Texas Academy of Family Physicians

12012 Technology Blvd.
Suite 200
Austin, Texas 78727
p (512) 329-8666
f (512) 329-8237
www.tafp.org

June 1, 2009

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
OMB Control Number 0938-0971
Document Identifier: CMS-10116
725 17th Street, N.W.
Washington, DC 20503

To Whom It May Concern:

On behalf of the Texas Academy of Family Physicians (TAFP) and the 5,500 family physicians, residents and medical students in Texas, thank you for the opportunity to submit the following comments and attachments to be considered concerning the data collection and paperwork burdens associated with the rule entitled, Conditions of Payment of Power Mobility Devices, Including Power Wheelchairs and Power-Operated Vehicles (CMS-3017-IFC).

In an attempt to meet the Centers for Medicare and Medicaid Services (CMS) power mobility device regulations, members of the TAFP developed a clinical guide that we believe captures the necessary clinical information to support a prescription for these devices, while significantly reducing the paperwork burden on an already overloaded family physician's office. Subsequent to posting the clinical guide we were informed by CMS' reviewers, CMS, and several suppliers that the contract reviewers would reject prescriptions that followed our clinical guide.

We have corresponded with the CMS contract reviewers, met via conference call, and met with officials at CMS responsible for provider compliance in Baltimore. In addition, we met last year with representatives of the Office of Management and Budget (OMB) to emphasize our concerns regarding the paperwork standard. We have attached with these comments prior correspondence between TAFP and the government on this matter and include them as part of our comments to you.

These discussions have been cordial and candid. Additionally, CMS officials have graciously offered to speak at continuing medical education seminars to further enhance physician knowledge of CMS expectations. We both understand the difficulties of assuring optimal physician compliance with a complex regulatory standard.

We understand and agree that a form with simple check-off boxes provides insufficient information for a reviewer who has not seen the patient. However, most of these devices are prescribed by a family physician, on average less than

3 times per year. It is at best unrealistic that a family physician would have the requisite knowledge as to coverage and documentation requirements without support of a clinical guide.

At a meeting at the CMS office in Baltimore this past March, the TAFP offered to further refine our guide to accommodate their concerns regarding documentation. At my request, three of our family physician members have since met at length with a former contract reviewer with expertise in disability ratings who has developed a comprehensive, 12-page document that would likely cover every conceivable element when evaluating a patient face-to-face. The physicians reviewing the document observed that its thoroughness would translate in day-to-day practice as '$600 worth of physician time for a $40 reimbursement.' Furthermore, the burden alone is more excessive that the 10 minutes CMS has stated in its comments to you.

We have argued to CMS that the regulation, which contemplates handwritten narratives and explanations, contradicts the logical progression of medical practice toward electronic health records, evidence based medicine and its comparative effectiveness. Templates and guides are already common, a prerequisite to complying with impending federal mandates to convert to EHRs, and essential if family physicians are to get the right care to the right patient at the right time.

We respectfully ask OMB to review these regulations in the proper context of the exam room and help persuade CMS to further simplify and refine its requirements and allow for the use of clinically sound guides to assist the treating physician.

Should you have any questions, please feel free to contact me (512) 329-8666.

Respectfully,

Tom 2 B

Thomas Banning
CEO/EVP

Cc: Alfred Gilchrist, CEO, Colorado Medical Society
Christine Fisher, Executive Vice President, Florida Academy of Family Physicians
Brenda Aguilar, Office of Management and Budget

Texas Academy of Family Physicians

12012 Technology Blvd.
Suite 200
Austin, Texas 78727
p (512) 329-8666
f (512) 329-8237
www.tafp.org

September 14, 2007

Office of Management and Budget
Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
Room 10235
Washington, D.C. 20503

Dear Ms. Lovett:

I am writing on behalf of the Texas Academy of Family Physicians (TAFP) and the 5,500 family physicians, residents and medical students in the state of Texas concerning the data collection and paper work burdens associated with the rule entitled, "Conditions of Payment of Power Mobility Devices, Including Power Wheelchairs and Power-Operated Vehicles (CMS-3017-IFC)."

To date, the Centers for Medicare and Medicaid Services (CMS) has not put forth any specific guidance for physicians to follow when evaluating Medicare patients for consideration of a power mobility device. In an attempt to meet CMS' regulations, our physician members developed a clinical guide for physicians to use that we believe captures the necessary clinical information to support a prescription for these devices while significantly reducing the paperwork burden on overloaded physician offices.

The use of standardized clinical forms are commonly used and accepted to satisfy private insurance and state requirements. CMS regulations state there is no form or format for the face-to-face examination report and simply requires this information be included in the patient's medical record. Yet, the bulletin issued by CMS' Regional Carriers would suggest otherwise.

We respectfully request to meet with you and members of the OMB leadership team who oversee this issue at your earliest convenience. Please contact Tom Banning, CEO/EVP of the TAFP at (512) 329-8666 should you have any questions or comments in the meantime. We look forward to working with you to address this issue.

Respectfully,

Linda M. Siy, MD

Linda Siy, M.D.
President
Texas Academy of Family Physicians

Texas Academy of Family Physicians

12012 Technology Blvd.
Suite 200
Austin, Texas 78727
p (512) 329-8666
f (512) 329-8237
www.tafp.org

November 1, 2008

Paul Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A
NHIC
75 Sgt. William B Terry Dr.
Hingham, MA 02043

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B
National Government Solutions
8115 Knue Rd.
Indianapolis, IN 46250

Robert D. Hoover, Jr., M.D., MPH, FACP
Medical Director, DME MAC, Jurisdiction C
Cigna Government Services
2 Vantage Way
Nashville, TN 37228

Richard W. Whitten, M.D., MBA
Medical Director, DME MAC, Jurisdiction D
Noridian Administrative Services
901 40th Street South, Suite 1
Fargo, ND 58103-2146

RE: Face-To-Face Mobility Examination Report from TAFP

Dear Drs. Hughes, Oleck, Hoover and Whitten,

On behalf of the Texas Academy of Family Physicians, I wish to respond to your letter from October 1, 2008 regarding the TAFP's mobility evaluation guide as well as a more recent posting by Dr. Oleck on this same concern. We share Dr Oleck's general views and appreciate his acknowledgement of the intrinsic value of these kinds of templates.

The purpose of this letter is to respectfully urge our physician leaders to meet with you and/or your fellow directors at your earliest convenience, in person or via conference call, to determine more specifically how our guides can be improved to assure a thorough and clinically acceptable result. We are very concerned, as seems to be implied by your correspondence, that family physicians' use of our guide will result in summary denials and subsequent lengthy appeals to satisfy the regulatory imperatives.

As we have noted in correspondence to you several months ago, family physicians typically see most of the Medicare patients who may need mobility assistance, yet may not prescribe more than or two or three units each year. It is not possible for those with very busy practices to understand the complexities and ambiguities of the coverage and documentation requirements, which is why physicians in our organization who have treated these patients helped us develop a guide to assist in evaluating them.

We can appreciate the problems of your reviewers and auditors dealing with a range of forms and checklists that are inadequate and want to collaborate with you on this medical condition of mutual interest and patient welfare. As you can well appreciate, in those instances when a patient needs mobility assistance, our colleagues want to get it right the first time, especially if the clinical assessment perceives, absent a PMD, a rapid deterioration in their patient's quality of life and risk of falling.

Dr Oleck's comments provide broader guidance, but the difference is still unclear between a guide that incorporates, including narrative commentary, all the elements mentioned in his posting that is attached as part of the medical record, and submitting a medical record with essentially the same information.

The latter approach seems counterintuitive to where Medicare specifically, and all payers generally, are headed. Given the increased applications of evidence-based standards, quality initiatives and pay-for-performance pilots initiated by CMS, it is important that physicians prescribe the right care to the right patient at the right time with accurate and clinically consistent documentation. We believe that with the push for electronic medical records, the formal SOAP format will most likely disappear and be replaced with some template format. Forms such as the TAFP form can be adapted for template where pure narrative reports will not.

Moreover, a free-form narrative approach will certainly take the typical family physician longer than the estimated 15 minutes reimbursable by CMS. We have brought this to the attention of OMB as what seems to us to be an excessive paperwork burden not applied in many, if any, other patient encounters.

Again, we are eager to discuss with you and your colleagues how to determine, if not this guide, then what kind of guidance is CMS willing to give physicians assessing the mobility needs of these kinds of patients that allows for an efficient but reliable means of determining medical necessity. I look forward to your prompt response. Should you have any questions, please feel free to contact me.

Respectfully,

Tom Banning
CEO/EVP
Texas Academy of Family Physicians
12012 Technology Blvd, Suite 200
Austin, Texas 78727
(512) 329-8666 ext. 22
tbanning@tafp.org

Texas Academy of Family Physicians

12012 Technology Blvd.
Suite 200
Austin, Texas 78727
p (512) 329-8666
f (512) 329-8237
www.tafp.org

December 29, 2008

Paul Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A
NHIC
75 Sgt. William B Terry Dr.
Hingham, MA 02043

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B
National Government Solutions
8115 Knue Rd.
Indianapolis, IN 46250

Robert D. Hoover, Jr., M.D., M.P.H., F.A.C.P.
Medical Director, DME MAC, Jurisdiction C
Cigna Government Services
2 Vantage Way
Nashville, TN 37228

Richard W. Whitten, M.D., M.B.A.
Medical Director, DME MAC, Jurisdiction D
Noridian Administrative Services
901 40th Street South, Suite 1
Fargo, ND 58103-2146

RE: Face-To-Face Mobility Examination Follow-Up from TAFP

Dear Drs. Hughes, Oleck, Hoover and Whitten,

On behalf of the Texas Academy of Family Physicians, I want to thank you for taking the time to discuss our mutual concerns regarding federal documentation requirements when assessing the power mobility needs of our patients. We appreciate your candor and willingness to speak frankly about the more problematic aspects of the review process that often conflict with both legitimate medical need and the practical challenges family physicians face when trying to document that need.

The purpose of this letter is to summarize key elements of our discussion and how TAFP can better inform our physician members about the documentation requirement so that our members prescribe the right care to the right patient at the right time with accurate and clinically consistent documentation.

You commented that these prescriptions typically have very high rejection rates, while also observing that this has more to do with documentation failures rather than purposeful misrepresentation or fraud. You were quite frank in

acknowledging that in an audit it would be unlikely that many physicians would have proper documentation.

You further noted that the conflict arises when the information you review on a submitted form (such as TAFP's evaluation form) is not reflected in the medical record. You frequently emphasized that more documentation is needed than merely "checking boxes."

We have respectfully countered that the TAFP form is a template that provides for narrative sequences that will be attached to the patient's medical record. We emphasized that the inevitable transition to electronic medical records virtually dictates that our practices work from such templates.

You suggested that chart notes from physical or occupational therapists are often more complete and provide the reviewer with better guidance as to meeting these complex multi-element coverage requirements.

The unresolved aspects of our conversation seem to us to be:

- The high rejection rates suggest that not only do well-intentioned doctors not understand what is required from them, but patients with a compelling need for mobility support within their homes are often not getting medically necessary and covered power mobility support, or at best are getting them after significant delays.

- A properly constructed mobility guide—not merely a set of check-off boxes, including narrative on all the clinical indicators required—can be, if attached as part of the normal course charting to the medical record, more than adequate for determining medical necessity and coverage.

- The amount of time anticipated to satisfy the federal law and regulations far exceeds the G code reimbursement. It was not clear that as reviewers you had a sense of how much time this actually takes from a busy practice. We also respectfully emphasized that our guide was intended to streamline this burdensome process without compromising the clinical fundamentals of a comprehensive evaluation.

- The federal coverage—for which you as reviewers have no say—applies only to in-home mobility, and is likely overly restrictive in terms of legitimate medical need.

We believe this discussion demonstrates a compelling need for ongoing collaboration with you, as well as ongoing communications with physicians and physician organizations. We both understand the challenges of keeping busy physicians informed on these admittedly more burdensome documentation

requirements, especially if the means of communicating is only an occasional bulletin or letter, however succinct or well crafted.

We will be adding further guidance and examples to our Web site for our physicians who want to adapt from our guide when assessing a patient, and would like to share that advice and guidance with you as this progresses.

Thank you again for your time and your candor. We look forward to working with you on this matter of mutual interest and importance.

Respectfully,

Tom Banning
CEO/EVP
Texas Academy of Family Physicians
12012 Technology Blvd, Ste. 200
Austin, Texas 78727
(512) 329-8666 ext. 22
tbanning@tafp.org