Centers for Medicare & Medicaid Services
Special Open Door Forum:

Suggested Electronic Clinical Template for Power Mobility Devices

Tuesday, July 10, 2012
2:00pm – 3:00pm 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: 69288422
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) and to view Frequently Asked Questions 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/071012ClinicalElectTempPMDsID69288422.mp3

Centers for Medicare & Medicaid Services

Moderator: (Matthew Brown)
July 10, 2012
2:00 p.m. ET

Operator: Good afternoon my name is (Jay) and I will be your conference facilitator today. At this time I will like to welcome everyone to the "Centers for Medicare and Medicaid Services Clinical Electronic Templates 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 will like to ask a question during that 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. Mr. (Matthew Brown) you may begin the conference.

Mr. (Matthew Brown): Thank you very much (Jay). Good afternoon and good morning to those joining us from the West Coast. My name is (Matthew Brown). I work in the office of public engagement here at the Centers for Medicare Medicaid Services. And I'm going to moderate this call.

Today's call as (Jay) announced is one in a series that the Centers for Medicare and Medicaid Services will host to provide an opportunity for suppliers and physicians to provide feedback on the clinical electronic template for power mobility device is for Medicare purposes for our possible nationwide use.

At this point I'd like to take the opportunity to introduce our call leader for today, (Melanie Combs-Dyer) the Deputy Director of the Provider Compliance Group here at CMS. There will be an opportunity to ask questions at the end of the presentation. And we'll go over those instructions once we get to that point.

We are getting started a bit late and I know there are some folks still dialing in. So we won't waste any time and with that I'll turn the call over to (Melanie).

(Melanie Combs-Dyer): Thank you. This is (Melanie Combs-Dyer) and I just want to make sure that everyone has been out to our website to find the template that we're going to be talking about today. In case you have not, it is go.cms.gov/eclinicaltemplate. There is no www at the beginning. It's just go.cms.gov/eclinicaltemplate.

Today we're going to be focused mostly on the template. We simply are at near final document. Although if you have any suggested changes you want to tell us today we will still take those changes.

Then we're going to talk a little bit about our plan to begin some work with ONC. And then I'm going to tell you a little bit about an upcoming manual change that we are planning to our program integrity manual, that will talk about templates.

And we may have a frequently asked question that goes along with that. And then finally I will be talking just briefly about the possibility of us issuing a letter to physicians to talk about the electronic clinical template.

We're going to start off today's agenda talking about the latest version of the template which was posted today. So if any of you are working from yesterday's version of the template, you want to go back up to the website and get it. It's listed in the download section at the URL that I just gave you. And it's the last item on the list. It's called a suggested PMD electronic clinical template version 9.6.

So everybody should have that version 9.6 in front of them. And I'm now going to turn it over to (Doris Jackson) to highlight a few of the changes that were made since the last version.

(Doris Jackson): This is (Doris) speaking and I'll like to say thank you for your comments and suggestions. We've received quite a few. Some were repetitive in nature, which is OK because that helps us to identify areas that we need to focus on.

One area in particular that tend to resonate with a lot of comments, were concerns about the occupational therapist or physical therapist that (CMA)

will (be able) to conduct the mobility evaluation. I want to clarify that the PT and OT (inaudible). They cannot conduct the face to face exams.

But what they can do is conduct a mobility evaluation. That in conjunction with the physicians documentations for the face to face examination. And of course (inaudible) physician, has to sign off on the documentation from the therapist.

In addition how that person documents. That was a question by some of the commenter's will they be filling out a face to face type evaluation? No. These professionals have been conducting mobility examination for a period of time. And so whatever format they have been using in the past, that's what they should continue to use at this point in time.

There were some other basic comments about the person's work history (different) types of questions of that nature. We did remove those type questions with the understanding that the use of the power mobility device is for in home. And we did have other questions that made reference to usage outside.

In order for Medicare to pay for that equipment, it must be used within the home. So we removed those type of assessment questions from the template. I think those were the major things that really stood out. Can you think of anything doctor?

(Melanie): This is (Melanie) and I can think of one thing. There were a number of suggestions that we add to the note that appeared at the very beginning. Right before the chief complaint section. And as we continue to add and add and add language there, we began to realize that it was looking longer than a note.

So we actually moved that information up to a prior page. So the note sort of appears as a cover sheet almost to the data element from the electronic clinical template. I just want to make sure that folks new that that had happened.

(Doris Jackson): I think that, that's pretty much the main thing. Dr. (Hoover) did you have anything that you wanted to add?

Dr. (Hoover): No not this time, thank you.

(Melanie): And Dr. (Miller) how about you? Anything else you wanted to highlight about how this has changed since the last version?

Dr. (Miller): No, I think that about covers it.

(Melanie): OK. So the next thing I wanted to discuss, very briefly was what the next steps are? We are hoping that by the next time we have one of these calls which September the 25th I think. We are hopeful that we can share with you our final plan to begin an initiative with the Office of the National Coordinator for Health IT.

We actually have someone on the phone today. (Mera Choi) from ONC and she can help me address any questions if some come up at the end. But we are hopeful that by the September 25th call we can give you some more details about how the hand off is going to work. From CMS to ONC. I am expecting generally that the ONC initiative once it does kick off this Fall will involve public calls where folks can dial in and in fact we'll also have documents posted to a webpage, sort of a wiki style webpage. That's the way that most ONC initiatives work. A series of phone calls.

And that the frequency of the phone calls may pickup. We've been having calls about every month or two. And I believe that ONC often times has frequent calls than that. And so the electronic clinical template imitative with ONC may involve more frequent calls. It's also possible that there will be two separate series of calls.

One to talk about the actual data element of a progress note. And another that will focus mostly on the digital signature or electronic signature. And we haven't yet figured our exactly what the names of those (inaudible) are going to be. But we will certainly share with you more information about that at the September 25th call. And we'll make sure that everyone knows how they can sign up for getting on to those ONC calls. Again we don't have that information now, we're still working on inter agency agreement between CMS and ONC. But we're hopeful that we'll have more of those details at the September 25th call.

The next thing I wanted to talk about was a manual change that we are going to be working on. And we hope to have posted before the next call. It will be a change to chapter three of the program integrity manual. And it is in response to a number of comments that we have received through the mail box with people asking questions about, what's the difference between a template and a form?

Is it considered a part of the medical record? When does the review contractor have to accept it and consider it? What if it's done this way? What if it's done that way? So we're hoping that some of the language that we issue in our new program integrity manual change will address lots of those questions. And so I would encourage everyone to be on the lookout for that.

Again we will post something to our website to let you know. I think we're at least a month away. So you don't need to be checking everyday right now. But certainly a week or two before the September 25th call we do hope that we'll have something up on the website by then. And we may also have like a page of frequently asked questions that go along with that.

Again just sort of addressing templates, these progress note templates. What are they? And what's the difference between, can we use a paper version? All that sort of stuff, we really hope to spell out in greater detail in the program integrity manual change that you will see in the next month or two.

And then finally I wanted to mention to you that we did get some suggestions, from a number of folks. That we send out a letter to physicians at least those physicians who have order PMD in the last year or two. And make them aware of these data elements. Make them aware of our electronic clinical template initiative. And so we are exploring that possibility right now. And I hope that at the September 25th call that I'll have more information to share with you about those dear ordering physician letters.

So I believe that, that's all that was on our agenda for today. Yes I'm looking around; it looks like I covered everything. So I think at this time we are ready

to open it up for questions from the callers. So operator if you can give the instructions on how folks can ask a question, we would appreciate it.

Operator: Certainly, as a reminder ladies and gentlemen if you would like to ask a question please press star then the number 1 on your telephone keypad. And to withdraw a question please press the pound key. Thank you very much. We'll pause for a moment and compile the Q&A roaster.

The first question comes from the line of (Maggie Dee) of KUSS disability, your line is open.

(Maggie Dee): Hi, its disability and senior news report. Thanks very much for this opportunity. I know I have one shot at having a comment period because there's so many of us on the phone. So if you bear with me. I've made some quick notes on several subject matters.

One, I'd like to suggest that you think seriously about that home (bound) rule. There are those of us that need to go to doctor appointments. We need to go to church and so I am hoping that you'll take interest and time to review that home bound rule. It's very isolating. My next point is that scooter dealers are given virtually free range to supply scooters getting benefit payments whereas the wheel chair dealers have a much more difficult time getting what we really need.

So people are turning to scooter dealers instead of the people that they really need to go to DME suppliers. My next topic is managed care is coming to California. The (plans) are using are off the shelf (power) chairs rather than the necessary customized chairs that are needed. And especially for people that have a long history of custom chairs.

People are having extreme difficulty getting what they need. And another topic is doctors have no clue what is necessary for a patient in their chair. And that's why they turn to OTs and PTs for assessment. And when you say they have to sign off on it they really don't know the first thing about DMEs. And their heavily dependent on the OT/ PT. And if you don't require managed care plans to have the OT/ PT do the assessment, people are going to

get in the wrong chairs and they're going to pay a heavy price if not their lives as a result of it.

And my last topic and comment is we will not be allowed to see auto specialists in this managed care program. CMS rates health plans and the health plans that have been chosen for the State of California are one and two star plans. Which means we have the worst of the worst. And so I'm hoping that CMS and in particular with the DMEs is really carefully scrutinizing these plans. And that they're having to prove that we're going to get the custom chairs that we really need and have had a history of needing those custom chairs. Thank you for this opportunity.

(Melanie Combs-Dyer): Thank you (Maggie) this is (Melanie Combs-Dyerr) and I will take your questions in order. Your first question had to do with the home bound rule and would CMS consider changing its home bound requirement? And the answer is no we can't because that's a statutory requirement. So congress needs to change that and I would encourage you to write to your representative in congress and see if they can change that rule.

I have heard that there are some organizations who are trying to get congress to change that rule at least for beneficiaries of a certain age. But I don't know where that stands. The second question that you raised was about how scooter dealers operate under a different set of rules than power wheel chair suppliers.

And let me assure you that in fee for service Medicare that is not the case. Power mobility devices including all of the items, the scooters and the power wheel chairs that are on the list, everyone has to abide by the same rules. It's the same documentation that a physician needs to put in the patient's medical record to describe the patient's condition and explain what their medical need is.

And so for at least fee for service Medicare scooters and power wheelchairs are treated equally. Your third comment was about managed care doesn't allow custom chairs. This power mobility device demonstration is operating in the fee for service Medicare space.

So everyone that's here today presenting, we're only talking about fee for service Medicare. I can't speak to any changes that may be happening in managed care or in the private side of managed care. We just aren't talking about managed care here. This is a fee for service Medicare program speaking.

(Maggie): A lot of people in California are opting out of managed care because in keeping our fee for service.

(Melanie): I can assure you that our program of fee for service, PMD demonstration is designed to make sure that people get the chairs that they need. Physicians will document in the patient's medical record what the patients need. And so long as all of the Medicare covered requirements are met, that's what the patient will get.

You also talked about, can a physician refer a patient to a physical therapist? And I'm going to turn that over to Dr. Miller from our office of clinical standards and quality to talk about can a physician make a referral to a physical therapist or orthopedic specialist or any other kind of specialist, as they are completing the face to face evaluation of the patient. Dr. Miller?

Dr. (Miller): Thank you. If a physician, for example a primary care physician who has not been trained in mobility devices or PMD wishes to do so. He or she may refer the Medicare beneficiary to a licensed certified medical professional such as a PT, OT and orthopedic specialist, a (physiatrist) etcetera.

Who has experience and training in mobility evaluation to perform a part of the face to face examination? There are some restrictions regarding the professional and more specifically, we state that, that professional may have no financial relationship with the eventual supplier of the mobility device. But otherwise you may see a specialist in order to have the mobility portion of the face to face evaluation performed.

(Melanie): Thank you very much. And before we take our next question, I'd like to remind folks that this call is designed to talk about our electronic template initiative not to talk about the PMD demonstration. We have a separate series

of calls set up for that. So please wherever possible try to limit your question to the electronic clinical template project.

Operator can you remind folks how they can get in the queue to ask a question.

Operator: And once again I you would like to ask a question, please press star then the number one on your telephone keypad. Again that's star one and if you would like to withdraw your question please press the pound key.

The next question on the line comes from (Laura Cohen) of (commission) task force your line is open.

(Laura Cohen): Hello I'd like to thank you for the opportunity to comment on the (iterative) clinical template. I'm the Executive Director for the (commission) task force and we have submitted comments in the past. And are in the mist of preparing some detailed comments we hope to have for you by the end of next week.

My comments today are twofold. First of all I think that over the last six or seven years there remains to be a lot of confusion around the terminology that CMS uses. And when we think face to face examination, often times physicians think that it's the data their looking at that patient in their office. And in fact the way that CMS uses it is a face to face examination process.

So I think that further clarification or even changing some of that terminology may help simplify the process and make it more intuitive. Specifically the e-clinical template I believe is talking about the medical examination process that the physician does.

The second part of what they do often times is the referral to another professional PT or OT or physiatrist. And then you have the mobility evaluation portion of the exam that the doctor can do if they feel qualified to or they can refer that portion out. And then there is the portion where the summary of the whole face to face examination process, which is putting all of those pieces together, reviewing the recommendations from the specialist regarding the specific device.

And equipment that's recommended and signing off on the oversight of that process. Then I wanted to talk about as far as the content. And I haven't had a chance to read through it because I just found the version just now. Is the comment earlier that all of the references to mobility or evaluation outside of the home had been removed from the template.

And that's very concerning, because standard medical practice considers all of the persons needs and all of the environments that they typically encounter. And if we create an e-clinical template that is adopted by electronic health record vendors and implemented across the board in medical practice, you are changing medical practice forever.

And that's problematic, because there are a lot of people who do not have Medicare but that this will become the gold standard for. And we have Medicaid programs that have a different standard of care that they are responsible for and private (insurers). And my recommendation is that this e-clinical template be consistent with standard medical practice that all of that information is collected and documented.

The reviewers in CMS (inaudible) and processing the claims obviously will apply the CMS policy standard in making those determinations. But then all of that information will be collected and documented. I fear that if this is created only for CMS policy once it's released medical practice will be changed permanently and that's a very scary thought.

(Melanie): (Laura) this is (Melanie). Thank you so much for your comments. I'm going to take your second one first and then I'll have Dr. (Miller) or Dr. (Hoover) address your first question about the face to face exam versus face to face exam process.

Your second comment had to do with how we had removed the outside the home questions from our data element list. You were concerned because that was making it a Medicare specific data element list and you would like it see it be opened to be used by Medicaid or other payers. And let me just remind you that right now it is a CMS document. It is a Medicare document but that

when we turn it over to ONC sometime after September the 25th they will be convening a group that has more than just Medicare members.

It will have other payers, private payers, Medicaid and electronic health record vendors. Lots of other folks at the table. And so I think you should rest assure that there will be a place at the table for others. And it will not in the end, end up being a Medicare only document. It looks medicarish right now because that's where we're starting.

But the end product I can assure you will be something that will be workable for all payers. Now on your first question about the confusion around terminology, face to face exam and face to face exam process let me ask Dr. (Miller) to comment and then we'll have Dr. (Hoover) comment. Dr. (Miller)?

Dr. (Miller): Yes thank you. What is required of the face to face exam which is the terminology which has been accepted by Medicare is clearly spelled out in various national and local coverage determination that are available obviously publicly for physicians to peruse. And basically the point of the face to face examination is to make sure that the patient's medical condition sits with the mobility device that is eventually chosen for the patient.

We recognize that many primary care physicians will not know or be able to comfortably perhaps perform a mobility evaluation which may specify the exact chair or scooter that the patient requires. And that is why we have certainly allowed for a licensed certified medical professional who has knowledge and experience in mobility evaluations to also contribute to the physicians examination.

(Melanie): Dr. (Hoover) anything from you on that point?

Dr. (Hoover): Thanks (Susan) you did a good job answering that.

(Melanie): OK great.

(Laura): I think that I agree Dr. (Miller) with what you're explanation is. I think that where confusion happens in the field is the fact that the term face to face examination sounds like one event. And the way that it's described in all the

writings is it's a process that has multiple steps. And it's the completion of the process that constitutes for example the face to face examination date. And you know even today seven years after it was implemented, there is ongoing disagreements between suppliers, therapists and doctors about what that date is. And I think that if it were referred to as a multi step process where the face to face medical examination is one step of that process that may help make it clear to the team that's involved.

Dr. (Miller): And I understand your comment. If you go to the local coverage article, for power mobility devices in your jurisdiction it will spell out the time frame and the steps that are required for a power mobility device.

(Melanie): And (Laura) this is (Melanie) again. We can try to add a question and answer to our FAQ list. We know that a source that a lot of people go to. And so we can repeat sort of issue a reminder that would reference back to the local coverage determination and the language about the process. And the referral and the date that need to be included. We may also be able to add some language about that to the dear physician letter that we're going to be sending out. So thank you for your suggestion and we will try to get out an FAQ and some language in the dear physician letter.

Operator can you please give the instructions again and let's take our next call.

Operator: Certainly. If you do have any questions please press star one on your telephone keypad. The next question comes from the line of (Tory Pegevsky) of (Marki mobility). Your line is open.

(Tory Pegevsky): Hi, referring back to the question regarding the face to face and what the doctors perceive is that we are a DME provider of the power wheelchairs. And almost all of our doctors think OTs and PTs can do the face to face so they just refer them to them to complete that. And we're having to have to go back to the doctors to educate their offices to let them know that yes a PT or an OT can see the patient, do the evaluation but they also have to do the face to face as well and review that.

I think that's where some of the confusion is in the face to face. Because a lot of doctors are refusing to do them.

(Melanie): (Tory) this is (Melanie). When you are educating you physicians about this, do you send them something in writing? Or do you call them on the phone or how do you remind them about the rule?

(Tory): We send them guidelines for what Medicare requires in their face to faces. And I personally talk to them. Our mobility specialist will stop in the offices to speak to them as well. And they just think that the PTs, OTs can do faces to faces. And then you know we have to tell them well yes they can do part of it but you still have to see the patient as part of the face to face.

(Melanie): Right that's a very good point and we'll try to make sure that we remind physicians of that when we send them the dear physician letter. Operator can we have our next question please?

Operator: One again if you would like to ask a question please press star then the number one on your telephone keypad to queue up. The next question will come from the line of (Tim Zip) of the scooter store. Your line is open.

(Tim Zip): (Melanie) this is (Tim Zip) and once again I told you this in Dallas when you came out there to do this presentation. But we appreciate the efforts that you all are under taking. Trying to give physicians better guidance on how to perform this face to face examination for PMD. We think it's a very worthwhile effort and something that from a provider side we've struggled.

And you can hear from comments on the phone we struggle with working with doctors everyday trying to help them understand what's in the LCD. What components need to be covered and we think this will go a long way to helping that out.

Having said that, I have a couple of questions and our comments. We'll submit some more comments in writing to you but we've got to update and taking into account the changes that I think that are made in this document. So I haven't fully had a chance to fully review what just got posted. But we'll update our comments to you.

One of the main comments has to do with what appears to be redundancy between the review of symptoms section and the examinations section. They have the same components, the same headings for constitutional eyes etcetera. And it just seems that the questions in each of those sections are very similar and could be combined to kind of maybe help the doctor get through the examination quicker.

And so my question to you guys is, is there a reason why those were specifically separated. A review of symptoms section and then the same components in the exams section. But those weren't combined because it was one of our main comments to maybe help reduces the size. It was started out at about five pages now it's at seven. And maybe back to six now because it looks a little shorter.

But is seems that it might be easier and less burden on the physicians if those can be combined.

(Melanie): Dr. (Miller).

Dr. (Miller): Yes in a traditional history and (physical examination) (inaudible) every medical student in the country, to review the system and physical examination are a distinct part in that H &P. So during the review of systems, the physician is asking a series of questions which will then point him or her to those organ systems which need to examined to support the patients complaints of difficulties or impairment.

And that is the point of the face to face examination. That the patients complaints are substantiated by the physical exam of the physician so that the patient can then get the mobility aid that he or she requires.

(Melanie): Thank you Dr. (Miller). The other thing I would add there is as we were trying to put together this list of data elements, knowing that our goal was to go to O&C and ask them to develop a standard. An electronic standard for this. We looked at some existing standards and found that there was one that had broad categories.

And they're the grey headings that you see in the document. For example social history and review of systems and physical exam. And so we think it's important to continue to have those separate sections because that's the way the electronic standards we think are currently designed. And like Dr. (Miller) said that's the way physicians are taught to document during their examination of the patient.

Dr. (Miller): Yes there is also something else. Because this is a standard method of documentation for all physicians, CMS has adopted a payment method where depending on the brevity or detail of each section that you complete, based on patient needs physicians are paid X amount. This has to do with the DNM codes. And we certainly wanted physicians to have something that was familiar to them. That they already knew and that they could then work through based on their prior education.

(Melanie): Thank you that's actually a really good point. One of our goals as we work with ONC on developing this electronic standard is that we make sure that we are developing it in a way that it will work for all of our payment purposes. So when a physician is documenting in their medical record, they're really documenting for a couple of purposes.

One is of course to document the needs for the PMD so that the patient can get the PMD covered by Medicare and the supplier can get their payment. But they're also documenting so they can get paid their E&M visit. And we need to make sure that we design the data elements that it meets all of those payment needs. And we'll make sure that we try to bring to the ONC table, all of the people who are familiar with the various (CMS) payment policies to make sure that we cover all of the basis.

The last thing we want to do is develop a template that gets built into EHRs all across America but then it doesn't work for physicians to get their E&M payment. Or it works with their E&M payment but it doesn't substantiate the PMD device. We really want to make sure that we're sort of covering all bases. (Tim) was that responsive to your question?

(Tim): It was. I appreciate that and to maybe follow on to that. You mentioned the E&M codes and the complexity of the examination. Will there be as you bring these folks together to discuss the next step that any type of recommendation that comes with this to physicians to indicate you know at a minimum. Now this is a complex examination, at a minimum it's typically a, I don't know the E&M codes so it's a level one, level two, level three, I'm not sure how many levels of examinations they have depending on the complexity and time that they spend. But will there be any type of recommendation that goes out to physicians of the expectation if you will of the type of examination. And the time to book for this type of examination.

(Melanie): Dr. (Miller)?

Dr. (Miller): Yes the type of exam the necessary detail that the exam requires as you said depends on the complexity of the patient. So if the patient has a straight forward knee for perhaps one reason for a power mobility device, that exam would be shorter than a more complicated patient with whom the doctor has to spend more time.

So we don't anticipate that there will be a recommendation that if you do a face to face evaluation for PMD that it will be a level whatever E &M payment. We expect the physician as they are asked on all their patient encounters to bill appropriately to the services rendered. Which of course depends on patient needs.

(Melanie): I would venture to guess Dr. (Miller) correct me if I'm wrong, that the payment of the level of the E&M level that they choose to bill would also vary depending on how much they refer out. If they refer out and someone else does the majority of the work I would imagine that the physician would not be billing at the same level as a physician who conducted the whole thing themselves and did not refer out to an LCMP.

Dr. (Miller): I think that would be correct.

(Melanie): All right. Operator can we please have our next question?

Operator: Certainly the next question comes from the line of (Debora Sefred) of AAFP, your line is open.

(Debora Sefred): Hi. Thank you very much and I appreciate this. I am the coding and compliance strategist for the American Academy of Family Physicians. I just have a couple of quick questions.

One you had stated that this would be the, for the evaluation and management and the PMD document. Is there a way then that we can create a form for our members to use based on these requirements? So that it is kind of more out in front of them?

(Melanie): This is (Melanie) and I think you should hold that question until the September 25th call. We will be issuing a program integrity manual change that talks about how people could use this listed data elements. How we expect it to be used in the future as we move through the ONC process. Eventually, hopefully get it built into EHRs across America. But I think at this point it would be easier for you to just hold off and bring that question back on September 25th.

(Debora Sefred): And when is the effective date for this?

(Melanie): This list of data elements will probably continue to reside on our electronic clinical template website for several years I will guess. But we are going to be handing off to ONC to continue with the next phase of the development of this initiative. And I anticipate that hand off to ONC would happen sometime shortly after our next call. So probably in late September or early October.

(Debora Sefred): And that's when the requirements would be, the physicians will be held accountable for those requirements.

(Melanie): No. Let me make sure that you understand the difference between the requirements today that are listed in our local coverage determinations written by each one of the DME marks. As well as the national coverage determination written by CMS. Those requirements are in place now and they've been in place for a long time. There are no new requirements that are listed here in this electronic clinical template.

This is just a way to try to build in some reminders to physicians into the electronic health records so that as their seeing the patient it might be easier for them to remember the kinds of things that they need to document in their progress notes to help them to make sure their covering all the bases that are needed to justify the PMD.

(Deborah Sefred): OK. I'm with you now thank you. I appreciate that clarification.

Dr. (Miller): May I just add that, this is Dr. (Miller) that it will not be required that any physician absolutely use this form or whatever final form that it comes through EHR. A physician may use his or her own method of documentation for a face to face exam for a PMD at any time.

(Melanie): Absolutely. And so even when we finish with our list of data elements and hand it over to ONC and ONC works through and develops the electronic standard. And it gets built into EHRs all across America, it will still be optional. Whether physicians want to use any EHR that has that built in. If they want to use any EHR that doesn't have these data elements built in. If they choose to use paper. Lord knows what kind of technology will be out there.

Maybe it would be some thing that they just sort of type in the air and somehow a computer will know what they're writing. It's really just a list of data elements that can be built into EHRs. That's really what this project is all about. And it will take some time to work through the whole ONC process. To actually get this built into the electronic health record system that physicians can buy.

(Deborah Sefred): Yes I'm just under the, you know currently I know that not all of our family medicine doctors have EMR. So anything that we can do to create a forum that even if they can take it back to their you know whomever to create their template until OMC makes it a mandated thing would be very helpful to them so that they are not reworking things. And that was my intent.

(Melanie): Yes and I will again suggest that you hold that thought and raise that at the next call. I think when you see the program integrity manual instruction in

front of you. That will hopefully answer any questions that you may have. And if it does not you can let us know at that next call.

(Deborah Sefred): Great thank you. I appreciate that.

(Melanie): Thank you (Deborah). Operator I think we're ready for our next question.

Operator: The next question comes from the line of (Tim Zip) of the scooter store, your line is open.

(Tim Zip): Thank you again. Sorry I just jumped back in queue. I had a couple of other comments but. In the form as it was before and it's still in there is a detailed strength scale with definitions (zero) through. I'm not sure how high the scale goes. Has there been any thought to also include somewhere in the initial muscle skeletal sections or other sections that a range of motion scale and or a pain scale. That builds some consistency on those sides since we had the strength and the weakness scale built to this template also.

(Melanie): The zero to five muscular strength scale is again one that is taught to almost everyone who goes through medical school in this country. And is found in all the basic HMP text. The pain scale are more varied and depends on the patient's ability to communicate. Physicians choose to use that which they so desire. The range of motion scale are really what a physician would just need to do is to provide the range of motion that he or she measures on a (certain) joint of the patient. And so therefore a scale will not necessarily be needed.

(Tim Zip): I guess maybe my comment is also, it seems to be explicitly prompted for a strength assessment if you will. And it seems that, that might be helpful to have that prompted whether you sight a scale or not for the pain and the range of motions. So that's something that's considered inside of the examination should that be causing the.

(Melanie): There are, OH I beg you pardon. I'm sorry. Did I hear your whole question?

(Tim Zip): Yes.

(Melanie): I shouldn't have jumped in there, I'm sorry. We do ask a question in the physical examination. Describe (inaudible) abnormalities of joint range of motions. So we would expect the physicians, if it were pertinent to look at that question, be reminded that he or she would have to note an appropriate abnormality. In the review of the system we have also asked questions regarding patients pain. And because that is subjective that would necessarily be a need. Physical exams is that physicians a taught that if they for example move some ones leg and the patient grimaces and indicates pain, that, that would be a (inaudible) that might be pertinent in the particular part of the physical exam.

(Tim Zip): OK.

(Melanie): Dr. (Hoover) did you want to add anything to that conversation?

Dr. (Hoover): I think (Susan) has done a great job.

(Melanie): OK. Operator I think we are ready for our next call.

Operator: Once again if there are any questions, that's star one. The next question comes from (Tory Pechelsky) of (Marki mobility your line is open.

(Rochelle): Hi good afternoon. This is (Rochelle) I'm on (Tory)'s line and I just wanted to ask a question about the reimbursement for physicians during the face to face examination. As a supplier the physicians currently asked if how much their going to be reimbursed from such a complex and comprehensive evaluation for the power wheelchair face to face?

And quite frankly they don't currently feel that the reimbursement amount compares to the amount of detail and evaluation that they have to provide even when it's combined with the E&M code. Will the G code reimbursement. Excuse me, will the G code reimbursement increase with this evaluation when it goes into effect?

(Melanie): This is (Melanie). We're not payment experts here so I'm not sure that we can fully answer your question, but there are no new requirements here. All of the things that a physician needs to document today, they have needed to

document for the last several years. So long as this LCD has been out there and NCD has been out there. So there are no new requirements. If you would like to submit a question into our mail box I'd be happy to pass it along to the payment experts here at CMS and we let them address your concern to the G code as doesn't pay enough.

But we don't have an expert here in the room today. We're just the electronic clinical template people.

Dr. (Miller): Let me also state that the E &M code is very different. The payment for the E &M code is for very different services than that for the G code. The payment for the E&M code is for the physician services which relates to the needs and complexity of the patient. And there are multiple levels for that including a level that approximates on hour of service to the patient.

Having done these exams that, you know in a very, very complex patient that may very well be appropriate and should be the code that is billed. However the progress note in whatever format it is recorded would have to basically demonstrate there's the need for that level of complexity and therefore the highest level of E &M coding.

The G code is to provide a reimbursement to the physician or physicians office only for sending of any record that must accompany his or her face to face exam. If that is necessary. So for example say the patient has a respiratory problem and say has had a pulmonary function test recently which show a much deterioration in the patients lung capacity and therefore they can't walk across a room to do their ADL in their own home. The physician may say to an assistant please (zerox) the pulmonary function test from 12 or 18 months ago and also (zerox) the current one. So therefore the physician would only have to write in his or her note the patients PFT has deteriorated over the last 12 months. And then they will staple those two tests to the face to face or send them electronically. And that way the medical reviewers will be able to just page them and say yes they did deteriorate and it would save the physician the time of writing all the little values that goes into these tests. So the G code is only to pay for gathering of some records and sending them forward.

It is the E&M code that pays for the physician's time. And these two methods of payment should not be confused.

(Melanie): (Rochelle) was that responsive to your question?

(Rochelle): Yes. I am clear on the difference between the G code and the E&M code. I understand that part. What I respectfully disagree with the answer on is that physicians currently have a medical record methodology that they use when they're seeing their patients. And now they're going to be forced to use a different form template electronic medical record version for power wheelchair evaluations.

(Melanie): No. There is absolutely no new requirement. Physicians who want to continue to use paper can continue to do so. No physician is being forced to use this template. CMS was asked by the supplier community to put together data elements that might help a physician who was uncomfortable doing a face to face exam for a PMC. It might help that physician, guide him or her to fulfilling the requirement of CMS in order to describe (his or her) patients impairment.

If the physician doesn't want to use that form, that's fine with us. If the physician wishes to refer the appropriate part of the exam out to a therapist or other physician specialist who is more familiar with this kind of exam, that's fine with CMS also.

(Rochelle): I see OK.

Operator: (Melanie) I have three after three. Do you want to continue for a few minutes or should we end this call.

(Melanie): No, I think we should go ahead and end. Let me thank everyone who participated today. We hope that this has been helpful in providing you some more information about our electronic clinical templates project. If you have any additional questions or suggestions please send them to our mail box which is listed on the website.

And we look forward to talking with each of you again at our September 25th open door forum call which again is 2:00 to 3:00pm Eastern Standard Time. Please check the website of which is the date for the dial in instruction. Thank you.

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

END