Centers for Medicare & Medicaid Services
Special Open Door Forum: Medicare Documentation Requirement Lookup Service
Moderator: Jill Darling
January 16, 2020
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all parties are in listen-only mode until the question and answer session of today's call. If you wish to ask a question at that time, please press star 0 on your phone and then mute your phone to record your name.

Today's call is also being recorded. If anyone disagrees, you may disconnect at this time. I would now like to turn the call over to Ms. Jill Darling. Thank you and you may begin.

Jill Darling: Great. Thank you so much. Good morning and good afternoon, everyone. Happy New Year. I'm Jill Darling in the CMS Office of Communications and welcome to today's Special Open Door Forum, Medicare Documentation Requirement Lookup Service.

Before we get into today's presentation, I have one brief announcement. This special open door forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And I also just want to say thank you all for waiting. I know we're starting a few minutes after our start time. But as always, we try to get as many folks in as we can for the presentation. So now I will hand it off to Ashley Stedding.

Ashley Stedding: Thank you very much, Jill, and good afternoon, everyone. I want to thank you all for joining us today and welcome you to the fourth special open door forum on the Medicare Documentation Requirement Lookup Service.

And before we get started, I just wanted to make participants aware that there is a slide presentation for today's forum that is posted on our CMS Web page for those that wish to pull up the slides and follow along.

And that link to the Web page can be found in the calendar invite and the announcement for today's forum. And the link is go.cms.gov/MedicareRequirementsLookup. And the M in Medicare and the R in requirements and the L in lookup must be capitalized. Again that's go.cms.gov/MedicareRequirementsLookup.

And with that, moving on to introductions, my name is Ashley Stedding. And I am a management analyst in the Provider Compliance Group at the Centers for Medicare and Medicaid Services. I am also the government task lead for the Medicare Fee for Service Documentation Requirement Lookup Service Project and I will be helping to facilitate today's discussion.

Also with me today is Connie Leonard, the acting director of the Provider Compliance Group at CMS along with a couple members of the MITRE CAMH team, including Larry Decelles, who is the DRLS technical advisor, Bob Dieterle, who is the project technical advisor and Nalini Ambrose, who is the project lead.

The objective of today's special open door forum call is to educate the public about a new initiative underway in CMS to develop a Medicare Fee For Service Documentation Requirement Lookup Service prototype, or what we call DRLS for short.

In this session today we are going to start by giving a quick overview of the DRLS for those who may not have attended any of the previous forums. We will cover the current state of the DRLS prototype development and pilot testing.

We will provide a summary of the DRLS activities that have been occurring to advance awareness and buy-in amongst stakeholders and also identify ways to stay informed and to get involved in this initiative.

And then finally we'll open up the floor to questions and comments from participants.

So to kick things off I'm going to spend just a couple of minutes sharing some background information on why CMS is interested in this initiative and give a quick overview of the Documentation Requirement Lookup Service.

And for those following along, we're now moving on to Slide 5. Among a number of things, CMS has been hearing feedback from providers saying that documentation requirements are too hard for find.

For example, the Medicare documentation requirements appear in various locations and on separate Web sites, which is also true for most other payers as well. And this causes burden on providers who must navigate those various Web sites to find coverage requirements, including things like documentation and prior authorization requirements.

As part of the provider listening sessions, CMS has also heard repeated suggestions that payers should publicly disclose their requirements in a

searchable electronic format and clearly communicate to prescribing and ordering providers what supporting documentation is needed.

So this initiative is really just one of the steps that CMS is taking toward displaying the Medicare fee for service rules in an electronic format that will be easily accessible to providers within their clinical workflow.

Moving on to the next slide, in terms of a high level overview, the DRLS is an electronic data exchange service that makes it easier for providers to find Medicare fee for service prior authorization and documentation requirements right at the time of service and right there within their electronic health record or integrated practice management system.

So by using the DRLS providers will also be able to download either printable or electronic documentation templates and the latter, which can automatically be populated by the EHR.

So the DRLS essentially is introducing automation to a largely manual process by streamlining workflow access to those coverage requirements. And we strongly believe this automation will provide significant time efficiencies to the process of discovering this prior authorization and documentation requirement actually right there at the time of service, thereby helping to overall reduce provider burden, reduce improper payments and appeals and ultimately improve provider to payer information exchange.

And at this time point I'm going to turn it over to Bob Dieterle, who is going to pick up on Slide 7 and talk about the HL7 Da Vinci Project and how CMS is leveraging industry efforts through this initiative. Bob?

Bob Dieterle: Ashley, thank you very much. So as Ashley said, we'll be starting on Slide Number 7. The HL7 Da Vinci Project was formed roughly two years ago. The goal of it was to bring together a multi-stakeholder workgroup, including providers, payers and HIT vendors to help solve value-based care problems, in particular involving exchange of information between payers and providers.

The goal is to make sure that we have one solution that can be adopted for a single problem so that we minimize the complexity and the number of solutions that get deployed by the industry to solve common problems.

We're focusing on industry-wide architecture, standards and adoption. If you look at the right-hand side of the slide, you'll see a makeup of the membership of Da Vinci.

On the industry associates, we currently have NCQA working with us on quality standards and HIMSS and their broad reach and representation.

As far as providers, we have large and small provider groups, but on the large side we have groups like SutterHealth out of California, Rush out of Chicago and Weill Cornell.

On the payer side, we have all of the major payers, CMS, Blue Cross/Blue Shield Association, United, Humana, Cigna, Aetna and a number of others, all of whom are coming together to provide common solutions for problems that providers experience and patients experience in getting delivery of care or getting care coverage.

On the EHR/HIT vendor side, I will focus on the EHRs although we have a large number of the other HIT vendors. We have Cerner, Epic, Allscripts,

ECW and Athena Health. And across that group we represent probably 80 plus percent of all certified EHR installations.

We also show on here that we have 17 different use cases that we've worked on. So if you go to the next slide, Slide Number 8, you will see how they break out.

There are 9 (Implementation Guides) that have been balloted, which is a formal process in HL7, to adopt a standard. They have not yet finished ballot reconciliation and publication but that will happen over the next couple of months.

There are three of them that are currently in ballot. And we'll go through the ballot reconciliation process soon.

Gaps in care and information is in the process of getting started and we have four others, including patient cost transparency, that are in what we call the discovery phase, meaning we're trying to understand the scope of requirements before we start the formal project.

These individual use cases cover a number of areas, topic areas, such as quality management, authentication of services (think prior authorization), the exchange of clinical and payer data and support concurrent patient care and the ability to deal with things such as patient cost transparency where we try to bring information to the forefront when patients are making a decision on what specific treatment they are electing to pursue.

If you look at the top right-hand corner, we have two specific use cases, coverage requirements, discovery and documentation templates and rules that

make up the core of DRLS, in other words the subject of this particular special open door forum.

Coverage requirements, discovery is focused on allowing a provider in clinical workflow to ask the payer the question, is there anything I need to know or do regarding this particular or planned treatment?

It allows you to get answers back (from the Payer), like, 1) there's no specific requirement 2) you need to have prior authorization or 3) you need to have specific documentation in the record to support the demonstration of medical necessity and appropriateness.

Documentation templates and coverage rules allows the provider to pull down the payer rules, in this case Medicare fee for service rules, that review and provide information on what is necessary to be documented in the clinical record to support the particular service or device that is being considered or ordered.

DTR allows you to have the patient record interrogated by the software to look for information rather than have the provider enter it directly. And if information is missing to remind the provider that it's missing information, to supply it and document it back in the clinical record.

So at this point I am going to turn it over to Larry Decelles, who is going to walk us through how DRLS actually works. Larry?

Larry Decelles: Thank you, Bob. Hi, everybody. As Bob said, I'm going to walk you through an example at a high level of DRLS and in this case an example scenario where the clinician determines the Medicare Fee For Service patient needs

home oxygen therapy and initiates the process of ordering home oxygen therapy.

So, again, for those that are following along, we're on Slide 9. The first interaction is a patient visits a clinician who determines she needs home oxygen therapy.

The clinician enters an order in the EHR. Then the EHR initiates a query to the Medicare Fee For Service DRLS to ask if there are coverage requirements, including documentation and prior auth requirements for home oxygen therapy.

In this scenario for home oxygen therapy, the Medicare Fee For Service DRLS responds by saying, no, prior auth is not required, but yes, there are document requirements.

The clinician and/or staff clicks the SMART on FHIR link, which in this case is the DTR application that Bob previously mentioned, and initiates a second request to DRLS asking for the appropriate templates and rules.

DRLS returns the appropriate templates and rules digitally and the SMART on FHIR app prepopulates the templates with any existing applicable FHIR-based data from the EHR.

Next DRLS identifies unpopulated sections of the template that the clinician and/or staff can manually complete. Once completed, the clinician and/or staff can make the completed template available to the DME suppler or, when appropriate to Medicare Fee For Service and optionally storing the electronic copy to the EHR.

I should say moving forward this won't be optional. We're going to make this a mandatory process where the electronic copy will always be stored back to the EHR.

The last step, Step 8, the clinician and/or staff can perform necessary actions based on documentation to ensure compliance with Medicare Fee For Service rules.

The next slide, please, Slide 10. And we'll just move through this one. Now we're going to move through the current DRLS status. Next slide, please, Slide 11.

DRLS is currently in a prototype status. Within Da Vinci we like to call it a reference implementation. CRD, which is the first use case that's used in DRLS, is currently managed by the HL7 Financial Management Workgroup. It may go through more HL7 balloting.

Regarding DTR, which is a second use case within DRLS. We have a project scope statement and we provide a link for those who are interested in reading up on that. As far as the specification or what we call an implementation guide for DTR, we provide a link in Slide 11. That will be your third bullet down. This essentially talks about all the functionality and how the different objects are specified for a FHIR-based exchange.

The last bullet talks about what we call, and what I mentioned earlier, the DTR reference implementation or prototype. Which we provide, because this is open source. We provide a link to the source code so folks can actually go there, download the source code and run DRLS.

The reference implementation was drafted March 2019. This is hosted at Da Vinci's hosting provider, Logica Health, formerly HSPC. It's expected to complete HL7 normative ballot reconciliation September 2021, according to the PSS, which is the project scope statement, the second bullet above.

Next slide, please, Slide 12. This slide kind of gives a little bit of information about rule sets. Typically, home oxygen therapy is initially called a topic. The ruleset is a composition of CQL rules and templates that combine to make up what we call rulesets for a topic.

Rulesets are related to ordering specific durable medical equipment and other services. These are to be part of the DRLS pilot testing.

Currently we're building out 12 different rulesets, home oxygen therapy, positive airway pressure devices, home blood glucose monitors, non-emergency ambulance transportation, respiratory assist devices and seven others.

The ruleset selection is based on improper payment rates and other factors. The rulesets will reside in the prototype DRLS repository. And with that, I'll hand off to Nalini.

Nalini Ambrose: Great. Thanks, Larry. Hello, everyone. I'd like to present some of the findings from our recent stakeholder engagement efforts that was related to DRLS, which were completed in the spring of 2019.

There were three primary initiatives that we engaged in. The first was a survey that was sent to providers, EHR vendors and other commercial payers to assess their readiness and functionality in being able to implement DRLS.

And we followed-up with some targeted stakeholder interviews with a smaller set of industry partners. And we also convened a DRLS stakeholder Work Group. And we have some recommendations from that Work Group which was a very active Work Group made up of diverse industry partners last year.

And moving to Slide 13, for those of you who are following the presentation, in our survey to EHR vendors, we learned that a majority of them do support mandated functionality and maintain some of the standard interfaces that would support regular business transactions.

But most have not really gone beyond meeting the minimum necessary requirements. And a lot of vendors are deploying FHIR but not necessarily working with the latest version of FHIR or have all of the resources needed.

And we learned from payers that although they do have documentation and prior authorization requirements available, they typically don't make them publicly available, which was seen as a barrier.

And even today, most exchanges with providers, including requesting documentation requirements, were made manually, primarily via fax and some via mail and phone.

And clinicians identified many pain points in the process. As Ashley earlier mentioned, they do go to multiple sources to obtain documentation requirements. They go to Web sites and other policy documents and benefit manuals, et cetera, which makes the process cumbersome.

And they also use primarily fax for not just payer communication but also for suppliers and making orders, et cetera.

Clinicians expressed an interest in DRLS; I think we had unanimous interest in DRLS and having EHRs display these requirements, but the concern that was correspondingly expressed was that might place time demands on a clinician and might increase the work burden that a solution like DRLS might create.

And in doing some follow-up interviews, moving to Slide 14, EHR vendors really tended to focus on the marketplace demands and serving their customer needs and also addressing some of the regulatory requirements. And they indicated that took up a lot of their time.

And so they focused on these initiatives rather than focusing on implementing individual applications like DRLS. And they are updating their technology by building out and expanding their file resources.

There is a lot of work that's currently going on with several EHR vendors. But the majority of them are less focused on some of the tools needed by DRLS, such as CDS Hooks.

And clinicians and providers, again, find payer documentation requirements to be really confusing. They asked to reduce documentation burden; they were all for that.

They wanted more standardization and consistency both across payers and between payers and suppliers. But, again, the corresponding concern was that this may disrupt the clinician workflow and might impede the physician-patient relationship at the point of care.

And all clinicians unanimously felt that this was a problem that has to be solved by the industry as a whole and suggested that EHR vendors, clinicians

and payers all need to be at the table in order to be able to solve these problems.

And now moving on to our Stakeholder Work Group findings. We had a very engaged group of partners, and they came up with three primary challenges. The first was that payer rules are not always readily available to clinicians at the point of service and at the point of care when it's most needed and they were not in a queryable format.

The second challenge was that requirements exist, but they exist in many places within the electronic health record and unstructured clinical notes. Although there are some elements that are in structured format, a good number of them are not available in structured format.

And the third challenge was the perception that DRLS was really more of an alert system that could potentially disrupt a clinician's workflow.

And so, some of the recommendations that the group came up with was that DRLS was an initiative that really needed to be implemented very iteratively with ongoing education and outreach to industry stakeholders and the possible offering of incentives.

And another recommendation was that the clinician ordering workflow should be reviewed and examined and assessed to identify some of the operational gaps that could potentially be automated.

Another critical component was to identify missing information at the point of care and at the time of service that earlier was highlighted in the DRLS workflow as something that would potentially be addressed through DRLS.

So, with that I'll move on to some of the next steps for DRLS, moving on to Slide 17 for those of you who are following.

We plan to continue our pilot testing efforts for the DRLS software prototype that we engaged in significantly last year.

The graphic that you see on Slide 17 shows the DRLS information exchange between the provider and the payer using the two use cases that Bob had earlier referenced that were part of the Da Vinci set of use cases, the first being: are prior authorization and documentation requirements needed, and the second query going out for the actual documentation requirements and the template that would then populate within the EHR.

And we tested this exchange last year using three types of testing, the first being point-to-point testing, which really tests the transaction and the interchange between a single provider and a single payer, in our case, CMS Medicare Fee for Service.

And multi-payer testing involved a single provider with multiple payers. And we did successfully test the endpoint transaction with several other commercial payers.

And the third form of testing is provider acceptance testing where clinicians test DRLS in their clinical workflow and make an assessment as to whether DRLS fits within their workflow, whether it reduces their burden, et cetera.

And as I mentioned, we have been conducting ongoing pilot testing at HL7 Connectathons -- moving on to Slide 18 -- where we successfully tested the DRLS prototype.

The picture that you see on the right side actually shows a pilot testing demonstration that was held last year at the HIMSS Interoperability Showcase as part of the Da Vinci booth.

And this year we have started our pilot testing with a schedule for ongoing testing through August of this year and possibly beyond. You will see the timeline laid out on Slide 18 at the bottom.

And moving on to Slide 19, we are planning for a significant presence at the HIMSS forum again in Orlando in March of this year at the Da Vinci Showcase.

And we have had great participation and engagement from our Stakeholder Work Group last year, so our team is continuing to convene the Stakeholder Leadership Group this year, which is made up of more than 50 members from federal and state government; we have commercial payers, providers, clinicians, EHR and other health IT vendors and others. And we have a smaller Work Group that conducts more focused discussions on specific topic areas that are identified by the Leadership Group.

We have kicked off the first couple of meetings and we are gearing up for our next Work Group meeting in January next week. And we look forward to having this group make recommendations related to DRLS implementation. And we hope to share these findings at a future open door forum.

Thank you, and now I will hand it back to you, Ashley, to review some of the DRLS resources and links.

Ashley Stedding: Thanks, Nalini. Before we wrap-up our presentation for today, I just wanted to highlight some of the primary ways for folks to stay informed about this initiative or to get involved.

To keep up with current DRLS activities, we encourage you to visit any of the Web sites listed here on Slide 21 or email us at any of the email addresses provided here if you are interested in getting involved.

And for those who might be interested in learning more about any of the other related topics discussed in today's presentation, here on Slide 22 we have also listed additional relevant links and resources.

And that brings us to the end of the presentation portion of today's call. At this time, I think we are ready to open it up for questions and comments from the participants.

Coordinator: Thank you. If you would like to ask a question over the phone, please press star 1. Please ensure your phone is unmuted and record your name to ask a question. Again that is star 1 to ask a question. One moment, please.

Our first question comes from (Patrick Kennedy). You may go ahead.

(Patrick Kennedy): Yes. Thank you. Question, these requirements would be applicable across all Medicare jurisdictions. Would there be any differences between the contractors in different jurisdictions?

Ashley Stedding: This is Ashley Stedding from CMS. The two rulesets that we have developed so far and tested are for oxygen and CPAP, which are both DME items. And the DME (MAC) policies are consistent across the country.

But once we move into topics that fall under Part A and B, there will be differences in the rulesets depending on the region that the provider is in based on, you know, the differences in the policy across the nation. So that will be accounted for in the rulesets that are built into the system so the requirements that the providers see will be accurate for the state that they are in.

(Patrick Kennedy): Great. Thank you.

Coordinator: Once again, if you would like to ask a question, please press star 1 and unmute your phone and record your name to ask a question.

Our next question comes from (Tammy Crowe). You may go ahead.

(Tammy Crowe): Hi. So will this process involve the new pre-cert for the new five procedures that's beginning in July?

Ashley Stedding: This is Ashley Stedding from CMS. I apologize. I am not familiar with that. I'm not sure if Connie Leonard is on the speaker line and might be able to speak to that. But if not, we'll have to take that question back and get you an answer.

You could also send that question to the Medicare DRLS mailbox. And the address is listed on the last slide, Slide 23, of today's presentation.

(Tammy Crowe): Okay. Thank you.

Coordinator: I have not seen Connie dial in yet.

Ashley Stedding: Okay. Thank you.

Coordinator: Our next question comes from (Dave Engle). You may go ahead.

(Dave Engle): Thank you. It sounds interesting and somewhat exciting. What I'm curious to know is how is this technology going to be paid for? Is there additional reimbursement at the facilities that providers would expect down the road?

Ashley Stedding: Bob or Larry, do you want to take that one?

Larry Decelles: Bob, did you want to give that a shot?

Bob Dieterle: Yes. Let me do it this way. There are a number of payers that are planning on implementing the equivalent of DRLS, meaning CRD or DTR with the intent of making it available to the various users of EHRs that I mentioned before plus others.

So it really will become an add-on, if you will, or part of the native capability of the EHR to go out and touch the payer and ask them if something is necessary to be done for documentation or prior authorization and then to be able to bring down the rules to ensure that the record is complete or gather the information as necessary to submit for a prior auth.

So our expectation is this is going to become quite prevalent in the industry over the next couple of years as we start to see the ONC final rule and the requirement for support for FHIR as part of the certification process.

(Dave Engle): Okay, great. Will this be a mandatory requirement utilizing DRLS technology, I guess, as providers in the future?

Bob Dieterle: At this point in the federal - in the NPRM from CMS it was mentioned as something that would be of value. It was not cited as a requirement or a requirement potential for the final rule.

(Dave Engle): All right. Thank you.

Coordinator: The next question comes from (Paul Comitchak). You may go ahead.

(Paul Comitchak): Hi. Thanks for holding this forum today. I know on one of the slides it was mentioned that there were going to be templates that clinicians could use to fill this in.

Will this be at some point married up to the electronic clinical templates that are kind of currently in various different states as far as DME is concerned?

Larry Decelles: This is Larry. Currently the way the templates are built-out, they're kind of computer little templates in the form of what's called a JSON file that are downloaded and then rendered in a browser and at the same time they're populated by running what's called CQL rules, which is clinical query language, which is what we do to kind of pull data from the EHR in the form of FHIR-based data and populate those.

The templates that you talk about, could you describe a little on how - I'm not sure how different they may be so.

Bob Dieterle: Larry, do you mind if I elaborate a little bit?

Larry Decelles: Yes. Go ahead. Go ahead. Yes.

Bob Dieterle: The templates you're referring to are on the CMS Web site. These templates and clinical data element, are actually the input into what Larry just described.

(Paul Comitchak) Oh, I see. Okay. Yes, yes. Sure.

Larry Decelles: And, so, yes, just to further elaborate what Bob said, we're actually using those paper-based templates to map out the FHIR-based data and build more of an automated software related solution here. So we're using the templates and CDEs to be clear. CDE is clinical data elements for those who don't know.

(Paul Comitchak) All right. Thanks.

Coordinator: The next question comes from (Dale Gibson). You may go ahead.

(Dale Gibson): Somebody already asked my question. I thought I retracted my request.

Ashley Stedding: Do we have any further questions?

Coordinator: Sorry about that. (Rhonda Burmaster), you may go ahead.

(Rhonda Burmaster): Hi. Thank you. My main focus is in the DMEPOS industry. And you mentioned oxygen and CPAP that you're currently doing some pilots with. I guess I want to know how it's going.

What are the responses from practitioners in that area and suppliers in those areas? Has it been successful? Has it been easy? I'm kind of looking for some feedback.

Larry Decelles: This is Larry. I think we've only had a few pilots thus far. We hope to have several more this year. So far so good. Most of the feedback we've gotten is good.

It has been a bit of a challenge finding pilot participants on the provider side. It's much easier on the payer side because a lot of the payers are very interested in this project, I believe and that's one reason.

Yes. So I think the feedback has been pretty good. Bob, I don't know if you want to add to that.

Bob Dieterle: Let me do it this way. We built the implementation guides based on what we assume will be the standard required by ONC and CMS, meaning FHIR Release 4.

So we're somewhat dependent on EHR vendors implementing FHIR Release 4 and making it generically available. The expectation is that will happen over this current year. So we'll see a lot more capability in the EHRs to support it.

The DME suppliers are actively at the table looking to support the other end of the exchange related to DME, meaning getting this documentation and the orders electronically.

And the payers certainly have a tremendous interest in trying to go and deal with issues related to collecting data for prior authorization in the way that minimizes the impact on the provider and minimizes the delay and burden for the patient.

Does that answer your question?

(Rhonda Burmaster): It does. Thank you. I forget the gentlemen's name that had the initial response, but he mentioned...

Larry Decelles: Larry.

(Rhonda Burmaster): ...there was a struggle getting providers to partake in the pilot program. When you say providers, what do you mean by that because that seems to be a loose term? Are you talking physicians, hospitals, CMEs or all the above or?

Larry Decelles: Yes. It's kind of all of the above. But I think Bob kind of alluded to a very important point is we're working with a FHIR-based standard. And if an EHR that a particular, I'll say a hospital in this case. For example, we're working with Rush Medical right now out of Chicago. And they've been a great pilot participant.

But other equivalent hospitals might have a different EHR with a different version of FHIR that they support. So it's not always the actual provider that can't - well they essentially can't integrate for that reason just because they're not maybe up on the latest integration standards that we're working with.

And as Bob alluded to, this is all kind of mapped out in the implementation guides or specifications. And there may be other reasons, but that is a reason that we have to qualify pilot participants with before we move forward with a pilot.

Does that answer your question?

(Rhonda Burmaster): It does. Thank you.

Larry Decelles: You're welcome.

Coordinator: Thank you. The next question comes from (Diane Pence). You may go ahead.

(Diane Pence): Good afternoon. I have a question regarding accessibility to the common working file for a provider. I work for an ambulance service. And our coverage is often contingent upon if the patient is in a Part A stay at a SNF or if they're in a hospice stay. However, we don't have any access to that data. So is that part of the plan?

Ashley Stedding: This is Ashley Stedding from CMS. That is not currently part of the plan but that's definitely something. I think it's a great point for us to take back and kind of have internal discussions on to see if that's something that we might be able to incorporate down the road.

(Diane Pence): And there are probably other provider types that need similar information. But I only, unfortunately or fortunately, only know about ambulance requirements.

Coordinator: Thank you.

Ashley Stedding: That's a great comment and good point. Thank you.

Coordinator: Currently there are no additional questions. Once again, to ask a question please press star 1, unmute your phone and record your name. One moment, please.

Our next question comes from (Jill Young). You may go ahead.

(Jill Young): Hi. My question was simply this. I heard you talk about the participants that you do have and that there are requirements that their EHR systems have to have.

But I guess the unasked question was, are you looking for only large systems to try this? Are you looking for more down home in the trenches practices to volunteer to step up that may have the electronic requirement when you get to that level? Or are you only at the high, lofty, like Rush Medical and not Dr. Smiths in the community?

Larry Decelles: This is Larry. You know, I don't think we disqualify anybody based on the size of their practice or facility. It's a technology thing at this point. It's a prototype or reference implementation that we want to test out.

So if they have the technology, I think we're willing to definitely talk about a potential pilot.

(Jill Young): Okay. And how would someone contact the appropriate person if they felt they had the technology piece that you needed?

Larry Decelles: Nalini, would you have a suggestion there?

Nalini Ambrose: Yes. Sure, Larry. Please proceed to email me directly or, as Ashley pointed out, the CMS Medicare lookup email is there that you could also directly email to. And I'm happy to share my email offline.

(Jill Young): Okay. Thank you very much. I appreciate that because I think one of the things that I have seen in projects is when you only have a certain, if you will, demographic of your test group some of the problems that arise at the smaller level get not discovered until way too late. So thank you.

Nalini Ambrose: Absolutely, yes. Yes, we are looking for a diverse set of providers to test with. And we've been looking at larger and smaller systems and, you know, even

smaller group practices and providers and also looking at a good geographical mix.

(Jill Young): Okay. So I can email in and get the actual requirements to submit to IT to see if we would qualify. So thank you very much.

Nalini Ambrose: Absolutely. Thank you.

Larry Decelles: No problem. Nalini, you might want to just indicate that on Slide 22 there is an email address to participate in DRLS pilots.

(Jill Young): Perfect.

Coordinator: At this time, there are no additional question. Once again if you would like to ask a question, please press star 1, unmute your phone and record your name.

Our next question comes from (Danielle Root). You may go ahead.

(Danielle Root): My question just is kind of segueing off of Nalini's. I'm looking and I don't see an email address listed. And I'm just how we could find out if our EHR could participate in this.

Ashley Stedding: Hi. This is Ashley. There is an email address listed on Slide 21, that is the second sub-bullet under the first bullet that says to participate in pilot, contact CMS at the email address below and that's medicaredrls@cms.hhs.gov. And that email address is listed on the last slide, Slide 23, as well, and it is also posted on our Web page.

(Danielle Root): Thank you.

Coordinator: Once again, if you would like to ask a question, please press star 1, unmute your phone and record your name. One moment, please. There are no additional questions at this time.

Jill Darling: Ashley, do you have any closing remarks?

Ashley Stedding: No. Nothing other than just to thank everybody so much for participating today. And we look forward to your participation in future open door forums.

Coordinator: That concludes today's conference. Thank you all for participating. You may now disconnect. Speakers, please stand by. Oh, I'm sorry, one question did come in. Would you like to take that?

Ashley Stedding: Sure, yes.

Coordinator: Okay. Let me get their name and I will be right back. This question is from (Ella Bera). You may go ahead.

(Ella Bera): Thank you. Just a quick question. Will the DRLS replace the current requirement for using the clinical data system for advanced diagnostic imaging?

Ashley Stedding: No. It will not replace those current requirements for the clinical data system.

(Ella Bera): Okay. Thank you.

Coordinator: There are no further questions.

Jill Darling: All right. Well thank you, everyone. You'll get a few minutes back of your day and have a good day.

Coordinator: Once again, that concludes today's conference. Thank you all for participating. You may now disconnect. Speakers, please stand by.

End