Claims Attachments and Incremental Interoperability

Get the gain with way less pain

(Compared to other HIPAA regs)
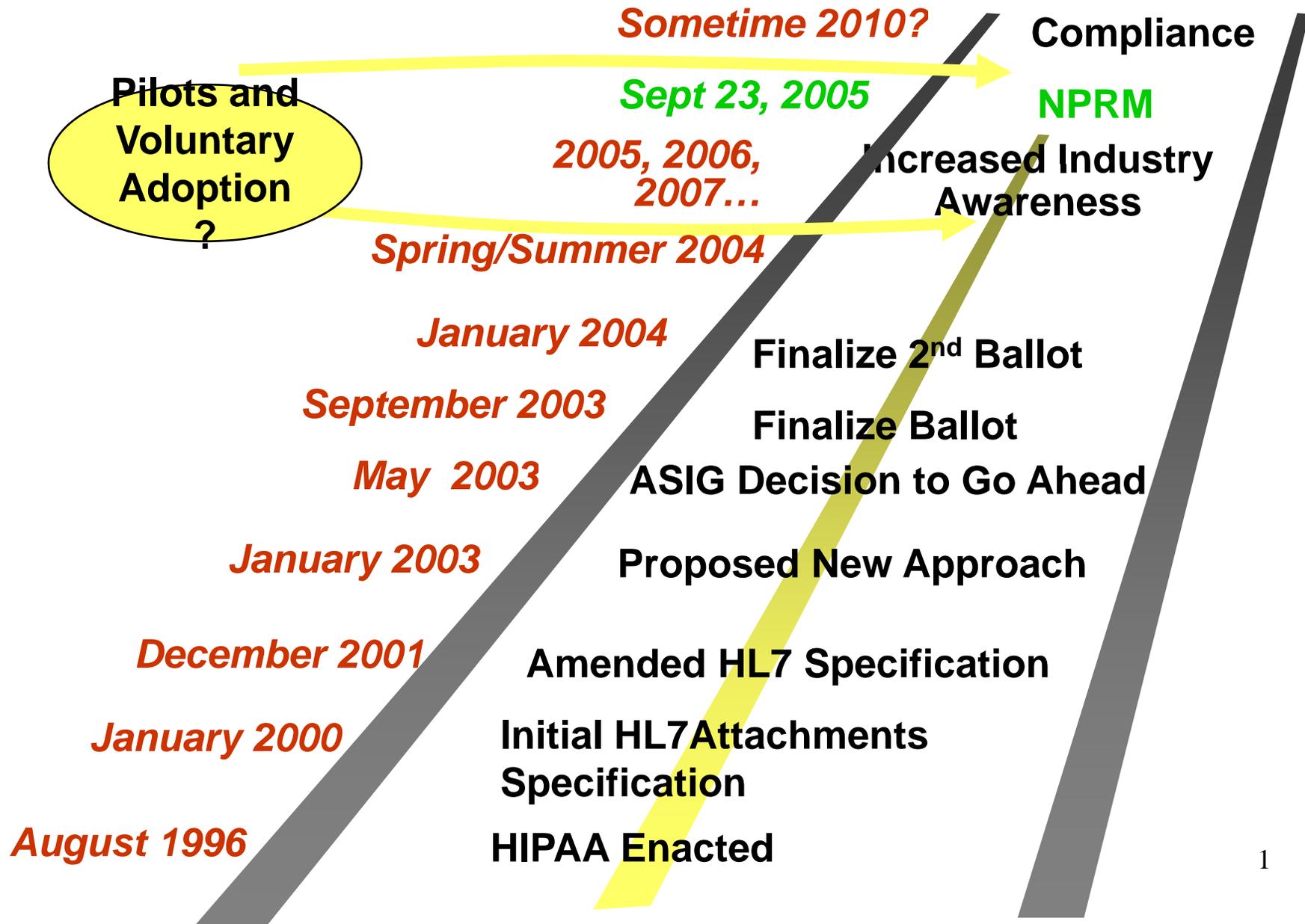
Wes Rishel

Testimony to NCVHS

17 November 2011

Rosslyn, VA

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Timeline...*dates subject to change*

Pilots and Voluntary Adoption ?

Sometime 2010? — Compliance

Sept 23, 2005 — NPRM

2005, 2006, 2007… — Increased Industry Awareness

Spring/Summer 2004

January 2004 — Finalize 2nd Ballot

September 2003 — Finalize Ballot

May 2003 — ASIG Decision to Go Ahead

January 2003 — Proposed New Approach

December 2001 — Amended HL7 Specification

January 2000 — Initial HL7 Attachments Specification
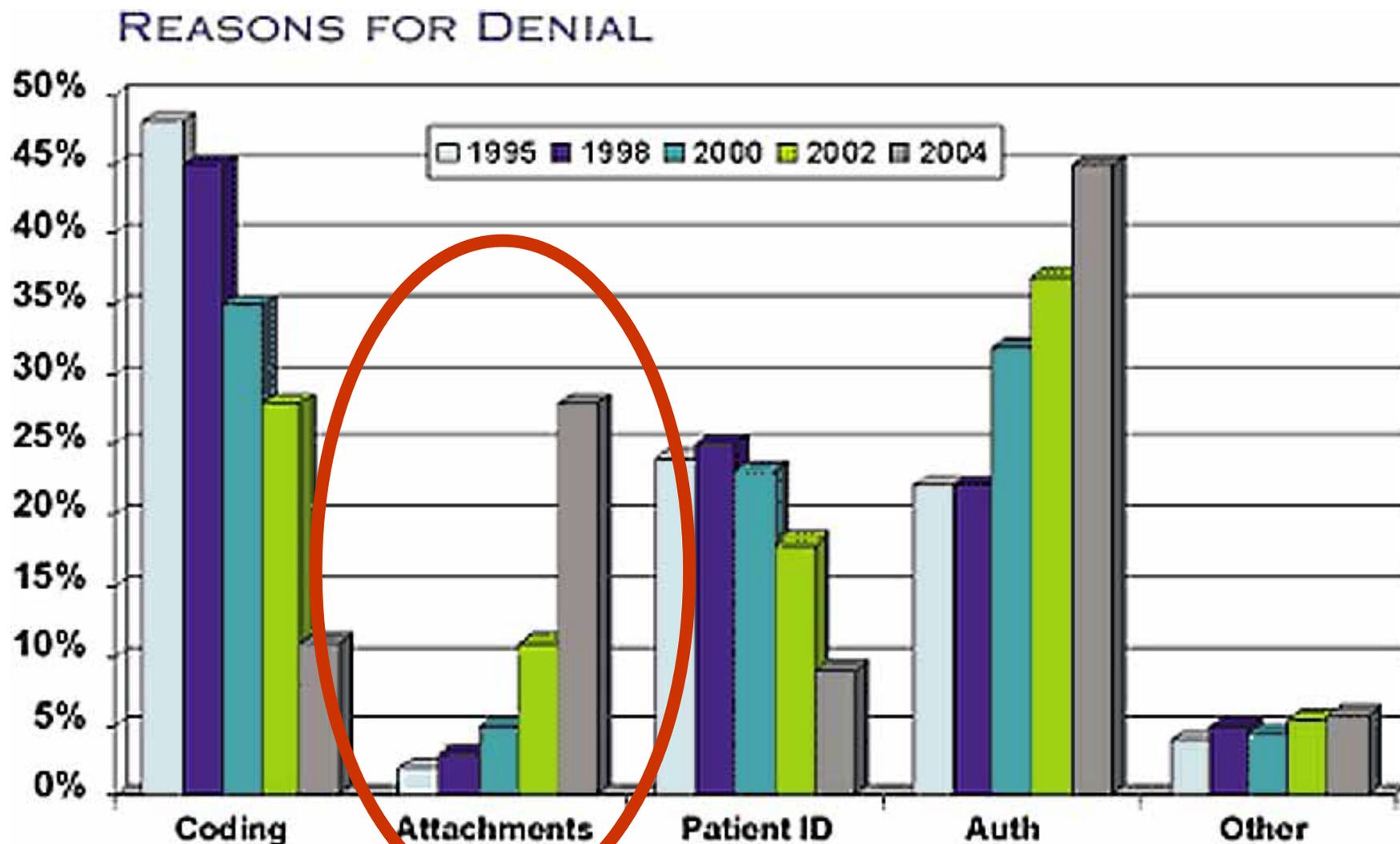
August 1996 — HIPAA Enacted

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- **Why do we even have attachments?**

  - ✓Today's business needs require attachments
  - ✓The 837 is already over burdened with data and that has partly caused slow adoption
  - ✓The Claims Attachment did not yet exist so that the only option was to add data to the 837. The 275 + HL7 will now be able contain the specialized data that is intermittent in the 837.

Problems with Claims Attachments

- Providers don't know when/what attachments are needed
- Providers proactively submit attachments "just in case"
  - delays claim submission, however…
  - expectation is that it decreases DRO
- Requests get misrouted, misplaced in hospitals
- Payers lose attachments or can't re-associate with the claim
- Major source of delays, denials and write-offs
- Defeats the use of electronic claims in some cases
  - Some concerned about Medicare requirements
  - 5 - 20% of claims require attachments
  - varies widely, almost 100% for some specialists
- One estimate: 700 million attachments annually

The Problem is Growing

REASONS FOR DENIAL

Legend: 1995, 1998, 2000, 2002, 2004

Categories: Coding, Attachments, Patient ID, Auth, Other

Source: Altary, Inc, 2003

Structured Data:
Must We Sell the Future to Gain the Present?

- Present (*near future*)
  - Limited ability of providers to provide structured data
  - Limited ability of payers to use structured data
  - ROI available by saving People, Paper, and Postage

- Future
  - increasing levels of autoadjudication
  - better medical management
  - more extensive collection of quality data
  - requires structured data

There is a way to have both!

Preventing FIS:
Frozen Interface Syndrome

- Make incremental interoperability a fundamental business premise
  - Variable structure
  - Require mappable code upgrades
  - Flexible utterances
- Use business incentives to drive upgrades to system informatical levels

"Human-Decision" vs. "Computer-Decision" Variants

Human-Decision Variant
- Matches the most prevalent workflow: a person reviewing the information to make a decision
- "Low-impact" on health plans (easy to display using common tools)
- "Low-impact" on providers (supports low-cost document preparation and "fax-like" use of existing paper or document images)

Computer-Decision Variant
- Permits computer-assisted adjudication or autoadjudication
- Includes specifications for breaking data down into computer-accessible elements
- Includes LOINC codes to identify the questions
- Includes answer codes suitable to the question
- Processable in "Human-Decision" mode by health plans that have not adopted a computer-decision approach.
- Can be applied selectively, one attachment at a time.

Incremental Interoperability
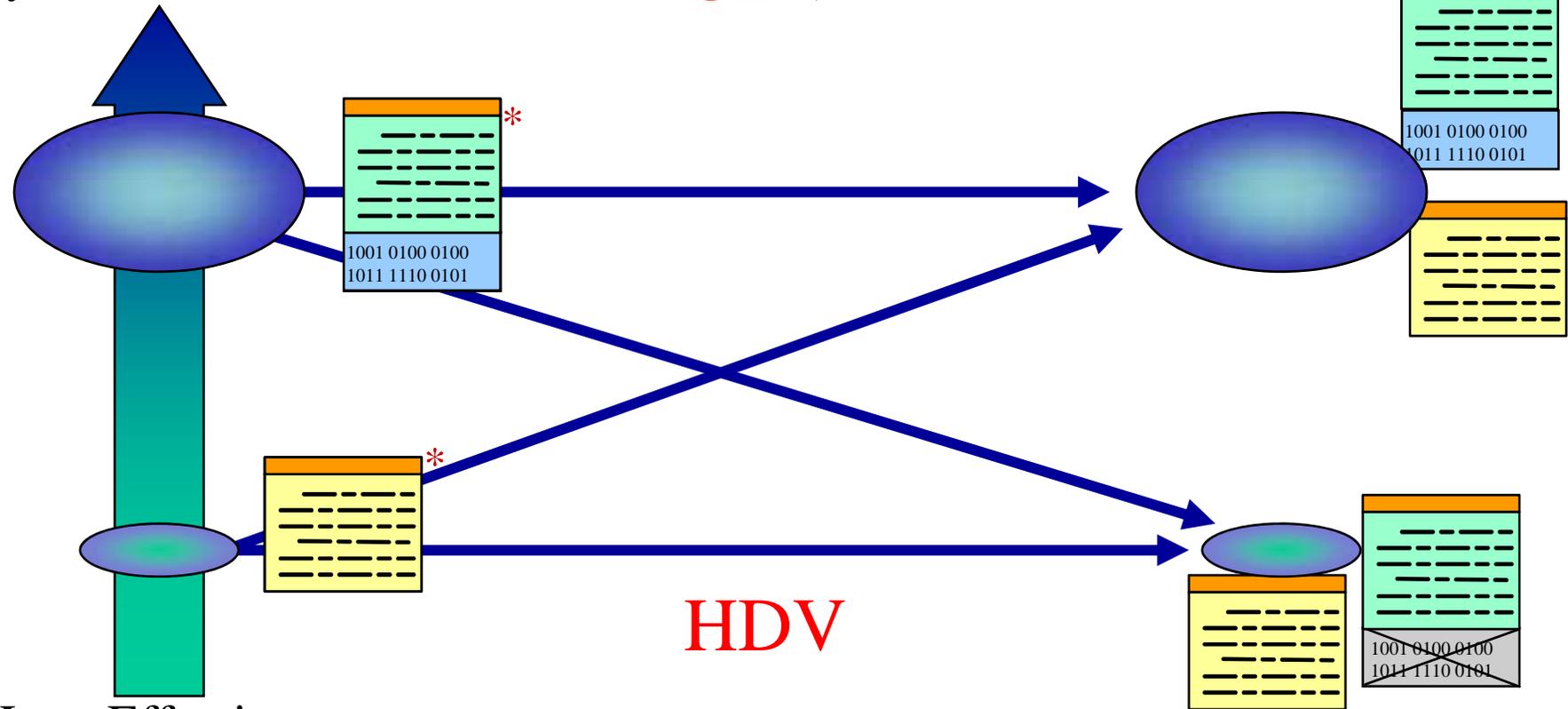
Gain Immediate Benefits...

- Providers
  - ROI available by saving People, Paper, and Postage
  - Maximum opportunity for immediate participation
  - Reduction in appeals
  - Fewer claim denials

- Payers
  - ROI available by saving People, Paper, and Postage
  - limit early implementation costs to basic Qs and As
  - less early use of LOINC codes (could limit it to attachment IDs)
  - initial investment more justified by higher provider participation
  - Improved denials management
  - Reduction in appeals

…But Don't Sell Out the Future

- Providers
  - Health plan incentives for structured data provides financial benefit for acquiring a computer-based patient record
  - Timing for conversion is a business decision rather than an enforced decision

- Health Plans
  - After the basic ROI is obtained, advance to the use of structured data without another regulatory cycle
  - Selectively approach the use of structured data as business opportunities arise, rather than forced by regulation

Recommendations

✓ Remember: not all data is structured in EHRs

✓ Treat claims attachments as the leading edge of provider-payer clinical interchange, not just a single business transaction

✓ Where possible, meet the business need with document specs already required of EHRs

✓ Show early ROI by focusing first on people, paper, postage and process

✓ Avoid FIS and enable future ROI by making the use of structured data an economic rather than regulatory decision

✓ Consider, the iPAD: future-proof the transaction by using Internet-savvy formats.