

Centers for Medicare and Medicaid Services
Special Open Door Forum
Medicare Documentation Requirement Lookup Service
Moderator: Jill Darling
Tuesday, October 23, 2018
2:00 p.m. ET

Operator: Good morning, good afternoon my name is (Simon) and I will be your conference operator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum Medicare Documentation Requirement Lookup Service Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling you may begin your conference.

Jill Darling: Great, thank you (Simon). Good morning and good afternoon everyone, I'm Jill Darling in the CMS Office of Communications and welcome to today's Special Open Door Forum. Before we get into today's presentation I have one brief announcement.

This Special Open Door Forum is not intended for the press and the remarks are not considered on the record. 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 have any enquiries, please contact CMS at press@cms.hhs.gov. And now I will hand over the call up to Ashley Stedding.

Ashley Stedding: Thank you very much Jill. Good afternoon everyone, I want to thank you for joining us today and to welcome you to the first of a series of special open door forum calls on the Medicare Documentation Requirement Lookup Service. And for those of you who wish to follow along with today's presentation, the slides are posted on our CMS web page which can be accessed through the link that is included in the invitation and in the special open door forum announcement.

So my name is Ashley Stedding, I'm a management analyst in the Provider Compliance Group here at the Centers for Medicare and Medicaid Services. I'm also the government task lead for the documentation requirement lookup service project and I'll be helping to facilitate today's discussion.

Also with me today is Melanie Combs-Dyer who's the Acting Deputy Director for the Center for Program Integrity at CMS. And we also have a few other speakers joining us from the MITRE CAMH team, there is Andy Gregorowicz who is the project technical lead and Bob Dieterle who is the project technical advisor.

So on slide three we'll just cover the agenda. The objective of today's discussion is to educate the public about a new initiative underway in CMS to develop a Medicare Fee for Service Documentation Requirement Lookup Service prototype or DRLS for short. We're also going to talk about how CMS is collaborating with and leveraging ongoing industry efforts to streamline workflow access to coverage requirements.

Later in the slides we're also going to talk through in detail how the documentation requirement lookup service will work, and lastly there will be time towards the end of today's call for participants to ask questions. So what is the documentation requirement lookup service and why is CMS interested in this project?

Among a number of things, CMS has been hearing feedback from providers that documentation requirements are too hard to find. So for example, the Medicare documentation requirements appear in various locations on a

number of different websites which is also true for most other payers as well, and this causes burden to providers who must navigate the various websites to find coverage requirements.

So the AMA along with a coalition of 16 other organizations released a comprehensive set of prior authorization and utilization management reform principles which says that payers should publicly disclose their requirements and what supporting documentation is needed in a searchable electronic format.

So this DRLS prototype is one of the steps that CMS is taking towards displaying the Medicare Fee for Service rules in an electronic format that will be easily accessible to providers within their clinical workflow, rather than outside of their EHR system.

So the overall goals of the documentation requirement lookup service initiative at a high level are to reduce provider burden, help to reduce improper payments and appeals as well as improve the exchange of information between the provider and the payer. Now we're moving on to slide seven, this is just a graphic at high level that shows how the DRLS will work for providers. And I'm not going to go into too much detail now since we'll be breaking this down at a more granular level later on in the presentation.

But we just wanted to show this graphic at this point to give those on the call an idea what documentation requirement lookup service looks like and how it will work. And you can see on the left hand side the provider is in their EHR rather than being outside of their EHR looking at different websites.

And then on the right hand side you can see the different payers indicated by their lookup services or their repositories and you notice that those are all separate repositories. Each payer will have their separate database full of their rules and we'll talk about this like I said in more detail in later slides. And at this point I'm going to turn it over to (Bob Dieterle) to talk more about how CMS is leveraging industry efforts.

(Bob Dieterle): OK, well Ashley thank you very much. As Ashley mentioned, one of the goals of the project is to leverage industry efforts in particular related to FHIR based solutions. Andy will talk about FHIR and what it is a little bit later.

On slide nine we're going to talk about one of those industry efforts it's called the Da Vinci Project. The Da Vinci Project was convened by HL7 International which is a health care standard developmental organization or SDO.

The President of HL7 Charles Jaffe led the effort to go and create the Da Vinci effort which is a multi stakeholder industry led effort to develop FHIR based solutions to critical exchange problems between payers and providers or between providers and providers. The effort is led by (Jocelyn Keegan) who acts as the program manager and Dr. (Viet Nguyen) who acts as the technical director.

The goal is to focus on rapid development of unique solutions to interoperability problems in particular those being faced by value based care efforts in the industry. On slide 10, you'll see a high-level view of the composition of Da Vinci. It has 11 payers, most of the leading national payers are involved. It has three top EHR vendors as far as their install base, it has 10 of the leading (HIT) vendors providing specific interoperability solutions and a half dozen provider organizations that are involved.

Da Vinci supports initially nine specific use cases and we'll talk about them on the next slide. There's a link on slide 10 to the HL7 webpage describing the Da Vinci Project and detailing each of the members of that project. We encourage people to go to that particular website so they can understand both who is involved and what the detail is behind the specific use cases.

On slide 11 these are the nine use cases that Da Vinci initially prioritized to focus on. Phase one, which is the initial work that was being done since its inception back basically in March of 2018 up to date is an effort around quality reporting framework. It's called DEQM data exchange for quality

measures using a 30 day medication reconciliation as one of the scenarios to test the exchange framework.

I'm going to skip the next two boxes, we'll come back to them because they're the source of the work we are discussing today, the conversations around the DRLS. The work that has just started in Da Vinci is focused on health record exchange for the purpose of collecting information for HEDIS and STARS measures as well as to exchange clinical information between providers and payers, payers and providers and providers and providers for the sake of improving care coordination and managing value based care.

Phase two solutions or use cases include things like notifications or alerts, providing assistance for prior authorization called authorization support, exchanging laboratory results on a global basis, quality measure reporting (taking the results of these calculated measures and reporting them back to the appropriate agencies), and risk based contract member identification (the ability of a provider to know who they're responsible for -- meaning who's in their panel with a particular payer and program).

The top two use cases which are the basis of DRLS are in light blue. The first is called coverage requirements discovery, this is the ability for a provider to ask the question, for the action I'm about to take, is there anything that I need to know or do to cover requirements of the payer? That could be a requirement for prior authorization, it could be a requirement for specific documentation.

But the intent is to be able to go and ask that question and get the answer in workflow, clinical workflow. The second is called documentation templates and rules, this is a specific use case to take what are currently paper based or PDF based documents or templates and make them actionable at the point of service; to be able to go and pre-populate them with information that's already available so that providers don't have to answer the same question repeatedly, (but rather) to ask only those specific questions that are necessary to acquire the information that's required for that particular service and not to ask them to go and do work that is redundant with what they have already done. So

those two become the basis for what Melanie Comb-Dyer will explain as the documentation requirements lookup service and its flow.

On slide 12 we have a second industry effort related to FHIR and that is called the P2 FHIR Task Force. The P2 FHIR Task Force was convened under ONC and championed by Dr. Rucker, who is the head of ONC, and led by an individual called (Stephan Konya).

The goal of the P2 FHIR Task Force is to address scaling issues that we'll face as an industry as we start to take these FHIR based solutions and use them on a national basis. So, (the P2 FHIR Task Force covers) things like how I identify an individual or a provider or an organization, how do I authenticate them and authorize them, how do I look up electronic end points et cetera?

These two efforts, Da Vinci and P2 FHIR Task Force, work hand in hand to solve significant interoperability problems using FHIR as a standard. If you want to think of it (this way), P2 FHIR task force is building an interstate highway system and Da Vinci is designing and building the cars that drive on it.

At this point I'm going to turn this over to Andy, he is going to take you through some of the standards that are involved in DRLS. Andy

Andy Gregorowicz: Thank you (Bob). So as you've heard the work that we're doing revolves a lot around this FHIR standard and so you may be asking what is FHIR? Well on slide 13 we describe what FHIR is. FHIR stands for fast healthcare interoperability resources. It's an HL7 next generation standard, so this is an international standard that is being worked on by the HL7 organization. That is the same organization that (Bob) described that is orchestrating the Da Vinci project.

And this standard at its core really helps two computer systems talk to one another, and the way it does that is first FHIR uses what's called resources as the standard components. So for the things that we need to communicate about in DRLS things like patients, practitioners, organizations, device requests that type of information FHIR gives us rules for how those should be

represented. You can think of those as nouns if we were going to be building a sentence.

FHIR also supports common exchange methods. So if you were thinking of a sentence this would be the verb in the sentence. And the way that it does that is through a pattern called (REST) which many engineers if you're on the call might be familiar with, but that is a very common pattern that's used for building web services but it also supports messaging documents and other services.

So through this combination of verbs and nouns we can have sentences that allow two systems to talk to one another. So for instance the verb might be create and the noun might be a device request so we could create a device request on one system going to another. The important thing about FHIR is that it works at all levels of information exchange so different types of systems can participate in this exchange.

It could be a mobile phone application, it could be an electronic health record system, it could be a larger institutional information system on the backend but they can all use FHIR to communicate. So given that, moving on to slide 14 how will we be using something like this for the Da Vinci team to accomplish our goals?

Well the first thing that will happen is that we are going to create implementation guides based on FHIR standards and you could think of these as sort of a blueprint. So FHIR gives us some of the building blocks we need, but we need to arrange those specifically to make sure that the systems can communicate with each other in an effective manner.

Second, we're going to create a reference implementation to prove that it works. You can think of this as a piece of prototype software that takes that blueprint and builds an initial version of it to make sure that what we're describing can actually work and that software can be built to make this actually happen. And then to really prove out that this works, we will be launching pilots where people will be able to use the implementation guides

and the reference implementation that we have put together to push this in real world like scenarios.

So describe how this is going to work in action, I'm know going to turn it over to Melanie Combs-Dyer to talk about how DRLS will work.

Melanie Combs-Dyer: Thank you Andy. I'll pick up on slide 16 and show how the DRLS system will actually work. First, there will be a trigger of some sort usually based on a specific clinical workflow event like the patient is calling up to schedule a visit, or the physician is beginning an encounter with the patient, or the physician wants to order something or begin to plan treatment for the patient, or maybe the patient is being discharged from the hospital.

That provider will be interacting with their electronic health record, their EHR, and in this example we're going to be walking through a physician who is ordering oxygen. Moving on to slide 17, you can see that the transaction that is picking up on information like gender and state and the provider's NPI and HCPCS code for the oxygen that the physician is ordering.

A physician may be clicking a button that says are there prior authorization or documentation requirements? And that transaction gathers up all the needed information to answer that question and goes through the FHIR based exchange process to land on our doorstep, the Medicare Fee for Service repository of rules doorstep. If the patient actually was a United patient it might land on the doorstep of payer number two, or if the patient was an Aetna user they might land on the doorstep of payer number three.

But in this scenario they're landing on the door step of the Medicare Fee for Service program and its repository of rules. Slide 18 shows you what comes back then from that Medicare Fee for Service repository. Coming back would be either a yes or no to whether or not there are documentation requirements and whether or not there's prior authorization.

So for example because of Medicare Fee for Service program does not have a prior authorization component for oxygen but does have documentation requirements, the response back would be no there's no prior auth but yes

there are documentation requirements. And that will display to the provider right in the EHR, no getting out of the EHR and going to a separate website, right there in the EHR and right at the time of service.

You may recall when (Bob) was talking a few moments ago about the nine use cases and there were two that were circled in red. These two arrows that we just talked about are there prior auth and documentation requirements and the answer coming back yes or no, that completes the first of those two blue little boxes the coverage requirements discovery process.

But that then launches the second set of arrows that you see further on down the page and are highlighted on slide 19. That is the documentation templates and rules use case. Here the provider might click the button to say well, show me the prior authorization requirements or the documentation requirements and templates. Again in the case that we're talking about here with oxygen, it would be show me or give me the documentation requirements and templates because there is no prior authorization requirement in the Medicare Fee for Service program.

Again that particular transaction will go through the FHIR based exchange process, land on our doorstep and then be able to return back to the provider, here are the requirements and here are the templates. And we're hoping that at some point in the future the EHR programmers will be able to actually begin to pre-populate some of those templates.

For example if the template is encouraging the provider to document 10 things in the EHR and three of them are already known because they're lab values that were already conducted the results already appears somewhere else in the medical record, that information can be pulled in and pre-populated into the template. So the physician will only have to add the new information into that template and then sign it and close it out and it becomes a permanent part of the EHR.

Slide 20 shows how you can get involved. Any providers that want to help to establish the standards can contact one of the FHIR based standards

organizations. And they can also contact their EHR vendors and talk to them on whether or not they together, the provider and the vendor, want to participate in one of the pilots that we'll be conducting.

Anybody that is interested in participating in a pilot should send us an email and just let us know that you and your EHR vendor are interested in participating in a pilot. And anybody that just wants to be informed should try to follow what's going on at our website that's go.cms.gov/MedicareRequirementsLookup.

We anticipate having more of these special open door forum calls, probably the next one will be in about December or January and we'll continue to update our website and put helpful links and sort of let you know where we're going and what the latest status is. At this stage of the game let me turn it back over to Ashley who can close out the call.

Ashley Stedding: All right so as Melanie mentioned, on the last slide there's an email address, MedicareDRLS@cms.hhs.gov where anyone can send us feedback and suggestions. And at this point I think (Simon), we're ready to open it up for questions.

Operator: Certainly. At this time ladies and gentlemen I'd like to remind everyone that in order to ask a question, please press star then the number 1 on your telephone keypad. We'll just pause for just a moment to compile the Q&A roster.

And your first question comes from the line of (Jackie Maholich) with (UPMC), go ahead your line is open.

(Jackie Maholich): Hi, listening to your information I was wondering if this would work retrospectively or would it only work at the time service is being delivered?

Melanie Combs-Dyer: That's a really good question. The way that we are designing this now would be to work prospectively right at the time of service. But we do envision that not only will these EHRs and providers using these EHRs be interested in seeing the rules that in the repository, we suspect that there will

be lots of other people who would be interested and maybe they would interested for retrospective use.

For example I could see a subscriber to the documentation requirement lookup service being a company who does medical record self checking services. Maybe they promise a provider to run their medical records through the Medicare rules and tell them whether or not Medicare would cover that particular item or service or not cover it. And so I would suspect that they would be very interested in ingesting these rules and being able to sell their services. So yes, I think that would be possible.

(Jackie Maholich): It would also be a benefit for those who do appeals retrospectively to ensure that we have the correct information we need and we understand the rules.

Melanie Combs-Dyer: (Jackie), that's a great suggestion. I had not even thought about use of the DRLS in the appeals process but that's a great example. Thank you for suggesting it.

(Jackie Maholich): Thank you.

Operator: Your next question comes from the line of Gary Gartner with (Next Gen Healthcare), your line is open.

Gary Gartner: Yes, hi this is Gary Gartner, VP of clinical solutions at NextGen. I did have a couple of questions around your timeframes. And also just as an example if you have it or maybe you can point me to a resource of what types of documentation requirements based on the different services are you potentially looking at?

Melanie Combs-Dyer: So none of these would be new requirements, all of these would be existing requirements. And so if you are a provider who bills the Medicare program for oxygen, you know probably pretty well what those documentation requirements are. For example the patient's CO2 level has to be within a certain range, and there has to be evidence in the medical records that the patient will be using the equipment in their home and there's other

documentation requirement for every item and service in the Medicare program.

Sometimes the physician who's doing the ordering or a provider who's providing lots of different items and services may not be very familiar with all the rules all the time. And certainly it gets more complicated when the rules change and then if you happen to see more than just Medicare patients you're having to learn not only Medicare's rules but Aetna's rules and United's rules and all the other payers rules.

So it really does get quite complicated but those are the kinds of things. There are again no new requirements, they are things that are sprinkled throughout all of the Medicare manuals today. They can be found in the Claims Processing Manual, the Program Integrity Manual, the Local Coverage Determination, the National Coverage Determination and so on and so forth.

This would pull them all together and put them in a machine readable format so that the EHR can suck them in and display them right to the provider. Did that help answer your question Gary?

Gary Gartner: Yes, all those examples are great. What about the timeline for the pilot and presumed steps to get actual implementation? Thanks.

Melanie Combs-Dyer: Let me turn that question over to (Bob). (Bob), can you say a few words about when pilots might begin?

(Bob Dieterle): Yes, I'll be happy to do so. We have already tested the reference implementation that Andy referred to both on a Virtual Connectathon and at the HL7 Connectathon in Baltimore at the end of September.

We're on the process right now of recruiting organizations that would like to pilot DRLS as EHR vendors or as providers, or as health plans. And we have a number of participants of Da Vinci that have already indicated their interest in doing it.

We would want to start those pilots, depending upon what portion of pilot you're interested in, the next two to six months. And there is a belief that we will continue these on; they will not just be pilots but rather be the first step for early adopters of the implementation guide and the services. Does that answer your question?

Gary Gartner: Yes it does, thank you very much.

Operator: Your next question comes from the line of (Tom Powers) with VGM Group, your line is open.

(Tom Powers): Hi, thank you very much. (Bob) or Dr. (Dieterle) my question is does this interoperability extend all the way to the suppliers not just the physician providers and will it be accessible at the supplier end as well?

Melanie Combs-Dyer: This is Melanie and I'll start that question and then see if (Bob) wants to add to it. What we're talking about here today is use case number two and three. If you go back to the slide that lists all the use cases that (Bob) was walking us through, you know that there are nine use cases, I'm looking at slide 11 and there are two use cases called coverage requirements discovery and documentation templates and rules and that's what we're talking about here today.

And yes, the call for pilots would be for any provider that would like to have access to the coverage rules, the documentation rules in the Medicare Fee for Service program. We are thinking that the more interested people will be the ordering provider not the supplier. We think that most oxygen suppliers already know what the rules are, they don't really have a need to look them up. I could be wrong and we might get a handful or maybe a lot of DME suppliers who say yes, yes, yes I want to be able to look up those rules.

But our guess is that most of the time it's going to be the ordering provider who's going to want to look up the rules and get back the answer. More further down the pike will come the next use case which again on slide 11 is listed as e-health record exchange and there in the yellow box you see it talks

about provider exchange that might test physician to DME supplier exchange of healthcare information.

And if Medicare gets involved in one of those pilots, we would definitely be interested in working with some suppliers and ordering providers to try to see if we can get that exchange going. But what we're talking about here today is just the use case called coverage requirements discovery and documentation templates and rules and we think that the most interested providers are going to be the ordering providers. Does that answer your question (Tom)?

(Tom): Yes, thank you.

Operator: Your next question comes from the line of (Ryan Antel) with (Dusera Corp), your line is open.

(Ryan Antel): Good afternoon. As a durable medical equipment provider I would say that this information would be very beneficial to our organization. And some of the things that I'm interested in wondering if they're being considered for inclusion especially from a non-Medicare perspective is an insurance company's particular plan and also the authorization requirements tend to sometimes differ based on fee schedule amounts.

So you have a couple of things that not only does net healthcare require have different requirements based on a beneficiary's individual plan but based on contracts and fee schedules requirements also differ. So I'd like to be able to understand whether these kind of considerations are being taken into account because this is information that we would like to access as the information is like you mentioned scattered.

Melanie Combs-Dyer: This is Melanie and I will start that answer and then turn it over to either (Bob) or Andy to finish off the answer. Which specific insurance plan is involved is something that the standard is building in, however in the Fee for Service Medicare program we only have one. We are the Fee for Service Medicare program.

And so in the pilots that we are implementing, there will not be specific plan details. The response that comes back from the repository what the documentation rules are will not vary because they are the same for all Medicare Fee for Service patients for oxygen. If there was going to be some variation it could be that there was variation in the state where the beneficiary resides or the state where the service is going to be provided.

For example if you're familiar with the local coverage determinations you know that for many Part A and Part B services that policy might be different depending on where the service is being rendered. That's not usually the case in the durable medical equipment world. They are typically word for word identical local medical review policy and so you won't see those kinds of variations.

However for the other payers who are participating in this effort the Da Vinci project, the insurance plan information will vary from patient to patient. And we do believe that the standard will capture that information and be able to ping the right place in that private plan's repository to pull out the specific rules for that insurance plan. I'm not sure that I understood your question about fee schedule. Let me see if (Bob) or Andy understood that part of your question or if they have any follow up questions back to you (Ryan).

(Bob Dieterle): Yes, this is (Bob). Let me clarify, we developed a standard for (inaudible) discovery which is the underlying standard for DRLS to allow the communication of the payer and the specific plan on which the individual that's being seeing is being covered. So the payer can then respond appropriately based on the specific plan coverage information so yes for the first part of your question.

As far as fee schedule, there is conversation about the ability to display at point of service information related to cost to the patient. That's still in conversation, no one's made a decision whether to move forward with that at this point or not. So while we're considering the idea that individual pricing could be part of the response, that's at the moment a future enhancement. Does that answer your question?

(Ryan Antel): I think so yes. I think definitely on slide 16 you've got you've indicated like future functionality to incorporate additional payers beyond Medicare. And then definitely I think even if from a doctor's perspective if they are trying to order oxygen but for United Healthcare a Medicare Advantage plan is requiring authorization because the billed amount or the charged amount for a particular procedure code falls within the dollar range versus the total dollar amount for an entire claim falls within a certain dollar range it completely changes the prior authorization requirement.

So it's for future viability and in occasion of additional payers certainly would have to be considered.

Melanie Combs-Dyer: Thank you (Ryan). This is Melanie, thank you (Ryan). Slide 10 talks about the makeup of the Da Vinci membership talks about how there are 11 payers. I am but one of those 11 payers, there are 10 other organizations like United and many others who are also building their repositories of rule information.

So yes, the pilots that we are trying out this spring will involve not only Medicare but other payers as well. We have all agreed that oxygen and CPAP will be the first two items that will be included in our repositories but there is no limit on just those two. Some of the other payers may choose to go well beyond CPAP and oxygen for where they're putting rules into their lookup service.

(Bob), do you have anything to add there?

(Bob Dieterle): Yes, I wanted to add one thing and I wanted to be clear that this is not prior authorization, this is look up to see if there are coverage requirements. So, for example, if there is a prior authorization requirement, the fact that there is one and potentially the template would be returned to the ordering provider.

The prior authorization process however would follow the current HIPAA guidelines and standards. So this (DRLS) is just to tell you that it's there (e.g.

the requirement for prior authorization exists for the specific device or service).

Melanie Combs-Dyer: And this is Melanie just one last point, if you look at slide 11 again, the slide with all the use cases on it, the two use cases that we're talking about today are the coverage requirements discovery those first two arrows and the documentation templates and rules the second set of arrows on our graphic.

The middle box the yellow box is called e-health record exchange and that is the area where the provider and the supplier might be sending information back and forth to each other like here's the order and the lab results, wait you forgot to sign this order and oh by the way I need a progress note. Here's the signed order, here's the progress note. All that backing and forth between two providers might be benefitted by the yellow box the e-health record exchange box.

And then down at the bottom you see in phase two in 2019 and beyond there are a bunch of black boxes. And we have not decided what order they will be in but you can see that the second one there on the bottom is called authorization support or support for prior authorization. And that would be the place where perhaps someday we will get to laying out all of the standards that are needed to actually support an electronic prior authorization of DME. (Simon), I think we're ready for our next question.

Operator: Excellent. Your next question comes from the line of (Sheila Robertson) with Preferred Homecare, go ahead your line is open.

(Sheila Robertson): Thank you for taking my call. My question relates to the fact with DME Medicare fee for service templates are not standalone are not allowed. So is that something that would then become part of the chart note this template and that would be used then for audits and stuff?

Melanie Combs-Dyer: We have written in our manual in the Program Integrity Manual that checkbox templates are not encouraged but open ended templates are perfectly acceptable. And we anticipate that this will be one of those sort of open ended

templates that will allow the provider to enter whatever information is pertinent for that patient. Does that answer your question (Sheila)?

(Sheila Robertson): Yes, thank you.

Operator: Your next question comes from the line of (Thomas Triantafilu) with American Geriatrics, go ahead your line is open.

(Thomas Triantafilu): Hi, thank you for taking my question. I'm in Chicago right now and I'm kind of trying to process what has been said. And I have to admit I'm a geriatrician and I'm thinking more of the process from authorization support. But kind of backpedaling to what I heard of what you're doing, I think a concern of mine is I'll give you two examples of concerns.

One of them is we're upgrading, we're changing from one EHR to another one. So let's pretend that you've created this bridge and today you have system A and then three months later you have system B. Is it going to crash because the FHIR sounds like a bridge but if you change what you're doing the other person won't know what there won't be a communication. So I wonder if there's any forethought? So it sounds like you guys are just trying to put it together.

The second thing is the putting in and getting out information, so sometimes like you have a busy practice and you saw well Dr. (Tom) won't do it but (Jacky) my PA will do it. So I think it could be a variation from somebody's who's putting the information but also like OK it get processed putting back, and then the back is the redirectings. I got information but probably yes it's under my NPI but probably someone else needs to enter like a physician assistant and I'm wondering how that's going to be redirected.

Melanie Combs-Dyer: This is Melanie and I'll try answering both of those questions. The first one to me and as a non-technician and I'll hand it over to (Bob) and Andy to give a more correct technical answer, but from a non-technical person's mind I think back historically to when this country had private railroads and some railroad systems built their tracks three feet apart and some railroads built their tracks four feet apart.

And so we didn't have a nationwide system of railroads where the trains could run from one end to the other. They were not interoperable. And somewhere along the line someone declared a standard and said all railroad tracks are going to be three and a half feet apart. And because over time everyone began to move to three and a half foot railroad tracks, we now have a railroad system that works interoperably. I'm hoping that FHIR is going to do the same thing so that instead of having the Cerner way of doing it and the Epic way of doing it we'll have the FHIR way of doing it and everyone will be able to eventually interoperate.

The second part of your question had to do with who is putting information into the EHR, and I think your thinking was that it would be limited to the ordering physicians. And I think it will be limited to whoever has access to that EHR. If the PA has access to that EHR or the nurse practitioner or anybody else that's taking care of that patient and has access to the EHR or practice management system they would have the ability to get in and access this information. Let me though stop and see if (Bob) wants to add anything and then Andy after that.

(Bob Dieterle): Yes, this is (Bob). The important thing to remember is we're creating (balloted) standards with an international standards organization. So the underlying principles standards behind DRLS are coverage requirements discovery and documentation templates and rules. And if you implement (meaning if the EHR vendor implements) the standard then it should be interoperable regardless of which EHR vendor you use as long as they implement the standard.

That's the goal of the project, it's not intended to be a one off. And the standard defines not just how we exchange information (as Andy would have said the verbs), but also what the information is and what it means (in other words the nouns). So we're defining how you create a sentence and assuming we're going to speak the same language we shouldn't have a problem understanding each other. I think was there a second part to that question?

Melanie Combs-Dyer: Who can put in and who can like on the frontend and who could put in on the backend?

(Bob Dieterle): Yes, the way we're envisioning the workflow, the way Melanie described it, there is a trigger event that goes and sends the request for coverage discovery to the appropriate payer. The trigger is what decides when and where the information's exchanged. If the trigger is done while the provider's ordering, for example home oxygen, the provider's the one that would see the information.

Now just because the provider sees it doesn't mean that they have to complete the information. That could be tasked to someone else in the organization that isn't the provider where but is appropriate for going and completing whatever documentation requirement is necessary to support the service. The provider still needs to follow all of the same normal signature rules and ordering rules that Medicare has or another payer has.

(Thomas Triantafilu): Thank you.

Melanie Combs-Dyer: Dr. (Thomas).

(Bob Dieterle): Did that answer your question?

(Thomas Triantafilu): Yes. I mean I have to say I'm still wrapping my head around everything. I'm glad that you're looking for feedback, appreciate your effort.

Melanie Combs-Dyer: Thank you. (Simon), we'll take our next question.

Operator: Your next question comes from the line of (Paul Colmashock) with Pride Mobility Products, your line is open.

(Paul Colmashock): Yes, thanks for having this call. I had a question about specifically slide 17 and you discussed how the ordering provider really is going to be the one that's going to be driving this or is going to be the one that's going to need to know the details. And on slide 17 it specifically mentions the HCPCS code,

and I was wondering if there were going to be other options for ordering providers to look up policy as opposed to HCPCS code?

And the reason I say that is especially in the DME world there are some broad policy guidelines, but when you get into the HCPCS codes there are some fairly granular details between HCPCS codes. I'm thinking specifically of the PMD policy personal mobility devices, pneumatic compression devices, (parenteral) policies. And so an ordering physician may not know specific HCPCS codes where there are policy differences among HCPCS codes but they may need more of a broader policy overview as far as what does a client need to qualify for a power wheel chair as opposed to specifically maybe a Group 3 single power option chair with a solid seat pan.

Melanie Combs-Dyer: This is one of the things that I think we're going to be able to figure out as we do our pilot testing exactly what is it that a physician or an ordering clinician is putting into the EHR and how do they need to see it back? I don't know if a physician will just write oxygen or will write a particular type of oxygen or oxygen plus nasal cannula. It'll be very interesting as we work through our pilots to see exactly what works for ordering clinicians and what how it is that we want to display that information back to them. You raise good points though, thank you very much.

(Paul Colmashock): Sure.

Operator: Your next question comes from the line of Deepak Pahuja with Aerolib Healthcare, your line is open.

Deepak Pahuja: Yes, hi this is Dr. Pahuja, I'm the CMO at Aerolib Healthcare Solutions in Dallas. So question for provider education during this process, say a patient's in the hospital and you need to know what needs to happen for (bedding) status reviews, would some sort of an integrated learning management system for the providers satisfy this requirement that you're proposing?

Melanie Combs-Dyer: I'm not sure that I understand what you mean by a learning management system. I think that when I think of the word learning management system I think of a portal or a website that someone would go to. We certainly at CMS

have documentation rules that in addition to this documentation requirement lookup service we are working towards putting our rules in an easy to understand way on our website, and making enhancements to our website to make sure that it's easy for providers who don't want to see the rules in their EHR they'd rather interact with a portal to see the information we're clearly working on that.

Were you suggesting something else? I'm not sure that I understand what you mean by learning management system.

Deepak Pahuja: Right so for example your examples for oxygen when you want the ordering provider to order that, and if a patient's coming in for COPD their progress note should mention what the pulse ox was without oxygen support on ambulation, and that's the sort of information that needs to be in the progress note for them to go ahead and make the decision on whether oxygen is needed upon discharge or not. So would education on that platform real time help the providers in what you're trying to achieve?

Melanie Combs-Dyer: I'm not sure that a physician needs to see that information in a learning management system. We think they need to see that information right in the EHR right with the templates starting a note for them and filling in some of the information based on what's already in the EHR and leaving blanks where the physician needs to add more information. We think that might be the best learning tool of all for providers.

Deepak Pahuja: OK, thank you very much.

Operator: Again if you would like to ask a question, please press star then the number 1 on your telephone keypad. Your next question comes from the line of (Susan Jacobs) with Stanford Medical, go ahead your line is open.

(Susan Jacobs): Hi, thank you very much. This is very helpful to hear the efforts of CMS to help providers. My question comes from just input that as a provider I'm a nurse specialist in a clinic here, when we're ordering oxygen the best advance for us has been some of our DMEs using an online portal which lets us enter as you're mentioning these requirements for oxygen, and it will not let us

proceed through the process without having what we assume are Medicare require based testing three point testing et cetera.

So I think the idea of a physician or provider first in a clinic setting signing on to a Medicare site to determine if they meet criteria and what requirements are and then placing orders may or may not happen. And I would really hope in our broad vision for the future that these online portals for ordering oxygen are connected to this type of requirement based EHR that you're describing.

So that would be a long term goal that if these online sites which we find very much streamlining the process for our clinic nurses that they can enter the information one time, attach requirements and it won't let us submit the order unless we've met all requirements. If somehow CMS can link into that so that the process is really streamlined ...

Melanie Combs-Dyer: (Susan) thanks, yes it sure does. Thank you for the suggestion. We anticipate that there will be lots of people who will want to use our documentation requirement lookup service once it gets built. And it would not surprise me if there were online portals that wanted to access that information, build an API and subscribe and pull down the information and that way every time the Medicare rules change in the repository that gets sucked into their online portal system.

So, that we think will be available for companies to utilize. However, that is not the first place that we're trying to pilot test. Our first pilot test we think will be with the EHRs to the ordering provider's right at the time of service. But you're absolutely right that will be one of those additional use cases that we think will come down the pike.

(Susan Jacobs): Thank you.

Operator: And there are no further questions at this time, I turn the call back over to our presenters.

Jill Darling: All right, well thank you everyone for joining today's Special Open Door Forum and enjoy the rest of your day. Thank you.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

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