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The Promise of e-CMNs

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The next step in the evolution of electronic billing could impact your bottom line and your choice of billing software. But it is too early to tell what form e-CMNs may finally take.

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Nearly all HME providers struggle to get Certificates of Medical Necessity (CMNs) returned from physicians in an accurate and timely fashion.

Getting the CMN back in 30 days is a fairly standard industry goal, yet the reality is that only about half of all CMNs make it back to the provider in that period of time. Even then, many of those are incomplete or completed incorrectly. It is common for 120 days to pass before a provider receives an accurate CMN back from a physician.

Given that reimbursement for many types of equipment depends on the receipt of a qualifying CMN, finding solutions for CMN process problems has fallen almost exclusively to HME providers and the HME industry as a whole. Fortunately, the industry is poised to have a powerful tool at its disposal that may prove invaluable in meeting the goal of reduced CMN turnaround time. This tool is the electronic CMN or e-CMN.

Three e-CMN Philosophies

The advent of state and federal legislative acceptance of digital signatures, which give the same legal weight to electronically signed documents as to those that are signed manually, has made e-CMNs possible. So far, at least two software companies and the American Association for Homecare (AAHomecare) have entered the e-CMN field. Each has its own user interface and underlying database, and they take different approaches on how to collect e-CMNs.

Favoring standard software architecture and a central database repository for all electronic CMNs, AAHomecare, in conjunction with several large HME providers, has begun development of an e-CMN product. It features an open software architecture accessed through the Internet on which a variety of e-CMN vendors could theoretically build their own user interfaces, but which would share an underlying database (or central CMN repository) maintained by the association.

The software companies are understandably less universally minded than AAHomecare because they want their version of the e-CMN to be the industry-preferred one. But they also recognize that to be the industry leader they must make their system easy for physicians to use.

The first of the two private e-CMN vendors uses a Web site interface to make the system easily accessible. The physician needs only a Web browser program and an Internet connection to fill out an e-CMN.

It works as follows: Once the e-CMN form is prepared by the HME provider, an email notification is sent to the physician alerting him or her that a CMN is waiting in the vendor's secure Web site database. The email that the physician receives includes a link to the Web site where the physician can log in to access the CMN for completion and add a digital signature to the certificate. Once the e-CMN is complete, the HME provider can retrieve the e-CMN and enter the information into its billing system so that a claim can be processed for reimbursement. Finally, the CMN is either archived in its electronic format, or printed in a format that duplicates the current paper CMN.

The other entrant to the e-CMN market works similarly. However, this system requires that the physician download software to his or her personal computer to review, complete, and digitally sign a variety of documents that reside in this vendor's database, such as home health plans of care, prescriptions, and e-CMNs. At first glance, this would seem less convenient than just needing a Web browser, but this e-CMN vendor believes the ability to complete all electronic documents in one central place will offer time-saving efficiency to the physician.

Physicians Will Pick e-CMN Winner

With service cost estimates ranging from $0.25 to $8 per e-CMN depending on the vendor, competition is necessary in order to assure that e-CMN service pricing is reasonable for the HME provider. However, that same competition presents perhaps the largest hurdle to overcoming the final challenge to e-CMN providers—gaining widespread acceptance of electronic document processing by physicians.

According to a study of 1,200 physicians conducted last year by Fulcrum Analytics and Deloitte Research entitled "Taking the Pulse: Physicians and Emerging Information Technologies," the widespread acceptance of technologies such as e-CMNs will hinge on whether it saves the physician time and improves the operational management of the physician's practice.

Should more than one e-CMN program succeed in this, it is possible that many separate e-CMN databases

may develop. The more databases that hold CMNs for the physician to complete, the more places the physician must log onto in order to complete them—perhaps eliminating either the real or perceived time-saving potential of electronic document technology.

The possibility exists that individual physicians may require that HME providers use the specific e-CMN vendor he or she has chosen to work with, resulting in providers being compelled to subscribe to many different e-CMN vendors. At worst, physicians may reject the technology.

Meeting CMS Requirements
Another hurdle for the adoption of e-CMNs is that they must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), and so far HIPAA does not include e-CMNs as one of the document forms it recognizes. In addition, e-CMNs must meet Centers for Medicare & Medicaid Services (CMS) requirements, which say that electronic CMNs must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/ definitions. Electronic orders and CMNs also must allow the physician to add to or correct information entered prior to signing and dating the form. Furthermore, the program must keep a record of the original information entered and a history of what was changed, by whom, and the date of the change.

CMS also requires that electronic orders and CMNs have an electronic physician signature and a date that is entered by the physician. Each electronic CMN sent to a physician by a supplier must include the back page of the CMN, and the back page must still be attached when a physician sends a completed e-CMN back to the supplier. Finally, the supplier must be able to provide a legible copy of the e-CMN received from the physician.

If physicians adopt e-CMNs, it will become important for HME providers to have billing software programs that work with the e-CMN system physicians prefer, but it is too early to tell which, if any, of the above three systems will be chosen by physicians.

The AAHomecare proposal, which advances the idea of a single, central database accessible via a variety of user interfaces (presumably available through a variety of vendors), would seem to solve the problem of disparate databases and having to pick a single software provider. On the other hand, because fees would have to be charged to access the database, it puts the association in the somewhat unusual position of being a potentially large, and not so voluntary, vendor to the HME industry.

Nevertheless, if the industry decides that a single repository for e-CMNs is necessary to the success of the technology, it may be hard-pressed to find a more neutral partner than AAHomecare for a central database.

It is clear that e-CMN technology is still evolving, and that it has the potential to provide a huge benefit to HME suppliers. In the beginning, at least, it will likely fall to the HME supplier to market the e-CMN initiative to physicians. Any approach that wins out as the market leader will be an approach that physicians prefer. In essence, then, it will take HME suppliers providing feedback from the physician to the e-CMN vendor to drive the initiative to successful fruition.

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