# ELECTRONIC MEDICAL DOCUMENT INTEROPERABILITY (EMDI)
## DME eRx FHIR Workgroup Meeting Minutes

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| **DATE:** | 11/20/2019 | **TIME:** | 2:00 PM – 3:30 PM ET |
| **LOCATION:** | Teleconference | | |
| **DIAL-IN #** | +1 (408) 650-3123 | **ACCESS CODE:** | 451 749 677 |
| **CHAIR:** | Nandini Ganguly (Scope Infotech) | **RECORDER:** | Briana Barnes (Scope Infotech) |

## Attendees

| CMS | AA HOMECARE | APRIA | BINSONS |
|---|---|---|---|
| Christopher Lofts | Kim Brummett | Kenneth Hodel | Stephanie Legree |
| Candrea Smith | | Zane Schott | |
| Paula Smith | | | |
| Denise St. Clair | | | |
| **BRIGHTREE** | **COMPUTERS UNLIMITED** | **DARENA SOLUTIONS** | **ECLINICAL WORKS** |
| Kim Catts | Joe Simanton | Pawan Jindal | Debora Wade |
| Gary Bartlett | | | |
| **ELECTROMED** | **MCKESSON** | **REMOTE CARDIAC SERVICES** | **ROCKY MOUNTAIN MEDICAL** |
| Stephanie Labelle | James Courtney | Mark Brown | Kelli Ore |
| **ROTECH** | **SPECTRUM MEDICAL** | **SUPERCARE HEALTH** | **SCOPE INFOTECH** |
| Joni Moss | Meredith Hendrie | Paula Dahl | Pallavi Talekar |
| Jackie DeVries | | | Ray Wilkerson |
| **UNKNOWN** | | | |
| Manbubul Haque | | | |
| Wayne Joyner | | | |

## Absentees

| ADAPTHEALTH | AMERICAN COLLEGE OF SURGEONS | B.WELL | BRITKARE |
|---|---|---|---|
| Gwen Turner | Frank Opelka | Yelena Balin | Josh Britten |
| | | Philips Johnson | |
| **CLAIMSJUDGE** | **CONTRA COSTA HEALTH** | **DME WORKS** | **HOVEROUND** |
| John Bright | Troy Kaji | Emil Di Motta | Debra Silvers |
| Christina Fox | | | |
| J. Michaels | | | |
| **HOMECARE DELIVERED** | **LIBERTY MEDICAL SPECIALTIES** | **LINCARE** | **MEDSTAR** |
| Sean Riley | | Jeff Jackson | Peter Basch |

| MEDICAL SERVICE CO. | MICROSOFT | NATIONAL PARTNERSHIP FOR WOMEN & CHILDREN | PARACHUTE HEALTH |
|---|---|---|---|
| Josh Marx | James Fetters | Erin Mackay | David Gelbard |
| Michael McGill | Sachin Sinha | | Josh Lee |
| | Ben Katzman | | Matt Pestritto |
| | Jung Yoon | | Jon Chan |
| | Blake Badolato | | |
| | Todd Pliner | | |
| **REMOTE CARDIAC SERVICES** | **RESMED** | **THE VAN HALEM GROUP** | **UNITED HEALTHCARE** |
| Mark Brown | Ryan Burke | Wayne Van Halem | Anupam Goel |
| | Larissa D'Andrea | | |
| | Robert Jarrin | | |
| | Rehana Nathwani | | |


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| NEW WAVE | SCOPE INFOTECH | | |
|---|---|---|---|
| James Fetters | Bob Dieterle (SME) | | |
| Sachin Sinha | | | |
| Kate Wright | | | |

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1. **Welcome**
   a. Nandini Ganguly discussed the agenda for the workgroup: Panel Discussion on ePrescribing and a demonstration of the DME eRx SMART on FHIR App.
   b. Nandini Ganguly introduced the panelist for the ePrescribing panel discussion:
      i. Kim Brummett: Vice President of Regulatory Affairs at American Association for Homecare (AA Homecare).
      ii. Paula Dahl: Executive Vice President of Strategy and Business Development at SuperCare Health.
      iii. James Courtney: Product Manager of Technology and Services at McKesson.
      iv. Zane Schott: Director of IT Referral Applications at Apria Healthcare.
      v. Stephanie Legree: Manager of Medicare Reimbursement at Binsons.
      vi. Kelli Ore: Vice President of Contracting and Payer Regulations of Rocky Mountain Medical.

2. **DME eRx Panel Discussion**
   a. How does a typical order/referral process look like in the real world? Please walk us through the process.
      i. Stephanie Legree: There are three different ways that the order comes in at Binsons - by hand (patient walking through the front door), the fax machine (this can come into Binsons' system digitally as a Portable Document Format (PDF), but is still faxed from the provider's office ), or by their ePrescribing platform that is managed by their script department.
      ii. Kelli Ore: Stephanie Legree covered the general methods by which orders/referrals come into Rocky Mountain Medical's office.
   b. From a supplier's perspective, can you identify some challenges in the order/referral process with regards to the themes below?
      i. Kim Brummett: One challenge is the accuracy of the order. There are very specific guidelines and items that must be included in the order. Often times when the order comes into the supplier's business these orders are not accurate per the policy guidelines and the Local Coverage Determinations (LCDs) that Medicare has established. Beyond this is the challenge of documentation: when one receives an accurate order, the clinical documentation and lab values all need to be included. The ePrescribing platform does not retrieve all of the necessary data elements that the supplier needs to obtain. Another challenge is fulfilling the order: if a supplier retrieves an accurate order from a provider, there is still question if the order was submitted to the patient and the patient is receiving what they need. The final challenge is audits: the supplier is faced with a huge risk of being audited before the supplier is paid.
      ii. Paula Dahl: One of the challenges is the re-enforcing of the clinical guidelines and LCD requirements. Many providers/clinicians view the order/referral process with a holistic view of the patient and not the view of the payer. Providers all send all the information about the patient without being aware that different payers have different aspects of coverage requirements. The auditing interpretation and review of this documentation can vary.
   c. Is it possible for ePrescribing platforms to use Clinical Data Elements (CDEs)?
      i. James Courtney: Yes, I believe that this is possible to develop. He noted that most of the ordering solutions that submit patient demographics and other patient information through the ordered products, transfer related data elements to a notes field, which indicates that there is no place for these elements. This takes McKesson's customer service representatives more time to read and process an order at intake.
      ii. Zane Schott: Apria participated in the CMS CDEs for home oxygen therapy to include in the DMEhub application. Apria learned that there was push back where the CDEs were very comprehensive of a holistic view of the patient, but many people wanted to know which CDEs should be incorporated to get the DMEs delivered and billed. There was also some pushback to have ePrescribing platforms use CDEs, but it should be with harmonization with CMS' requirements and LCDs. This also speaks to the supplier perspective of the challenge with the referral process where order routing in the ePrescribe platform (using open Application Program Interface (APIs)) can over burden the provider by making it difficult for providers to capture the DME. As a result, providers may want to ban the use of


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ePrescribing. ePrescribe platforms can use CDEs and will be great to utilize, there is a need to harmonize and simplify the actions that can be billable and collected patient data.

iii. David Bruinsma: Colonial Medical has an automated flow that looks for required diagnosis and will automatically reject an order if the CDEs are below threshold. Zane Schott explained that their ePrescribe platforms built a platform of many rules for appropriation (documentation, use of DME, etc.) to allow for clinical evaluation and determination. The benefit eases the pain of entry and ePrescribe can achieve over 95 percent of orders being clean and deliverable. The CDEs have operational benefits that guide processes and allow non-clinicians to enter patient information and can be evaluated by the clinicians; the rules make the burden of entry and compliance easier.

iv. Kim Brummett: Not all ePrescribe platforms incorporate CDEs since some of them have an order generator. It will be beneficial to have suppliers and providers incorporate the CDEs.

v. James Courtney: McKesson developed their own APIs and has direct integration with Electronic Medical Records (EMRs) system and these EMRs do not have CDEs. This causes information to be transmitted as 'supporting documentation' and incorporated in a notes field. Zane Schott agrees that the CDEs should be required, so relative information does not end up being considered long extensive notes.

d. Will CDEs be considered as "met documentation requirements" if it used?

i. Kelli Ore: Incorporating CDEs will assist with suppliers meeting the documentation requirements, but it should be some product categories that will be necessary for additional guidance for ordering. These products can include power mobility devices (PMDs), since it is a two-step process for the ordering process. It is important for providers to work directly with CMS on what will be considered as 'met documentation requirement' versus 'contemplating medical records, if ePrescribing is a mandatory platform to be utilized to order equipment.

ii. Paula Dahl: It is important to have the ePrescribe platform incorporate CDEs and be accepted by CMS. The CDEs should create the efficiency in the ePrescribing platform where they can have a rule engine that can be engineered to meet Medicare and other payer guidelines. As a result, suppliers will see less issues and audits with documentation returned 'as not met documentation requirements. This can be done with Medicare support and guidance.

e. How can CMS help educate medical reviewers on CDEs that are used?

i. Kim Brummett: CMS need to make a policy of the transition to ePrescribing. There is a lot of program integrity, but without the policy changes then the CDEs will never be fully implemented. All of the LCDs and article requirements will need to be revised and transitioned to the electronic platform. At one of AA Homecare's CMS In-services in 2018 there were many presentations from representatives of applications with an audience of representatives from program integrity. One of the questions that was asked from this audience was 'when a document is created in an ePrescribe app following the CDEs, will this document be considered the face-to-face or the clinical documentation' and the answer for this question was no. This will be a challenge with adopting CDEs. The ePrecribing application should be considered an extent of the EMR to incline providers and suppliers to adopt this application.

ii. Paula Dahl: The ePrescribe platform need to establish consistency amongst reviewers. Often times the suppliers becomes the medium of medical reviewers and the physician and they are left with challenging the physicians on their clinical judgement of DMEs and requirements (i.e., including specific verbiage in their documentation). If they were able to establish consistency with CDEs and its order generation, then it will be less subjectivity in the medical reviewer opinions. They can take away ambiguity and create consistency by establishing CDEs in the ePrescribing and by educating the reviewers of accepting the documentation billed within the ePrescribe platform.

iii. Zane Schott: Believes that CDEs will be the largest success factors on the operational needs of the suppliers to accurately provide the equipment for their patients in a timely manner. The determinant data should be retrieved through open APIs. Open APIs just mean that systems can easily talk to systems in a common easy to understand language. Medicare should be supportive and reflection of the rest of the healthcare systems (i.e., ePrescribe Medication and ePrescribe related Computerized Physician Order Entry (CPOE)), in which DME ePrescribe system should not be treated any differently. These systems should include pre-defined sets of data that are determinant and appropriate for use to advance the communication that benefits all including the patient. CMS can help by supporting standards, supporting necessary information compliance, and helping shepherd the process to allow the independent marketplace to interact and interoperate to get to solutions. This has


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worked in other unfunded CMS mandate with the forcing of data related care plans for the Long Term Post Acute Care (LTPAC) communities.

f. What are the challenges associated with updating and maintaining Local Coverage Determinations (LCDs)?
   i. Kelli Ore: LCD requires suppliers to individually educate every physician that are referring orders. The supplier has to educate each physician on what has changed in an LCD or policy article, and how it may impact their referral/order prescribing ability. A CMS adoption of an ePrescribing platform is an approved list of ePrescribe platform that maintain and completes the update of the policy changes that get pushed to the physician. This eliminate the burden on the DME suppliers when educating physicians on the appropriate documentation and allows the physician to see these updates through the ePrescribe platform.
   ii. Stephanie Legree: That CDEs eliminate the supplier asking for appropriate documentation and provide insight that CMS is asking for the documentation, since suppliers receive backlash from their referral sources when requesting information. The CDEs follows the LCDs, but it is an extensive process to change the LCDs, which can be challenge.

g. If a patient doesn't meet coverage criteria, is there any guidance for physicians to complete the order?
   i. Stephanie Legree: We will currently use resources on the DME Medicare Administrator Contractors (MACs) website (i.e., LCDs or Program Integrity Manual) to provide to the physicians. Suppliers will manually educate the physicians with the issues or what may be missing in the coverage on the documentation that they receive. The CDEs can help with this guidance, since it will display what is going on at every point of the order (i.e., DMEhub tells if the oxygen order qualifies right away).
   ii. James Courtney: This is the same for me. McKesson's authorization specialist will work with the payer and order physician. These specialists offer guidance or education to the physician, which is usually done over the phone or via fax. Some of the ePrescribe solutions providers insurance, coverage, or decision support within their user interface (UI) at the time the order is placed on the clinician end. This solution is really effective.

h. What is the biggest barrier for CDEs adoption? How can CMS help to adopt the CDEs?
   i. Paula Dahl: The biggest barrier adoption is related to EHRs in which physicians will have to duplicate efforts with the EHR and ePrescribe platform. The provider has to remember which ordering system or application to use for their different suppliers. A universal platform that can be easily integrated with EHRs will increase the adoption rate.
   ii. Kelli Ore: There will be a greater adoption if more of the ePrescribing platforms, physicians, and EHRs knew that CDEs is acceptable by CMS.
   iii. Kim Brummett: If the CDEs are not mandatory then they will not be incorporated. She noted that the PMD CDEs were created years ago, but no EHRs incorporated these CDEs. They need to be mandatory for physicians, hospitals, and stand-along ePrescribing. They should also remove all the manual cumbersome documentation requirements. Pallavi Talekar asked CMS considered including these types of documentation in the patient over paperwork or provider burden programs. Kim Brummett replied that she believes that CMS Program Integrity that can oversee is being concerned, but CMS policy will have to revise items such as LCD and National Coverage Determinations (NCDs) to proceed with this. Kim Brummett suggested for CMS policy representatives to get involved in these discussions in order to make ePrescribing and CDEs to become more successful.

i. How would physicians address coverage criteria when documents are created outside of EHR?
   i. Zane Schott: There are cases where the coordination of care where other therapists involved where the documentation can lie outside their traditional primary clinical system, which can be difficult for the physician groups that do not have Direct Secure Messaging, network access, or storage for documentation. The ePrescribe solutions can take external sources for a complete and accurate order.

j. What are some challenges that current ePrescribing platforms face?
   i. James Courtney: Suppliers are now required to connect with multiple ePrescribe solutions, and it can be cumbersome to log into multiple portals. The lack of connectivity features of the ePrescribe solution roadmap and they need a higher priority of platform integration.
   ii. Zane Schott: There is an operational challenge with multiple solutions and tools (i.e. hospital lab system, EHR system, etc.). The suppliers should move toward APIs to remove the burden for suppliers. These challenges will resolve in the next few years when the current APIs mature.

k. How do we overcome the challenge of coverage requirements through an ePrescribing platform?


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i. Kelli Ore: The burden currently resides on the DME suppler to individually educate physicians. Physician believe that it is a DME supplier's requirement rather than a CMS requirement. I suggest building into the ePrescribe platform, like a questionnaire, and if the physician does not qualify then the platform directs the physician on information (i.e., policy articles) to understand why their patient does not qualify. CMS should do an integrated data mining from these platforms to provide information on the same scale of the CPT to a DME supplier.
ii. Paula Dahl: One should require adoption of the CDEs into the order to channel all physicians within this channel and provide education (i.e., coverage criteria). It is suggested to have a platform to remind the physicians of such requirements. The ePrescribe platform can provide the opportunity to educate physicians on the CDEs that is beneficial. This can assist CMS with educating the entire provider community.
iii. Kim Brummett: CMS can provide incentives to those implementing CDEs.

l. What challenges do DME Suppliers face finding hospitals or providers with ePrescribing functionality?
i. Stephanie Legree It is difficult for physician groups to adopt the ePrescribing platform because it may not integrate into their system. It was another challenge of the different logins for each platform. Some platforms that have not adopted CDEs are difficult to get certain information (i.e., medical records) from. This is difficult to obtain through some of the ePrescribing platforms for the physician.

m. What kind of challenges does suppliers face when they use a health IT system for order receiving and additional documentation requests?
i. Stephanie Legree: This is the same response from the previous question (login from different platform) and request of medical information of having the medical record to address medical necessity. Each time the order is sent through the ePrescribe platform then the providers are charged for many of these transactions. Kim Brummett said that it is a per transaction fee that suppliers pay, but they do not pay for the application.
ii. James Courtney: The cost per transaction continues to rise, which is why McKesson is developing their own API solutions and direct connections.

n. How does Open APIs address these challenges? How does DME eRx workflow solve a part of these challenges?
i. James Courtney: The open APIs allow for a broader range of developers to connect and test solutions. There is also more power to the patient (i.e., APIs allows the aggregation of the patient information that can assist the care giver).
ii. Zane Schott: Open APIs allow the follow-on benefit like the re-certification necessary for an order. Open APIs benefit the longevity of the ongoing patient care.

**3. SMART on FHIR App Demo**

a. David Bruinsma and Zane Schott provided a demonstration of the DME eRx SMART on FHIR App.
b. The SMART on FHIR App utilize real data using API to work with ePrescribing and supplier solutions.
c. The demonstration of the SMART on FHIR App provide an assimilation the launch of the DME inside the EHR. The provider will choose the order that they want to submit. This launches a Clinical Decision Support (CDS) Hooks server and its endpoint, and determines the documentation requirements links (i.e., provide links to LCDs and SMART app launch link).
d. Once the clinicians click the SMART App button, then this will launch the SMART app and it will display the FHIR questionnaire. This questionnaire is usually pre-filled with elements of the home oxygen therapy is derived from CMS CDEs. This questionnaire loads from a HAPPI FHIR server.
e. Zane Schott explained that the background of the SMART on FHIR App includes Keycloak for authentication, FHIR HAPI server (can be used as an EHR sandbox), CDS Hooks, Coverage Requirement Discovery (CRD) and Document Template Rules (DTR).
f. Zane Schott provided an overview of the DME eRx workflow. Mark Brown asked where the physician signature authenticated or owned in the workflow. Zane Schott replied that electronic signature can occur in the hub using a mobile iOS, android, or web signature. If the provider does not utilize the hub, then the supplier may need to do the appropriate follow-up with the provider.
g. DMEhub has critical date elements and rules that can be configured dynamically. DMEhub consists of various payer and CMS rules (i.e., CDEs). DMEhub also has available APIs and the ability to support to pilots and customers.

**4. Round Table**

a. Nandini Ganguly encourage all workgroup participants to visit the EMDI environmental scan.


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| b. The upcoming DME eRx Workgroup will be January 30,2020<br>c. The EMDI team is planning a virtual Connectathon for DME eRx on 01/14/2020 and 01/21/2020.2020.<br>d. The DME Order FHIR Implementation Guide will be going through Health Level Seven (HL7) January 2020 ballot. |

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| DECISIONS MADE |
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| 1. None. |

| RISKS |
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| 1. None discussed. |

| ISSUES |
|---|
| 1. None noted. |

| AI# | ACTION ITEMS | RESPONSIBLE PERSON | DUE DATE |
|---|---|---|---|
| | None noted. | | |

* Action Item numbers are assigned from an internal-facing list and may not be sequential between meetings.

**Next Meeting**: Tuesday, 01/28/2019, 3:00 PM ET


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