Centers for Medicare & Medicaid Services
Special Open Door Forum:

Suggested Electronic Clinical Template for Power Mobility Devices

Wednesday, December 19, 2012
4:00pm – 5:00pm Eastern Time
Conference Call Only

The Centers for Medicare & Medicaid Service will host a series of Special Open Door Forum (ODF) calls to provide an opportunity for suppliers and physicians to provide feedback on the Suggested Electronic Clinical Template for Power Mobility Devices for Medicare purposes for possible nationwide use.

CMS is exploring the development of a Suggested Electronic Clinical Template that would allow electronic health record vendors to create prompts to assist physicians when documenting the Power Mobility Device face-to-face encounter for Medicare purposes. You can find the proposed document by going to http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/ElectronicClinicalTemplate.html . Comments on the document can be sent to eclinicaltemplate@cms.hhs.gov .

Special Open Door Participation Instructions:

Dial: (800) 837-1935 & Conference ID: 69289478
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/121912PMDSODFAudioFileID69289478.mp3

Centers for Medicare & Medicaid Services

Moderator: (Melanie Combs-Dyer)
December 19, 2012
4:00 p.m. ET

Operator: Good afternoon. My name is (Lindsay) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Suggested Clinical Electronic Template for Power Mobility Devices Special Open–Door Forum.

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 one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

(Mrs. Melanie Combs-Dyer), you may begin your conference.

(Melanie Combs-Dyer): Thank you. I'd like to thank everyone who has dialed into to today's open–door forum on Electronic Clinical Template. Again, my name is (Melanie Combs-Dyer); I'm the Deputy Director of the Provider Compliance Group at CMS. And I just think we're going to have a fairly short agenda today. And then, we'll open it up to questions and answers from the participants on today's call.

First, in terms of background, I just want to make sure that everyone knows what we're talking about when we described Electronic Clinical Template.

We are starting this project just for one type of Electronic Clinical Template and that would be for a face–to–face visit that a physician has when they are evaluating a patient's mobility needs and trying to determine, if a Power Mobility Device, a PMD, is right for the patient.

There may be lots of other types of templates that we create in the future. But for starters, we are going to begin with just this one Electronic Clinical Template, just for a face–to–face evaluation for Power Mobility Device.

So, what do we mean when we talk about Electronic Clinical Template? What we're talking about is trying to identify the data elements that a physician needs to document during that face–to–face visit. What is it that they need to document that will demonstrate that this particular item is covered by Medicare; meets all of the coverage criteria, the medical necessity criteria.

I think that those physicians, who order lots of PMDs, perhaps podiatrists or others who end up ordering lots of these each year, probably, are very familiar with the local coverage determination for Power Mobility Devices. And they may not need a reminder about what to document.

But for family physician or someone who does not, oftentimes, order a Power Mobility Device for Medicare beneficiaries, they may not be as familiar with the local coverage determination and the national policy around when Medicare covers a Power Mobility Device.

And so, lots of folks have suggested that it would be helpful, if we could find a way to help remind physicians about what it is that they need to document.

We tried to do that in the past by putting out bulletin articles, (MedLearn) — excuse me —(MLN Matters) articles, we even published one in the form of a checklist to make sure you document this, this, this, this and this. But we're finding that physicians are sometimes still feeling like that might not be enough of a reminder about what it is that they need to document.

They think that it may be more helpful to try to provide that reminder at the time of service right there, while the patient is in the room and their — and the visit is underway.

And so, we've been exploring here at CMS how we could develop a template that would be used inside of an electronic health record. And that Electronic

Clinical Template a physician could choose to use and it would help to prompt them or remind them during visit about the things that need to be documented.

So CMS is planning on beginning an initiative with the Office of the National Coordinator for Health IT. We call them ONC and we have been dialoging with them for several months now about how to go about creating this Electronic Clinical Template.

We want to make sure that use the ONC process they call it the "Standard and Interoperability Process or the SNI process, to make sure that whatever it is that we developed is something that will be interoperable; it will work in all the EHR's. It'll work when one provider sends documentation to another provider, for example, from a physician to a supplier, if they are both using the same standards they'll be able to make sense of it. So, we want to make sure that we're doing this in a way that is interoperable for all those who are involved.

So, what we did starting earlier this summer was to begin holding a series of these open–door forum calls to identify the data elements that we want to be included in this Electronic Clinical Template. And those data elements are now published on this website. They are in draft; they are not final. And the next steps that will come will be — once we get some contracts in place for some standards and interoperability support, we will begin working through the ONC SNI process.

It will start with a — an email that goes to lots of people and invite them to come to weekly calls. And then, we will begin having those weekly — they could be bi–weekly calls, but they will, probably, be fairly, frequent calls to get everybody to agree on what it is that we want to include in the Electronic Clinical Template and how we are going to roll it out, how we are going to pilot test it with the electronic health record vendors, who may volunteer for the project.

So, that's what the Electronic Clinical Template Initiative is all about. And that's where we are in the process; we're in a little bit of a holding pattern that we have sort of identified our draft data elements. We're still waiting to begin

the actual sort of heavy listing with ONC in their frequent phone calls. But we thought we would go ahead and give everybody a status report on this call and just see if anybody had any questions about the process or where things are going.

So, at this point, I will open it up to questions from the audience. Operator, if you could please remind folks how they need to raise their hands to ask the question, I would appreciate it.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then 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 person to spend time for questions. If you require any further follow–ups, you may press star one again to rejoin the queue.

Your first question comes from the line of (Cindy Menthor) from (Mercy Medical Supplies), your line is open.

(Cindy Menthor): Hi. I have a question. Can a podiatrist prescribe the power wheelchair and do all the paperwork for that?

(Melanie Combs-Dyer): I might have to have (Dr. (Witten), (Dr. Brennan) help me out there. Can a podiatrist order a Power Mobility Device?

Male 1: Get this off mute? No, it would need to be a physician, a MDDO or someone, who can act as a physician fully for the patient's clinical condition, a full patient's condition, not the more limited area that podiatry would encompass.

(Cindy Menthor): Okay, thank you.

Operator: Your next question comes from the line of (Steven Kirschblond) from (Kessler Institute). Your line is open

(Steven Kirschblond): Thank you very much. I just wanted to ask how long do you think this one of the templates you have that it would for the physician to complete all the requirements of the document.

(Melanie Combs-Dyer): When I again asked (Dr. Whitten), (Dr. Brennan) to help me out here how long, (Dr. Whitten) or (Dr. Brennan) do you think it typically takes a physician to document a well–written progress note today, without a template, just how long does it take to document all the data elements that need to be addressed to cover all the things that are listed in the local coverage determination?

(Dr. Stacey Brennan): Hi. This is (Dr. Stacy Brennan), can you hear me OK, (Melanie)?

(Melanie Combs-Dyer): We sure can. Go right ahead.

(Dr. Stacey Brennan): Good. OK. Just looking at the draft that (said on the) website early in November and — which does a good job of identifying the items that a physician would need to cover with a patient, I believe, it, probably, would take somewhere between 30 minutes and 60 minutes.

Obviously, if this is a physician, who's well–acquainted with the patient, like a family doctor or an internist would, over a period of time, it might certainly take a little bit less if some of these elements are already known to that practitioner.

But if this were a first time meeting, say, with a rehab physician, I would think it would take a little bit longer to do the current job that we are hoping for. Did you have any other thoughts on that?

(Dr. Whitten): No, I think, it's — especially if it's a new visit. And the template — because it lays such things out so completely — actually looks as though it would longer to complete the template, then it takes just a (breakfast but it does help loose in a little electronic template and it does help provide a cue to which several would reply). So, the primary forces...

(CROSSTALK)

(Melanie Combs-Dyer): Dr. (Whitten), you're getting difficult to hear. Can you pull the microphone a little closer to your mouth?

(Dr. Whitten) Yes. It's about as closest as it will — you still can hear me well?

(Melanie Combs-Dyer): Thank you. We have it (better) now. Yes. Go ahead.

(Dr. Whitten)Thank you. The total record it — to answer (Dr. (Brennan) just gave was for somebody who was seen for the first time, somebody who's been followed for some period of time, it probably would take a fair amount less and had a previous record that has addressed certain issues would also be able to be used.

Remember that the exam is both an exam, a face–to–face exam, which is — which is, certainly, billed as an exam. And then, in addition, the completion of the forms, the materials sufficiently to be able to qualify for the Power Mobility Device. So, I think, her answer is quite reasonable; somewhere between half an hour and an hour depending on how well the patient was known and what some of the answers are.

(Melanie Combs-Dyer): (Steven), did that answer your question with those responses?

(Steven Kirschblond): Yes . And does the reimbursement for that visit, if it was a — the question up into the exam, again — and it would take close to — and I agree that it would probably take close to an hour to complete it. Based on the draft that I saw, what is the reimbursement for that?
Because my concern is, that less and less people will agree to complete these documentations. So, the patients, ultimately, will be the ones to suffer, unless the physician feels like they're going to get reimbursed for that hour's worth of time of documentation.

(Melanie Combs-Dyer): Well, it's — this is Melanie. It's important to keep in mind that this Electronic Clinical Template is completely optional. This is not a requirement, it is simply a reminder of the existing documentation requirements.

And those physicians, who remember those documentation requirements and can just write it in our note, without needing to prompt in an electronic template can absolutely do that.

Now, to answer your question about how long it — what a physician is allowed to bill for that — conducting that face–to–face exam, that visit with the patient, it doesn't whether they're using a template or they're just starting with a plain, blank piece of paper or a plain, blank piece of the EHR page. It's whatever they normally would bill for that level of office visit. My guess is it would be one of the higher level codes.

And (Dr. Whittener), (Dr. Brennan), am I remembering correctly that there may be a (G code) that's an add–on for this particular face–to–face visit?

(Dr. Stacey Brennan): Yes. That's correct.

(Dr. Whitten):

That's correct.

(Melanie Combs-Dyer): And that pays about $10.00 extra over and above the normal payment for the (ENM) visit?

(Dr. Whitten): I thought that (G code) can only be used separate and could not be combined with another note.

(Dr. Whitten): Well, then, (G code) is for the 1completion of the material. It's in addition to the face–to–face exam that's conducted.

(Dr. Stacey Brennan): Correct.

(Dr. Handrigan): Yes. This is (Dr. Handrigan), can you hear me?

(Melanie Combs-Dyer): (Dr. Handrigan), can you get a closer to your — to your...

(Dr. Whitten); (Mike), you're real (fuzzy).

(Dr. Handrigan): Yes. This is Dr. Handrigan. Can you hear me?

(Melanie Combs-Dyer): Barely. Keep going.

(Dr. Handrigan): I just wanted to add a couple of things to Dr. (Whitten's) and (Brennan's) answers. I think that the amount of time that it takes depends on several things.

Now, the first of which is how often the provider prescribes a PMD. For example, some do this on a daily basis, whereas, others may do this only once or twice in their career.

Secondly, it depends on, specifically, why the PMD is being prescribed. For example, a musculoskeletal disorder is different from a cardiovascular disorder that requires a PMD. And the documentation requirements vary according to the disorder.

And, thirdly, the entire template is not intended to be filled out on every single occasion.

But, in fact, it's designed to be the electronic framework that works in the (background to direct the provider to the right data elements that need to be documented in the chart.

And so, the amount of time will really vary upon quite a few things but in no way is the entire template expected to be filled out. Does that help clarify?

(Melanie Combs-Dyer): Let me repeat briefly what (Dr. Handrigan) said; three points he made.

Number one; the time that it takes may vary depending on how accustomed that provider is to ordering that PMD.
Do they order Power Mobility Devices on a daily basis? Or do they order twice a year?

Number two; the amount of time that it takes may vary based on the type of disorder. Is it a muscular skeletal issue? Is it a cardiovascular issue? The type of exam and the length of time may vary based on the patient's disorder.

And number three; (Dr. Handrigan) wanted to remind us all that not all the data elements in the template need to be completed, only the ones that are relevant to that patient.

(Steven)? Let's give you one more opportunity. Did we answer all of your questions?

(Steven Kirschblond): You answered them. I think that the — what we're seeing is that more and more people are just saying that it's not worth the time and that's unfortunate. But it's also impacting patients in getting the proper evaluations, including the paperwork that they need. But I'll give time for other people to ask questions. Thank you.

(Melanie Combs-Dyer): Thank you very much.

Operator, can you please remind folks one more time what to do to get in the queue.

Operator: And as a reminder, if you would like to ask a question press star then the number one on your telephone keypad.

Your next question comes from the line of (Carol Vargo) from American Medical. Your line is open.

(Carol Vargo): Thank you. Hi (Melanie), it's (Carol Vargo) at the AMA. Thanks for having this status report. This has been helpful. I have a question. Have you received input from the specialties that you noted that may be less familiar with this process?
And when you go into the S&I process, will the template be able to be altered based on additional feedback? Or do you envision that what you have going into the S&I process will be the basis, going forward?

(Melanie Combs-Dyer): We did get lots of input from lots of different specialties. I don't know that I know, off the top of my head, everyone that has commented but we did hear from lots and lots of folks.

In terms of whether it's a done deal? Or are these data elements still open to revision?
They are still open to revision.

We are hoping though that, as we move to ONC we'll be talking, perhaps, a little bit more around how we reach agreement on these data elements quickly. And then, move on to more of the IT issues around how we get these built into EHRs or how we get our physicians and suppliers to both have the software that it would take to transfer them back and forth.

But, no. We are — they are — this is not a final set of data elements. These are still draft.

(Carol Vargo): Thank you.

(Melanie Combs-Dyer): You're welcome.

Operator: Your next question comes from the line of (Mary Bunning) from the University of Louisville, Kentucky. Your line is open.

(Mary Bunning): Hi. We have a wheelchair seating and mobility clinic that serves both in–patients and out–patients, primarily, out–patients. How would these electronic medical — how would this template work with the process of the evaluation report that we provide?
Would the physician refer their patient for an evaluation and then complete this face–to–face template? Or would using the results from our evaluation to help identify data points for that template? Or would they complete that template first then send the — send their comments from that onto us?

(Melanie Combs-Dyer): Mary, Can you first describe what your process looks like today? Are you seeing the patient after the physician has ordered a Power Mobility Device? Or is the physician referring patients to you? You're doing an evaluation, sending the information back to the physician and then the physician is concurring or non–concurring with your report and then writing an order after that. How does it work today?

(Mary Bunning): The order is for a wheelchair evaluation and they rely on our judgment to help determine what mobility device is needed, whether that's going to be a Group 2 power chair, Group 3 power chair, a scooter, an ultra-light manual.

So — and the reason that it's happened both ways is because physicians don't know which to do and the suppliers are so concerned about not getting reimbursed for the product that they're providing; that they're going back to physician and requesting another face–to–face visit just so there won't be any discrepancy about the 45–day period.

In my opinion, the evaluation we provide and the doctor's co–signature on the evaluation could, in theory, and because of its completeness, serve — you know, serve as they face–to –face.

(Melanie Combs-Dyer): Let me turn this over to either (Dr. (Whitten) or (Dr. Brennan). Again, they are our contractor medical directors at the durable medical equipment Medicare administrative contractors who processed these claims. And let me ask one of them to start with it. What is an (LCMP)? And how does that fit in to the situation that (Mary) has here, where her clinic is conducting a wheelchair evaluation. How does that fit in to the bigger picture of the documents that their position is sending in the Medicare for coverage?

(Dr. Whitten): I'll make a start. I'll ask (Dr. Brennan) to go ahead and fill in.

It's common to have different types of wheelchair clinics. If I'm understanding correctly, this — the particular clinic that she's running is for occupational therapist and physical therapist, probably. And they receive requests from physicians for evaluations of what a patient may need for wheelchairs.

You don't have the physicians as part of your clinic. Is that correct?

(Mary Bunning): Not at this time. But in order to deal with all of the confusion, I have been considering starting that.

(Dr. Whitten): Well, that's one...

(CROSSTALK)

(May Bunning): But there is only an OT and a PT, who are both resident certified and who are seating in mobility specialists.

(Dr. Whittener): Sure. And that's one of the more common ways. That's why I asked the question. In that circumstance, the existence of this template wouldn't really need to change anything you're doing. It maybe that — in fact, it, probably, is the case now that what you're doing and completing is the majority of not almost the entirety of physicians use as to face–to–face exam.

As you know, the physician may initiate the exam and then send them to you and can have you do any on all portions of the exam to which they either then agree or go offer any additional comments at the end. And when they do that agreement at the end, which, then, they do not need a second face–to–face exam for that. You mentioned that they often do that and they can but they don't need a second face–to–face exam, if they've seen the patient ahead of time. That comes — that will complete all of the materials that need to come in.

It may well be, when this template is up and functioning but the material that's on the template would — would lend itself to the type of assessment you're already doing. Although, many of the PT/OT assessments are extremely complete and helpful. They're just not in this electronic format.

So, I don't think that — this would necessarily change anything you're doing. It, typically, would be most helpful to physicians, who don't have the services in someone such as your clinic.

And, (Dr. Brennan), what did I miss?

(Dr. Stacey Brennan): Well, I think, you covered it all. I'm just going to emphasize that we would still expect to see electronically furnished, somewhere on that evaluation that opportunity for the ordering physician to agree or as (Dr. Whitten) said to modify if there is a part of the evaluation that he or she would not agree with. And then, of course, to date it.

Now, you know, currently, we're doing in seven states a prior authorization review, which is not in Kentucky. And so, you know, we're looking and, in fact, reading a good number of the evaluations. If they're not done right now, obviously, on these electronic templates. But, we're seeing, I think, some very good examples. But, still, the ordering physician is still going to have to indicate agreements somehow.

So, I guess, on the template itself, if we're going to be transmitted over to that particular ordering physician that opportunity would have to be built in to the format.

(Melanie Combs-Dyer): And, (Dr. Brennan), thank you. This is (Melanie) from CMS. Thank you very much for reminding us that it will be very important that we capture a place in the Electronic Clinical Template for the physician to document that they are concurring or non–concurring with the wheelchair evaluation that is conducted by the LCMP, the licensed clinical medical professional.

And, (Mary), just to remind you what the (NCD) says and you may want to go out and read the local coverage determination, the physician needs to begin the face–to–face exam by stating that the purpose is to evaluate the patient's need for PMD. And then, they can either continue through conducting all of the mobility evaluation or they can refer the patient to an LCMP, a licensed clinical medical professional, like your wheelchair clinic.

(Mary Bunning): Yes.

(Melanie Combs-Dyer): And then, the LCMP conducts the mobility exam. That's your — what you would call a wheelchair evaluation and then send that report to the physician. And then, just like (Dr. Brannon) emphasized, it's very important that the physician documents if she agree with or disagree with that evaluation make modifications needed and signed and dated. And that's been complete, the full face–to–face exam; the stuff that physician did at the beginning, the stuff that the LCMP does in the middle and the physician concurring and signing and dating at the end.

Then, and only, then, should the physician be writing an order for whatever device the patient needs; a manual wheelchair, if that's what's right, or a Power Mobility Device, if that's what's right.

(Mary Bunning): OK. So, our evaluation can provide the list of the items and a justification for each. And then the supplier comes back to the physician and asks them to sign a detailed product description.

(Melanie Combs-Dyer):
That's correct.

(Mary Bunning):
OK. So, then — and we have a place on our form for the physician to sign and date and to indicate agreement. So, I think...

(CROSSTALK)

(Melanie Combs-Dyer): for a lot of physicians and LCMPs and suppliers, this whole process is either faxing back and forth and back and forth or asking the patient to hand–carry things. You know, take the order to the supplier or take — you know, deliver this referral form over to the LCMP, or whatever. And this Electronic Clinical Template project hopes to speed along the electronification of that process, making more electronic the exchange of information between the physician and the LCMP, the LCMP and the physician, the physician and the supplier, the supplier back to the physician. And ultimately, the physician or the supplier to Medicare.

(Mary Bunning): If you can allow for the inclusion of our documented PDF, then that would be just great.

(Melanie Combs-Dyer): For those of you who don't already know, we have a process that allows physicians or suppliers or anyone who gets a request from Medicare for documentation to respond electronically. And one of the formats that's accepted is PDF.

I don't know what we'll find out when we talk to ONC about all this backing and forthing between physicians and suppliers. It maybe that we are going to aim for having a more structured document; unclear whether PDFs would be allowed as well. But, (Mary), that's a very good question. And those are the kinds of things that we need to raise with ONC once we actually get into this SNI process.

Is it only going to structured documents? Or is it going to be structured documents
or PDF? Thank you so much for asking.

Do we have any other questions?

Operator: Your next question comes from the line of (Don Clayback) from (NCART). Your line is open.

(Don Clayback): Great. Thank you. (Melanie), just a couple of questions, I guess, and, I think, we all agree that this is an important (ordinary) and we appreciate the time that you and your group are putting into it. But a couple of, I guess, questions.

One is, given that the confusion that certainly exists out in the marketplace right now around the completion, we don't want to make things worse instead of better. And I think two things play into that.

One is, you know, the amount of input you're getting from real practicing clinicians that are prescribing this equipment?

Whether it'd be the physicians or the OTs or PTs that are specializing in this. And I know you said you've gotten some inputs from those folks. But, you know, I'm wondering how much of that has been incorporated? And, also, are there any additional plans?

For example, do you take — do you this document and find ten physicians and literally ask them to pile it in and use it in several evaluations to see how (factual) it is and what issues they run into, before it's widely publicized?

Because, certainly, there's a lot of information in here. And, I think, it would be very easy for a physician if they are exposed to this; the kind of — you know, to put a sign on their doors that we don't want to get involved in wheelchair prescription because of all the comprehensive nature of it.

And, I think, one of the things that probably needs more clarification is this idea of what actually is required? And what isn't? Because there's a lot of reference to the various medical conditions and testing whether it'd be x–rays or oxygen level testing. There's a lot of things in here that on the surface may make it very (onerous) for a physician. So, I guess, those are two questions.

One is there any plans to actually test this with some real live patients to see how it works before it goes too far down the road? And the other thing is to provide better clarity around what is required and what is optional based on the patient's condition?

(Melanie Combs-Dyer): So, first of all, based on your question about are we going to be doing a pilot test? The answer is yes but I'm not sure at what point in the process and that's — that would be a really good question to ask once we get the folks from ONC on the line.

I think it would be helpful to have a pilot test early on just from a clinical standpoint. Forget all the electronic exchange back and forth and does it work from an IT perspective. Are we asking the right questions?

And I'll also point out to folks that there is, certainly, no prohibitions against using the data element list that is currently posted to our website. Folks who, right now, want to pilot test the paper version up — print it out, pull it down, consider using it the next time somebody comes into your clinic for a wheelchair evaluation.

Look at whether or not it's clear. Whether or not there are questions that are confusing to your physical therapists or people, who don't understand, things that we could make better or clearer in the wording of the question. I would love to have any feedback that folks are finding in the real world;
that they're actually using this data element list today.

And then, in terms of what's required and what isn't required, we really are just listing out all the possible things that a provider may want to collect during this examination. But they really only require to document things that are relevant to that patient.

And so, we're hopeful that this will be a helpful reminder list, if you will, of what needs to be documented during a visit and prompting them to think about the things that need to be documented if they're relevant for the patient's condition.

(Don), was that responsive to your question?

(Don): Yes. Thanks, (Melanie). Just one follow–up, I guess, or maybe two quick ones. Relative to that feedback, what's the timeframe that folks have that continue to provide continue those comments on modifying the current draft?

(Melanie Combs-Dyer): My door is always open.

(Don): OK. And the other thing on the comprehensive nature, is there, then, consideration to once this would be put in final — to put in place that we're not going to run into problems, where reviewers may be asking questions? Saying, well, for example, there wasn't information —detailed information on the person's respiratory condition. And that's going to — it's going to open up additional questions when the physician may feel, "Well, I've already documented what — why the person needs it for other reasons and I didn't feel it's necessary to get into the respiratory details." Is that the concept that, as you said, the physician will make a determination on what is the primary reason requiring the device and other things that aren't relevant that he or she won't be obligated to provide?

(Melanie Combs-Dyer): Dr. (Handrigan), do you want to answer that one?

(Dr. Handrigan): Sure. I think that's a good question. And it's probably important to note that the coverage requirements haven't changed at all.

And so, what is required in the documentation now will still be required in the documentation.

What would be irrelevant will be continue to be irrelevant.
For example, if the patient required a (PMD) to get around because he's a bilateral amputee; the documentation related to the cardiovascular system) may or may not be important. It would depend on a specific case.

But I don't think and I don't want to speak for the medical reviewers at the (DME MACs). We can let them speak for themselves.

But the reviewer looks at the case, I think, they would be looking at the case relative to the indication for the PMD and looking for medical documentation that supports that indication. Does that answer the question?

(Don): Yes, thank you.

(Melanie Combs-Dyer): Operator? Can you remind us how to ask a question?

Operator: And if you would like to ask a question, that's star and the number one on your telephone keypad.

Your next question comes from the line of (Teresa Gregorio) from (TIRR Memorial Herman). Your line is open.

(Teresa Gregorio):Hello. I'm an occupational therapist and I'm a — ATP. And Ido specialized wheelchair mobility system evaluations.

I work in a spinal cord rehabilitation center, as well as an acute cancer center. They are two very different practice areas.
Of course, the physicians in the rehab center are the physical medicine doctors. And the cancer center, they're just — mostly oncologists. There are some (PNL) doctors but there's various and sundry physicians.

My question is very few — I would, probably, say three — doctors in this big complex know about the local coverage determination know even that they're expected to do a face–to–face evaluation with patients whenever they present to them for the need for mobility. Essentially, they just refer them for therapy.

So, my question is, being that all this energy and time is being put into developing this electronic template, how are physicians to learn about that the template is available? How are they learning what their responsibilities are? Because I received a lot of pushback from physicians of telling me, as the therapist, "Well, I referred them to you. I don't know what the person needs. So I'm referring to you."

And so, they, very infrequently, put even that they've referred to therapy in their progress notes to begin with. So, what that entails is that whenever I see the person, because they've been signed up for their therapy assessment, their evaluation — I have to send them back to the physician for a new face–to–face. So, the physician then can enter information into their medical record, the need — for the need for a — some type of Power Mobility Device. And that they're referring them for occupational therapists, which seems to be a lot of wasted funds for the patient.

So my question to you are, how are you going to educate the physicians? Are you aware that most physicians in all of these settings have no earthly idea about this process? And just how can we address those issues for the template to be most successful, if you do choose to go forward with it?

(Melanie Combs-Dyer): So, we are aware that it's tough to educate physicians. They're very busy. Oftentimes, they are not able to take the time to read the (Medlearn Matters) articles or the (Listerves) or all the other wealth of information that PMS puts out to help physicians understand what the rules are.

Nonetheless, these are very important rules and we continue to look for every opportunity, every avenue we can to help educate these physicians.

Let me tell you about one thing that we've done in our prior authorization states and then I'll tell you about something that we're planning to do in all 50 states.

One thing that we did in our prior authorization state, those are the seven states where they — physician or supplier must obtain a prior authorization

number — approval from the DME MAC before they can deliver the patient – – deliver the PMD to the patient and still receive a full payment.

What we did there was we sent a letter to every physician, who had ordered a Power Mobility Device in the previous three years of, again, just in those seven states. And we are hopeful that that actually was able to reach the eyeballs of the physician. I know they're very busy but we hope that was a helpful letter.

Now, what we're planning on doing in the 50 states to reach out to physicians and make them aware of this Electronic Clinical Template project and the data element list that's on the web right now, and this effort that we're about to be undertaking with ONC, we're going to be sending a letter to every physician in America in all 50 states, who has ordered a Power Mobility Device in the last three years. And we're going to be reminding them, where they can go to find the rules, reminding them that we are trying to help make things easier for them through developing this Electronic Clinical Template. But it's only – – it's only a suggestion, and it's voluntary. If they don't want to use it, they don't have to use it. And reminding them where they can find the data element, the paper date element list today on the website, if they think that that would be helpful to them in the interim before we are able to develop the electronic version.

But, (Teresa), we're totally open to additional ideas. If you have some suggestions about ways, other ways that we can reach out to physicians we would really appreciated it. Again, I think, that by developing an Electronic Clinical Template, building it into the EHR and making it right there at the physician's fingertips in the EHR as the patient is presenting, that may be the best education of all.
But we're totally open to other additional ideas that you and others may have.

(Teresa Greogorio): Well ,I think, one thing that could be beneficial is if in within the context of the template, if you include prompts throughout the evaluation tool, as a reminder that they can refer them to therapists for completion of it this evaluation and the consultation and the recommendations. And that functional mobility evaluation can help determine the appropriate item and

then provide that feedback. But, I think, maybe building that into your template is something that could be a very visual thing as well.

(CROSSTALK)

(Melanie Combs-Dyer): That's a great suggestion and we will make sure that gets built in as a data element, if it's not already there. Thank you.

(Teresa Greogorio): Yes. And I think if you have a practicing seating therapist involved with your ONC group would be an excellent idea as well because we can explain and tell you what what's the real what is really going on out here in the real world for seating. So, I think, that we have a wealth of feedback and input that would — you know could maybe help that process and help in looking at the template element.

(Melanie Combs-Dyer): Well, Teresa, I really appreciate your volunteering to do that and I would simply ask you to send us an email on that Electronic Clinical Template page you'll find an email. And if you would just shoot us an email that way we can make sure that you are included on the invitation email that goes out once the ONC, SNI Electronic Clinical Template workgroup kicks off.

And that's to everyone on the call; anyone who wants to participate in the ONC workgroup, please make sure you either check back to our website, periodically, the same one that told you about the dial–in number for today's call, the CMS website. Or send us an email and that way we can make sure that we include you on the invitation email that goes out to announce the ONC calls whenever they begin in January or February.

(Teresa Greogorio): Thank you very much.

Operator: And your next question comes from the line of (Dr. Don Lesley) from (Shepherd Center). Your line is open.

(Dr. Don Lesley): Thank you very much. My questions have been answered by some of the other clinicians. Thank you though.

(Melanie Combs-Dyer): Thank you, (Dr. Lesley). Any other questions?

Operator: Your next question comes from (Laura Cohen) from (CTS). Your line is open.

(Laura Cohen): Hello, (Melanie). I have — part of my question was answered with your invitation to email regarding the ONC workgroup.

One of the things that you had mentioned on a previous call was that the e–template was written, specifically, to the LCD for Medicare, which is a different standard that it is for, say, Medicaid and private insurers and that during the ONC process that this would be taken into consideration, so that any data elements that are adopted by the e — electronic health record vendors and incorporate into tools need to be sure that they — the (address) coverage for all — you know what real — what typical practice is, considering all of the person's mobility needs, whereas the Medicare coverage is limited to only in the home. And I wanted to ask how you plan to address that in that process.

(Melanie Combs-Dyer): (Laura), thank you for your question. While the focus of the S&I workgroup will be for — around Medicare rules, we hope that we can develop the framework, the S&I process that, you know, the discussion, the table, in such a way that other payers could easily replicate what Medicare is doing. And if Kaiser wanted to step forward or some state Medicaid organization wanted to step forward or anybody else wanted to step forward and sort of replicate the process for their coverage rules, they could. And, maybe, they would start with the Medicare template as their starting point and they would make whatever modifications they needed to for their particular insurance company.

We've also had some conversations and preliminary conversations with ONC around the development of a — not sure what the right technical word is — but a library of Electronic Clinical Templates so that EHR vendors could go in and make available whatever the latest template is for whatever payers choose to participate in this process. And it would be updatable, if we decided that, you know, a year into this, the (statue changes) or the national policy changes or the local policy's changed. And therefore, we need to go change the

Electronic Clinical Template for Medicare. We could make the change and put it in a library and it would be picked up on a schedule by all of the EHR vendors. It won't be overnight because software, you know, obviously, has a cyclical schedule around it. But we will develop a process so that it can be updated and we would encourage other payers to participate in the process assuming that we are successful in getting this built and piloted and adopted by software vendors and adopted by physicians. And I'm very hopeful that we are.

So, (Laura), we are hopeful that we're setting an example for other payers. We certainly have heard from the (AMA) that they are very anxious to make sure that we are putting something together that will — can be easily replicated by other payers. Again, the goal for many people who are participating in this effort is to minimize the burden on providers; make it easier for them to know exactly what they need to document or the various types of insurance that patients coming through their door may have.

(Laura), was that — was that responsive to your questions?

(Laura Cohen): Yes. I have a follow up, though.

(Melanie Combs-Dyer): Sure.

(Laura Cohen): One of the — yes, but the concern is for the end user, the patient, who need this equipment. And, you know, the Medicare requirement is more limited than what the requirement is, say, for Medicaid. And my concern of using a limited — a template that is limited in nature, to begin with, is little incentive for the Kaiser's, the (Ned's) Medicaid organization, et cetera, to broaden coverage. And that was one of our concerns (definitely for) started this endeavor with the template earlier this fall was that the template should be consistent with standard medical practice, so that all the information is corrected and it could easily be — when it's being reviewed, it can be reviewed and held to the standard of what is covered, without having to limit what information is collected.

And that remains a concern because, I think, that there would be little — there would be little incentive for any of the other payers to come in later and broaden the information and what...

(Melanie Combs-Dyer): I'm not positive I — that I'm understanding your questions. So, let me try to answer it. And then if I get it wrong, feel free to re–ask the question.

We want to make sure that this Electronic Clinical Template gives the physician a full ability to document everything that they need to document during that face–to–face evaluation, including if they need to refer the patient to an (LCMP), who needs to document a whole bunch of stuff and then send that note back to the ordering physician.

We do not, in any way, want to limit what a physician is able to document. We are only trying to set up sort of the minimum things that the physician needs to make sure at he or she is recording. Did that answer your question? Or did I misunderstand your question?

(Laura Cohen): I'll just give you a specific example, maybe it will help.

Under B; the history of the present elements. The question is limited to asking — collecting information about how a person needs the PMD in the home only?

The person also may live independently in order for them to get to the market and buy their food or to get to the pharmacy and get their medication or to get to their mailbox, they may need something different. Even though they need it in the home, they may also need it outside of the home. And that directly informs the type of equipment that's most appropriate for them.

But because the data elements are limited and the scope of information and the scenario of how we can report it, we no longer looking at all of the person's need, which is standard practice and all of environments that they typically encounter.

(Melanie Combs-Dyer): I can certainly go back and talk to my counterparts at ONC and here at CMS but I continue to think that we want to create something that will work for Medicare. We'll gather all the information that is needed for Medicare but certainly be open to other payers creating a different set of data elements if they need a different thing.

But let me ask if (Dr. Handrigan) wants to speak to this questions of some of our data elements being a little bit limiting and not allowing the physician to document everything that they need to document.

(Dr. Handrigan): Right. And, you know, I think that that's an important question and that the template or the data elements, as ONC frames up the standard that might — I think, it would be useful if the ultimate products are flexible enough to use across systems. But, I think, the example used was Kaiser and it may require more information that CMS currently requires.

I don't think that given that we're looking at the data elements right now, there would be any reason to restrict the providers in the amount of information that they put into the medical record. The template elements are really there to guide the provider down the road of making the right the documentation and not to limit...

(Laura Cohen): Right.

(Dr. Handrigan): …what they should put in.

(Laura Cohen): Right. And, I guess, they've got — just one value to, you know — we — the clinical (health force) has submitted comments on multiple occasions about this and removing the in–the–home (referenced) this document to allow us to document how a person — what mobility needs they have in all of the environments that they typically encounter is what standard practice is. And by just removing that term "in the home" allows us to write down all of the things that a person does. And if the person is reviving it, obviously, the (pride) in–the–home standard to it from that (inaudible). But it would not prevent us from writing down in all of their environment.

(Nick): (Dr. Handrigan), this is (Nick). Can I offer a thought here?

We just need to be a little bit careful. We're reviewing physician notes on a regular basis. I agree with what the — (Laura) is saying that the common way physicians would look at a patient's needs but the Medicare program requires us to look specifically at the patient's needs in the home. And we have to be careful to guide that the — that those questions will be answered for use in the home or we won't be able to conclude whether or not the benefit applies.

So, I understand that the request to try to have this be more general and it would be nice in physicians' point of view, if we were just looking at a patient's universal means but the Medicare benefit is specific to in the home. So, we will have to ask our questions in a way that when we come away and look at the material, we'll be able to answer the beneficiaries need in the home.

(Melanie Combs-Dyer): And, (Laura), I'm noting that we're getting to the end of our time. So, yours will be the last question.

I just want to finish up by saying we will definitely try to come back to this issue around one template that will work for all payers versus different templates for different payers at our next call. I think, that's a very good place for us to start. And, I — I'm not sure that I'm going to be able to have the – all the contracting issues worked out and actually be able to have the ONC folks on the next call. But I will, at least, try to be able to answer or, at least, begin to answer that question around one template for all payers versus separate templates. Or, at least, tell you where I am in my discussion on that topic.

To everyone who has asked a question today, thank you all so much. This has been a very helpful dialogue. I appreciate all the feedback and the input that you guys have given. And I really appreciate you taking the time this late in the day and this close to the holidays. For this very important topic. So, thanks to everyone.

Let me turn it back over to either (Matthew) or to the operator to give us some closing thoughts.

(Matthew): This is Matthew, Lindsey. Why don't you share the encore information with the callers and close out the call. Thank you.

Operator: Thank you for
participating in today's Suggested Clinical Electronic Template Discussion for Power Mobility Devices Special Open–door forum conference call. This call will be available for replay beginning at 7 o' clock Eastern Time today, December 19 through midnight on December 21st 2012.

The conference ID number for the replay is 69–289–478. The number to dial for the replay is 855–859–2056.

This concludes today's conference call, you may now disconnect.

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