medical Necessity, or CMN, and DIF elimination. We're going to have a discussion about that. So, thank you all for your participation and we look forward to hearing your input.

I do want to direct you to this slide deck that was posted on the reducing provider burden website. And probably the best way to get there is just to Google "CMS" and "reducing provider burden," the actual website itself is rather lengthy. But it'll basically just to say and echo the remarks I'm making today.

So I guess sort of the question or the first, the (similar) question is, why are we here? And, really, what we're here to do is to explore ways to reduce burden in providers and suppliers. So we're asking for your feedback and whether to eliminate the CMN forms and the DIF forms as required – as documents, the required documents, to determine medical necessity.

Sort of past history, CMNs were developed to provide evidence of medical necessity. And we found that CMN information often conflicts with the medical record itself, which our reviewers ultimately look to. We do have a mailbox that we've established. And right now, we're having some technical difficulties with it. And we will post at that under reducing provider burden website when we confirm that it's working appropriately. So check back there. The mailbox is reducing, with a capital R, provider, capital P, burden, capital B, all one word, ReducingProviderBurden@cms.hhs.gov. And once we confirm it's up and running, we'll keep it open for a couple of weeks just to make sure everyone's opinions, comments, thoughts can be heard. So we really do want to hear from all of you and get your feedback.

So, I guess the questions that were really, you know, that we really want to hear from you on are sort of (along) the same lines. And those are, what will be the impact of eliminating the form, the forms be on you? Would it increase or decrease your burden? And do you recommend keeping or eliminating the CMN?

So, I guess, we – I'll turn – and it's CMN and DIF. I'll turn it over to (Mike) now to sort of go through those three questions or to get your feedback on those three questions. What would the impact be on elimination? Would this increase or decrease your burden? And do you recommend keeping or eliminating the CMN? And with that, I'll turn it over to (Mike).

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

And your first question comes from the line of a participant whose information was not available. If you have asked the question, please state your name. Your line is open.

Kathy Lester: Hi. This is Kathy Lester. Can you hear me?

Female: Yes.

Dan Schwartz: Yes, Kathy, we can hear you.

Kathy Lester: Thanks, sorry. One - thank you for holding this forum. I'm here representing the Council for Quality Respiratory Care, which includes home respiratory care, providers, and manufacturers who care for just over half of the Medicare beneficiaries on home oxygen and sleep therapies. And obviously, because the CMN has been part of the home oxygen documentation, this is a very important issue to our members. And, you know, I get – my question for you is sort of your sense of timing and your process, but as you'd like, I can go ahead and answer the three questions you've post as well.

Dan Schwartz: Kathy, if you don't mind starting with sort of answering the questions and then we can sort of address any possible timing of as a follow-up.

Kathy Lester: Sure.

Dan Schwartz: Yes, that'd be great.

Kathy Lester: So, an answer to the first question, what is the impact of eliminating the forms? I think that, you know, one of the concerns of the CQRC has had (real large) has been about making sure that they are objective criteria. One of the experiences our members have had repeatedly with the DME MACs is having them – DME MACs deny a claim stating that the medical record does not indicate either the appropriate (length) of need or a number of other objective

criteria that are clearly set forth on the CMN. And so, the CMN has been a vehicle to establish that, in fact, there was medical need for the device, and the beneficiary is able to retain that through either the QIC process or the ALJ.

So I think, you know, one of our concerns about eliminating the CMN would be that if it were not replaced with objective criteria whether that could be part of the written order or some, ultimately some sort of electronic template, that serves as the primary place for providing the information that is confirmed by the medical record.

So, I think, you know, if there isn't that objective criteria, there will be an increased burden in terms of the number of denials that we would expect to see. However, if the CMN is removed because I know it's not perfectly aligned with where the local coverage determinations are, you know, we think if there is an alternative way of having that objective information provided by the physician, that that would be sufficient to address our concern, and then I think, you know, eliminating the CMN would eliminate some of the burden. But it's just really important to maintain that objective criteria so we can have at least that opportunity to make sure the claim is ultimately get paid.

Dan Schwartz: Thank you, Kathy. As far as timing goes, I think we really want to hear from the community before we sort of make a decision along those lines. So I think – I don't know that we have a particular time at this point, but it's certainly something we're considering. Thank you.

Kathy Lester: Thanks.

Operator: Your next question is from (Kathy Schmuck). Your line is open.

(Kathy Schmuck): Hi. I'm (Kathy Schmuck) and I represent a small local full service DME in Kalispell, Montana. The impact of eliminating the forms, I think that ties to question number two, the increase or decrease in your burden. It really depends, and I'll use an example. What's going to backfill it; it'd be put in place, again, as your first question or maybe stated also.

In particular, the oxygen CMN, that's the focal point for much of the references within the oxygen LCD. And so, I'm curious what would be replacing some of that or how that LCD would be revised. I think I'd like to see a revision of that LCD before I would say whether I wanted to keep or eliminate specifically the oxygen CMN. And then specific example of that is the oxygen CMN that asks whether the (stats) were taken well in a chronic stable state.

With the doctor answering yes or no to that, being the only one that can complete that, and then by signing that CMN attesting to that, that helps us as a supplier know whether that beneficiary was in a chronic stable state when those (stats) were taken. Otherwise, it becomes a little bit more subjective for the supplier to be looking through the medical records to determine.

So they kind of all tie together. And I think at first look, it appears that it may decrease burden not having to have those CMNs go back and forth. But I worry about what the full picture is going to look like, again, in the revision of that LCD and how that all falls out. So, that's it.

Dan Schwartz: And thank you. – Thanks for that point. You know, obviously there was need – there may be impact as far as LCDs go and that's something, (I think), we consider.

Operator: Again, if you would like to ask a question; press star one. The next question is from (Judy Bunn). Your line is open.

(Judy Bunn): *Thank you. I work for a regional supplier in the Midwest and we've seen the removal of CMNs for manual wheelchairs, power wheelchairs, hospital beds. From our perspective, and we work very closely with our national association as well as with all four regional carriers. Our experience is that the CMN is simply a placeholder effect for the processing of claims.*

All of the information that is on that CMN, including the chronic stable state question, must be proven in post-pay or pre-pay audit by the documentation that we should already be gathering anyway. For example, a physician, I've had the unfortunate experience of a physician stating that the test was done in

chronic stable state when the test was very clearly done in the emergency room, we shouldn't have taken the oxygen for that patient and we were rightly denied payment. So, a physician attesting to something on a CMN form when the medical record contraindicates is not necessarily proof that the claim should pay.

The proof is in the medical records which we are already required to get. The testing must be in the medical record. The chart notes must be in the medical record for those components that require that require the ACA component of the DWOPD where we're required to meet those requirements as well. In our opinion, the CMN is a burden which we would happily eliminate. Thank you.

Dan Schwartz: Thank you very much.

Operator: Your next question is from (Lorrie Corey). Your line is open.

(Lorrie Corey): Thank you. I'd have to agree with that last caller. Our burden is getting the paperwork upfront. The CMN is really a huge chore to get the physician to even fill it out, and we've spent so much time going back and forth. And as the last caller said, it doesn't hold up in an audit, it does nothing for us. Everything has to be substantiated behind that. So the amount of time that we spend trying to make that CMN right does us no good in the ultimate end if our documentation was not (in a row) to begin with.

We would love to see that CMN eliminated, and we would welcome the opportunity to – if there was a portal where you could upload all of your documentation so that you guys could review at anytime you wanted. If we're doing a good job as a provider, then that documentation is right, and we're proud to stand behind it with or without the CMN.

Dan Schwartz: Thank you very much for the comment.

Operator: Your next question is from (Virginia). Your line is open.

(Virginia): Hello. I represent Keeler's Medical Supply in Yakima, Washington. And I think I'm going to just kind of agree with the general consensus of the last two

ladies. Everything that we transmit on our CMN has to be supported with the chart notes. If we all just inputted the lowest saturation and the information and the fields that all of our systems are already set out for, they are absolutely right. The CMN itself is really of no value. It cannot stand alone. We get an intake order that gives us our length of need when the client is initially ordered the oxygen and everything, like the last two ladies said, subsequently must be in a chart note. And getting those doctors to put the lowest saturation is definitely more of a burden than me just inputting what I already have in front of me from our chart notes that we get on the setup day with the detailed order into those fields and letting that transmit.

I definitely agree that the CMN, especially on the oxygen, which I think is the reason we all keep hitting on that, is that's probably the most commonly used form out of all of these, besides possibly the food which again that DIF all have to be supported with the medical records. These forms do nothing to standalone. If they stood alone as the information that would be needed in an appeal status, they would still be very useful. Unfortunately, everything must be in a chart note to be a valid reason for the equipment to be used. So, I think eliminating these forms and just transmitting the information in what Medicare usually refers to as a dummy CMN status would be more than appropriate because our medical records support what we're transmitting, so – (I think that's it, though).

Dan Schwartz: Thank you very much.

(Virginia): OK, thank you.

Dan Schwartz: Yes, thank you. Thank you.

Operator: The next question is from (Lacey Cork). Your line is open.

(Lacey Cork): Yes, this is (Lacey). We run a DME down in the South, and a lot of our patients or a lot of the services that we provide are for pneumatic compression devices. And one thing that I've just noticed, you know, like I said, I'm going to agree with the last four ladies here, where, you know, no matter whether you have a CMN, if you have a supplier generated document, it doesn't

matter. It's not going to uphold and appeal or an audit, it still has to be documented in the note.

So if we're making sure that that's in the documented notes that we're obtaining from the physician in order to process that order and approve it based on the LCD for pneumatic compression, then, you know, it's – you know, like another individual said, it's just another document that we're trying to get the doctor to fill out when that information is already contained there somewhere else. And as long as we're adhering to what the LCD says and what the requirements of the LCD are and we have all of that, then why do we just need another document signed by the physician.

And particularly, I've heard a lot of talk about the oxygen, and this is the first time that the pneumatic compression LCD is being brought up. But if you look at the LCD and what's outlined for lymphedema and CVI with ulcers coverage, it doesn't – I don't find that the questions on the – the answers – I'm sorry the question from the CMN in Section B don't really apply to all situations. It's very limited in what you can provide. So, by just answering a question yes or no, you're not able to provide that additional documentation so that's why I think it's important to have that information in the notes like CMS required.

So, like I said, I think that elimination of the CMN would be quite fine, and it would definitely decrease the burden on our company here. So, my consensus, you know, like with the other three or four ladies that recently spoke is to get rid of CMN.

Dan Schwartz: Thank you very much.

Operator: Again, to ask a question, press star one. The next question is from (Sherry Hopkins). Your line is open.

(Sherry Hopkins): Hi, I am actually representing a lot of DMEs across the nation. I'm a patient advocate. And what I'm looking at, again, is the pneumatic compression device CMN. As (Lacey) said, the CMN has been outdated for a number of years now. It doesn't really match the NCD or the LCD. So, to eliminate it, it

would be a relief of burden on the industry and the patient that have to go through appeals and everything else because it's initially denied based on the CMN. Thank you.

Dan Schwartz: Thank you very much.

Operator: Your next question is from (Angela Hokes). Your line is open.

(Angela Hokes): Hi, my name in (Angie Hokes) and I represent Alick's Home Medical. I seem to agree with everyone in this matter, the CMNs are a burden, and trying to get the doctors to fill them out correctly, sometimes, I'm actually submitting them to the doctor three to four times because they do get frustrated there are so many little things. I mean if they miss even the duration, you have to send it back because, obviously, we can't touch it. And then, we get them back and we're faxing them so when they're coming back, a lot of times, CMS will state that they're ineligible because they have been faxed and faxed back and faxed back again. So I do agree with them, but my question to this is, will this cause more audits because you guys do not have the information upfront? And it seems like lately we are in an audit frenzy world, and I'm just afraid that if you do that, you guys are still going to want to obtain that information, and that would be the only way that you would be able to do it is through audits.

Jill Nicolaisen: This is Jill Nicolaisen, also from the Division of Medical Review and (Provider) and (inaudible). And I don't think we would expect that we would see an increase in audit. As we've said, what we're hearing from our medical review entities is that the information on the CMN itself is notoriously unreliable and often contradicts the information that is medical record. So I don't really think that we see a world that is much different than it is today.

(Sherry Hopkins): OK, thank you.

Operator: The next question is from (Judy Bunn). Your line is open.

(Judy Bunn): The only – thank you. The only other comment that I had failed said to make when I spoke earlier was the concern for timing to allow the carriers to update their systems to remove the CMN. I know that it occurred with beds, and I

know that it occurred with wheelchairs, but obviously, there does need to be some timing change there. Thank you.

Dan Schwartz: Thank you.

Operator: The next question is from (Tom Hemrick). Your line is open.

(Tom Hemrick): Thank you. Good afternoon. I would encourage use of the electronic medical record and mandating formatting since the government has incentivized physicians to move to an electronic medical record, why not then also format this information so that physicians are entering it directly, and reporting it out to suppliers eliminating a paper form altogether. Thank you.

Melanie Combs-Dyer: This is Melanie Combs-Dyer; I'm the Director of the Provider Compliance Group here at CMS. And we are looking at that. In fact, we have an initiative that we call the Electronic Clinical Template project. We have developed some data elements for a template for how our mobility device progress notes for oxygen orders, for lower limb prosthetic progress notes, and for home health progress note.

We continue to think about new ways to move forward with that project, more templates that we would like to develop in the future, and have actually begun working with ONC, the Office of the National Coordinator, for health I.T. to begin pilot testing some of those electronic clinical templates. If there's anybody on the phone who has suggestions about people who might want to participate in those kinds of pilot, using EHR systems to have providers enter exactly the right information, the Medicare needs right into the HER, we sure we'd like to hear from you, like you can respond to the e-mail address that's in the slide deck here and folks will root that on to the electronic clinical template project staff to pass along your suggestions about who might be interested in participating in those pilots. Thank you so much for this (inaudible) idea.

Operator: The next question is from (Kern). Your line is open.

(Kern): Hello. I'm pretty much in agreement with most of the other callers that the CMN is a huge burden on the provider currently with not only getting the doctor to complete the CMN correctly, but working as a large DME. We run into, quite often, a CMN coming in the payable status after we've gone out and gotten another initial CMN, which then pushes hours out of alignment causing us to go back and trouble the physician for yet another CMN. So I think it would not only alleviate a burden on the provider, but also on the treating physician.

Dan Schwartz: Thank you very much.

Operator: Again, to ask a question, press star one. The next question is from the line of a participant whose information was not available. If you have pushed star one, please state your name. Your line is open.

If you have asked a question, your line is open, please state your name.

The next question is from (Vicky Jones Mason). Your line is open.

(Vicky Jones Mason): ... and to obtain. But a question we currently utilize CONNECTs to check CMN status for oxygen equipment. And I was just wondering how would, that information become available to us, same, similar in the event that the CMNs are eliminated.

Melanie Combs-Dyer: This is Melanie again. And we may have to take that question down, and think about that one. I think your question has to do with using a MAC – a web portal to be able to see information about the Certificate of Medical Necessity. I don't know how that works today, and we will certainly follow up with that to see how that might work in the future. Thank you.

(Vicky Jones Mason): Thank you.

Jill Nicolaisen: So we ask that you submit that question in writing ...

Dan Schwartz: Yes.

Female: ... to the mailbox please.

(Vicky Jones Mason): Sure.

Jill Nicolaisen: Thank you.

Operator: The next question is from (Lorrie Corey). Your line is open.

(Lorrie Corey): Hi, I just wanted to follow up. I had commented earlier. But one of the things that I wanted to say as a respiratory company, that's all we do, so we have a lot of experience with the oxygen CMN. We employ one person that does nothing but work on trying to get those CMNs back.

So, from a burden perspective and a financial perspective, again, if it held up in an audit, it would be one thing, but the amount of money and time that we spend as a company suggest get those forms filled out correctly. I think the other callers stated they can go back – I mean three and four is really doesn't even speak to what we've seen from the physicians and how upset they get. And I think the burden on the provider is one thing, but then the burden on the physician is yet another. So, again, I'm fully, fully in support of getting rid of those CMNs. And, again, is there, any portal opportunities in the future where, like, uploading medical record so that they could be reviewed as needed. Any plans for anything like that?

Melanie Combs-Dyer: This is Melanie Combs-Dyer again. And our eClinical template effort is exploring the possibility of facilitating provider to provider sharing of information. So, for example, if a physician wrote an order using a template into their EHR and present it to the DME supplier, and then the DME supplier securely communicate back to the physician that have been left off of the order or what other documents needed to be sent, and sort of that backing and forthing that probably is done today through a fax machine. We think that may be very beneficial to providers in the future. And, again, we'd love to hear from folks that might be interested in participating in that, particularly around how our mobility devices, oxygen, and home health services, the places where we've already begun work on an eClinical template. Again, if you could respond to the e-mail box that's listed in the slide deck, folks can forward the information along to those teams of people.

Jill Nicolaisen: And this is Jill Nicolaisen. I think maybe you were asking about, is there a way that you could upload your documentation to a portal so that your MAC could get it when they ask for medical records for review. I know that several of the MACs are working on developing portals and may be close to having something like that in place if they don't already, so I suggest you check with your MAC to see if that's something that's available to you.

Melanie Combs-Dyer: There also is the electronic submission of medical documentation system, the esMD system. And if you'd like more information on that, you can go to www.cms.gov/esmd, like electronic submission medical documentation.

(Lorrie Corey): Great, thank you.

Operator: The next question is from Kathy Lester. Your line is open.

Kathy Lester: Hi. Thank you. I just wanted to echo what we're hearing a lot of and you heard from me before, which is how we can be part of the eClinical template initiative. I think that the concerns on both sides whether, you know, there are folks like me and my group who are concerned about not having that objective documentation, and those who are very vocal about this being a burden, all of that can go away if you have that eClinical template. So, you know, I think you already know this, but I'll offer up again, the CQRC willing to help, willing to work with you all to have our group help pilot and do what we can to really sort of move beyond this paper document chase and get to a very streamlined electronic system.

Melanie Combs-Dyer: Thank you very much. We really appreciate it.

Operator: The next question is from (Tim Wolf). Your line is open.

(Tim Wolf), your line is open.

(Pam Wolf): I'm sorry, did you say – it's (Pam Wolf), is that what you said?

Dan Schwartz: Yes, (Pam), please go ahead. Sorry ...

(Pam Wolf): OK, that's OK. No, I just want to – my question to this was, when you have the recertification, usually you send, you know, a recertification's certificate to the doctor. Would that – how would that be then? Would you just want chart notes sent then back and no forms when you have to do the (re-cert) in a year or the one after three months?

Melanie Combs-Dyer: That's correct.

(Pam Wolf): OK. That's the only question. Thank you.

Operator: The next question is from (Cindy Coy). Your line is open.

(Cindy Coy): Good afternoon. I just have a question with regard to – I agree with everyone else when they are talking about relieving that burden and it truly is a burden. I've just been curious of there is some information on that form, on the CMN form that we would still need to gather. And I'm not sure that – and the things that I'm talking about is like the length of need and some of those things. And so, I'm wondering, is there another document that you would be replacing the CMN with? I mean, would there be a requirement that we have maybe a WOPD that we are not required to have now for a concentrator? Or is there any – are there any alternatives that will be put in place of the CMN?

Jill Nicolaisen: So this is Jill Nicolaisen. I think that we heard a suggestion earlier that we may want to take some of those elements and add them to requirements for the written order prior to delivery. Certainly, that's something we could consider, but we would expect to see that type of information in the medical record anyway. So as long as it was documented in the medical record, it would not matter to us exactly what format the information was in.

(Cindy Coy): Yes, more times than not, the physicians are not documenting in the medical record what the length of need is. That usually comes to us through the CMN. So, we would need probably some education on the physician's side to be able to ask them to put that length of need in the medical records.

(Doris): This is (Doris) from Medical Review. (Inaudible) we have the LCDs that outline all of those things. And what we'll do is go back and review the (set

out) LCDs to make sure whatever requirement we come up with are based on the changes and eliminations of the CMNs and DIFs and that all the necessary documentation requirements are entered there. So, you know, we'll take a look at everything to make sure all our requirements are clear and you understand what is required for documentation. And once again, a lot of this stuff is already there. People just need to take the time and really look at those LCDs. And if you do have questions, you can surely call the DME Contractors to have them explain those LCDs to you if you're not getting what you feel you need.

Jill Nicolaisen: Well, thank you for that comment. Certainly, that is one of the things that we will consider, and if you had any specific suggestions, we would be glad to hear them. You can submit them to the e-mail address.

(Cindy Coy): OK, thank you.

Jill Nicolaisen: Thank you.

Operator: As a reminder, to ask a question, press star one. The next question is from Jim Bechtold. Your line is open.

Jim Bechtold: Hi, this is Jim Bechtold from Biomet. And I think I would agree with the early comment from Kathy. The CMN, to some degree, does provide a certain level of objective confirmation on some of the complex clinical issues. But it is certainly difficult to get in a timely manner. That's why the concept of an eClinical template that potentially has some logic built in, so certain questions that are redundant to another wouldn't be answered would – some of that could make the world of a difference in terms of being more meaningful and timely. Is there any consideration other than that of replacing CMNs with any other alternatives in review process? What's your thoughts; on that?

Dan Schwartz: I think we're – this is a listening session, so we are open to ideas that you – or suggestions that you or anybody else might have.

Jim Bechtold: I think the biggest drawn interest would be an intelligent eClinical template that doctors could complete or the suppliers complete with the doctor's participation.

Melanie Combs-Dyer: Thank you. This is Melanie. Of all the CMNs that are out there, other than power mobility device and oxygen, which one do you think we should put next in our list to create an electronic clinical template for? What should be next in our priority list?

Jim Bechtold: I think we should consider (oxygen) stimulators. That's one area that I'm involved with.

Melanie Combs-Dyer: Thank you.

Operator: The next question is from the line of a participant whose information was not available. If you have pushed star one, please state your name.

Kimberly Rogers-Bowers: Hi, this is Kimberly Rogers-Bowers. And I work for and represent a national provider, and we are also members with CQRC and the National Association of Home Care or the American Association of Homecare. And I, obviously, support the comments that were made by (Kathy). And that we do support the elimination of the CMN. However, you know, we have been hit with a number of audits through the last several years. And there's information that's definitely on the CMN that is very objective information that our recommendation would be that it is – that we clearly know that information which we do from the LCD that we would have either on our own written order prior to delivery or a detailed written order prior to delivery that is signed and dated by the physician.

Obviously, the electronic clinical record is the way to go and very excited to hear about that, and we will definitely provide information and details and our recommendations there. So thank you, Melanie, for that information. And the eClinical template is definitely the way that we want to go, but we realized that that might take some time.

So in the interim, I think the elimination of the CMN would be supported by a number of industry representatives. But we need to make sure that we have the objective criteria that we need and that if – you know, if we have – you know, there's five elements of a written order prior to delivery today, maybe there's 10 critical elements that are required on a written order to make sure that we are including the correct objective information that we need to ensure that we're not being denied so we end up in this appeal process which is severely broken.

Dan Schwartz: Thank you.

Operator: The next question is from the line of a participant whose information was not available. If you have pushed star one, please state your name.

Caller, if you have pressed star one, please state your name.

The next question is from (Rhonda Burmeister). Your line is open.

(Rhonda Burmeister): Thank you. I represent several DME suppliers or many DME suppliers for that matter across the United States. I work for member service organization. And I'm going to reiterate probably everything that's been said, but I just wanted to make sure that I got my opinion or point and I guess as well. But from what I had seen from my perspective from all of these different suppliers across the United States where the CMNs have caused (havoc) for the suppliers because of the increase in audit.

There was a time and day for CMNs (just as it was) for power mobility, hospital beds, and all the other ones and those were eliminated. And then in turn, documentation in the chart note, progress note or supporting documentation was required or asked of the suppliers in that same information that – for oxygen and (Enteral) and all the other ones, (TENS), all of the – are they still being required in addition to the CMN? So there have been many suppliers that have had money upheld, because of these audits and simple errors made on a CMN that the physician doesn't understand or whoever is not filling it out properly. But, all the information maybe in that supporting documentation or that progress note.

So I think there – I guess that there was a time and day for it, it works. But, now, it's time to eliminate those and I know that would be welcomed by many suppliers across the United States since they already have to gather that information and it is redundant. So – but I do agree with some of the other callers where they say doing the eClinical templates, electronic records, all of that will help the industry, especially in the way the pendulum swinging right now because of the decrease in reimbursement and (competitive bid) and all of that kind of stuff that's going on. So, anyway, long story short, I think it would be welcomed to have the CMNs eliminated and the DIF as well. So, thank you.

Dan Schwartz: Thank you for your comment.

Operator: The next question is from (Tom Hemrick). Your line is open.

(Tom Hemrick): Thank you. Just a quick suggestion, the (VA) health ordering, (VA) health systems, their ordering system is quite complete as far as the ability for physicians to get and obtain medical supplies. I have an elderly parent who is dependent in – or uses that system and I've seen it used very efficiently. I know the (VA) in the last couple of years has taken that kind of hard. But that is definitely one thing that the (VA) does well, and perhaps CMS could save itself some time and look at that system just initially.

Then the other comment I had was the blending of information that CMS already has in its system from the submission of Part A claims and other Part B providers to build up a total history for each client as the reviewing claims and to use the totality of the medical record that it already has.

And then the third point that I have is there are downstream contractors that often times look at these types of supplies not as frequently as the providers do. And so, they are not as educated and familiar with the nuances of the medical policy, RAC auditors and the like. So to take as much of the subjectivity out of the LCDs as possible is sometimes more beneficial for providers. Thank you.

Dan Schwartz: Thank you for all those comments.

Operator: The next question is from (Vernon Harrington). Your line is open.

(Vernon Harrington), your line is open.

(Vernon Harrington): Yes, representing the software vendor side, I do have – did have a question. If CMS were to pursue this avenue by eliminating the CMN and DIFs potential timing from the time the decision is made until implementation is everybody would probably expect. There's a lot of significant investment of rules and edits both on the CMS and claim formatting that would need to be reprogrammed and redone, and, you know, the software side, that's a consideration that would be need to be planned out and just didn't have any – didn't know if there was any expectation of timing once the decision has been made.

Dan Schwartz: I don't think we have any timing at this point, but thank you for your comment.

Operator: The next question is from (Sheila Robertson). Your line is open.

(Sheila Robertson): I support what everyone has been saying. I'm with a large regional supplier. And it's somewhat impossible to get CMNs at least get them correctly from physicians as other providers have said on this call. You fax them back and forth so many times that you end up having to get the doctor to redo one. Or you spend countless hours in their office trying to educate them on how to complete them. There are elements that are on there, they are not a required element of the (DWO) like lengths of need. So, why don't you just change its requiring (AD tablet) and order like you do on other (pieces) of equipment and make it that simple.

Dan Schwartz: Thank you for that comment.

Operator: Again, if you would like to ask a question, press star one. If you would like to remove yourself from the queue, please press the pound key. The next question is from (Noel Neill). Your line is open.

(Noel Neill): Actually, someone made the point that I wanted to make, but I'll just reiterating it nonetheless.

I totally agree with removing the CMNs. I do think though that there are still needs to be some form of documentation, whether the supplier, could even be a DIF, or a detailed written order that correlates the information on one particular document because as a reviewer myself, it helps when I know what the test date is for a qualifying oxygen, whether it's 10 years ago or it's a replacement.

I know where to look for that in the medical records. Just having that information in the medical records, we don't knowing where to point to, it makes it a little bit more time-consuming to do the audit on the file to review on the file. To that point, maybe we could put it on the supplier to have a template or something or maybe that's just a business decision.

The eClinical template is a great idea. I'll be willing to participate, I think probably – power mobility is probably one of the product categories that we should first experiment this on, because of the errors and all the values associated with those claims. And the thing I wanted to comment on, though, is what the previous caller, two calls before me, said about the subjectivity of the LCDs. There's too much room for a contract interpretation. And that cost a lot of these audits that eventually four years get overturned by the judge because the interpretation of the different contract is just wasn't logical. And they don't necessarily negate medical necessity of the item that is being ordered. So, that is the comment that I have.

Dan Schwartz: Thank you for your comment.

Operator: The next question is from (Erin Greeno). Your line is open.

(Erin Greeno): Hi. I'm with a large nationwide oxygen supplier, and I think we also agree with the comments that have been made. The other part for us is that we all routinely receive a high number of CMN denials due to issues at the common working file, inconsistencies with the way that CMNs are loaded as well as

transmission errors just getting the CMN to Medicare. So, for those reasons, I think we would also support looking at possibly removing CMNs.

Dan Schwartz: Thank you for your comment.

Operator: The next question is from (Gwen Turner). Your line is open.

(Gwen Turner): Hi. I represent a regional oxygen and a power mobility company, and my comment is that I fully agree and support the elimination of the CMN and the DIF. But on the other hand, I've listened to some of the comment of others today and making sure that CMS's MAC systems have been updated. It will be very important.

One of the comments sort of mentioned that there was no means of providing the length of need, the CMN was eliminated. You know, and I know that there are specific requirements in the LCD for the different products, particularly oxygen and the power mobility devices.

And I think that one of the other considerations that CMS should look at would be reinstituting clinical inference so that a lot of the denials that we're receiving in the audit could be eliminated if the medical staff has the ability to use their clinical inference to see that there's documentation in the medical record and making determinations on coverage for the product. And I also am definitely in support of the eClinical template. Thank you.

Dan Schwartz: Thank you for those comments.

Operator: The next question is from the line of (Virginia). Your line is open.

(Virginia): Hi. As I've been sitting here listening, I guess I have a little confusion because I keep hearing people say that there's information on the CMNs that is not part of the LCD. So I kind of sort of flipping back and forth and almost everything that I have seen on the CMN is in the LCD. If the criteria is printed out, it is all right there. And another thing is, we always get a length of need on our detailed orders because we have had denials at appeal status for

not having a length of need on the detailed order prior to delivery, regardless if the length of need is on the CMN or not.

So, I did look and it does not state that a length of need is required by Medicare for a detailed written order, but we have received denials. So as a company, we have always implemented that that be on there. And I do also want to agree with the gentleman who stated about using all of Medicare's records. We have had denials in regards to a date of a surgery for a patient. I know that mastectomy is not part of this, but we lost an appeal for a mastectomy bra because of the way that the doctor wrote the information on the chart note. When the patient had just have the mastectomy surgery paid for by Part A Medicare, not a month prior.

So those records were already with Medicare. So, I would love to see those actual records as well for those issues in those items that require surgeries to happen such as the osteogenic stimulator, I look in that while I was waiting and there are some surgery requirements there. Those records should be part of the patient's file already with Medicare.

So, the provider may need to know that information. But that information has already also been sent to Medicare and should be part of that patient's medical records there. So I would love to see the incorporation as well as the other vendors who've mentioned a Part A and Part B communication, as well as the drug part. I do know that the pharmacies in Washington State at least have to have the prescription for a nebulizer on file even though they don't administer the equipment, just the medication.

So, it seems like parts are starting to work together, but I think it would be more beneficial client health life and for patient care if all the entities were used together instead of as separate entities for the clients that that might help eliminate some of these concerns and some of these things that may or may not be being put into the medical records because those surgical dates should already be on file for the patient.

So, I guess that's all my follow-up is.

Dan Schwartz: Thank you very much.

Operator: The next question is from (Judy Bunn). Your line is open.

(Judy Bunn): Thank you. To (cover) on what the previous supplier commented, we've recently seen some changes to the use of what we consider a clinical inference by the payment of coagulant therapy for those patients for whom Medicare has played for transplant or transport therapies for patients who Medicare has paid for transplant. So, I think that's kind of the line that we're taking.

A question was asked, and the reason I called back in or beeped back in, was regarding what other items we would like to see have the ECTs. Particularly, we would be interested in CPAP and BiPAP for OSA, but especially the PAP therapist for the respiratory assistive devices, I think that would be, if not, number three, at least number four towards the top.

Two other comments, same and similar is something that can be seen with or without CMNs. The removal of the oxygen CMN certainly would not prevent you from seeing how many months have been paid, what the initial date was, even who the previous provider has been because we have those – we have the old CMNs, now we – and the industries refer to them as the dummy CMNs that the carriers maintain that show that information, so we would expect that same thing to happen with oxygen.

And then the last comment was regarding the recertification requirement. We initially – or looked for basic intent have the same requirement for PAP therapy. We have a three months requirement to prove not only compliance with the use of the unit, but also in additional face-to-face visit. I'm sure that an oxygen recertification at 12 months or for group two, three months could be handled in a very similar fashion. So, we also will be contacting you folks. We have a large hospital in Ohio interested in working with CMS for the development of ECT. So, I'll certainly be following up with the e-mail after the call today. Thank you.

Dan Schwartz: Thank you very much.

Operator: Again, if you would like to ask a question, press star one. To withdraw your question, press the pound key.

The next question is from (Lacey Cork). Your line is open.

(Lacey Cork): Yes. My question is; just not knowing a lot about the electronic clinical templates. Is this something that you all are looking to use to replace CMNs possibly or would this just be an addition to the CMN if you all decided to keep the CMN?

Melanie Combs-Dyer: This is Melanie Combs-Dyer. And the electronic clinical template project is moving forward with or without any changes to the CMN.

(Lacey Cork): OK. Well, we would definitely like to see an electronic clinical template put in place for pneumatic compression. And then, one just final thing that I would like to state is that if you all do decide to keep the CMN. Like someone outset it's very outdated, the questions particularly, I know for sure, for the CMN, for pneumatic compression and for (TENS) unit.

Again, if you look at the LCD the questions that just don't line up with the LCD. So I could see where, you know, all of these people are stating that they are getting denials and so are we, just based off of information that maybe contained in the progress notes but because of the way that CMN is written not necessarily just answered, it limits the options that the physician, it limits the way that the physician can answer because, I mean, you have – there's two answers, yes or no.

So, I would just add that if you all did decide to keep it, that that's reviewed and maybe of those questions be revisited or in that CMN be revised, you know, to not make the information so specific. But, again, I do vote that it's eliminated.

Dan Schwartz: Thank you very much.

Operator: The next question is from (Jim Bechtel). Your line is open.

(Jim Bechtel): Yes, hi. What would be the best e-mail address to contact any of the group on the phone today with questions?

Dan Schwartz: So this is Dan. I think... We do have a mailbox up that we have technical difficulties today in accessing. So, what we're going to do is reduce – but I'll give you the e-mail address, and we're going to post on our website under reducing provider burden ...

(Jim Bechtel): Got it.

Dan Schwartz: ... when it's up and running. But let me give you the – I'll give you the e-mail address which it's for. The caveat is you may want to make sure that that notice is posted saying its up and running. The mailbox will be capital ReducingProviderBurden@cms.hhs.gov.

(Jim Bechtel): OK. And one of the challenges with the CMN is when a supplier is having a serve dual purpose both as the written order prior to delivery and as the CMN. And, you know, there are times where physicians may not put all of the required CMN information on, and it has to be returned for completion. But it may very well complete appropriately all the written order prior to delivery elements in it. And, you know, that is a concern and I'm sure a number of us have wrestled with that from time to time. I'm not sure if there's a simple solution, or if the solution is obvious in those cases.

Dan Schwartz: Thank you.

Melanie Combs-Dyer:(Mike), we'll take one more question, please?

Operator: And the last question is from the line of a participant whose information was not available. If you have pushed star one, please state your name. Your line is open.

(June Levy): This is (June Levy).

Female: We can hear you, (June). Go ahead.

Dan Schwartz: Go ahead.

(June Levy): Oh, yes, OK.

My question is how ICD-10 play into this. Would you be able to – because my understanding, the CMNs were being updated to a (comm) data ICD-10 since that's coming in October 1st.

Dan Schwartz: Yes, this conversation would not have an impact on ICD-10. (Inaudible).

(June Levy): Oh, so they're – the CMN form is already going to be able to accept ICD-10?

Dan Schwartz: That is my understanding.

(June Levy): Without any programming updates by software companies?

Dan Schwartz: I do know the forms were revised to indicate that – to indicate just diagnosis codes as opposed to ICD-9 ...

(June Levy): I see.

Dan Schwartz: ... or something like that. (So, that's sort of as far as I can speak to).

(June Levy): Well, OK. Other than that, I agree with almost everyone else on the call as far as eliminating the CMN forms.

Dan Schwartz: Thank you.

Operator: That was our last question at this time. I will turn the call back over to the presenters.

Jill Darling: All right. Well, thank you, everyone. This is Jill Darling in the CMS Office of Communications. Thank you for all your questions today. Like Dan said, when the e-mail is up and running, you may have – or ask your follow-up questions, thoughts and comments.

Thanks everyone for participating today.

Dan Schwartz: Thank you very much.

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

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