What is Happening with Attachments?

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Who is HCSC

Health • Dental • Life • Disability • Connectivity • Pharmacy • Health IT

Exceptional financial stability
- Moody's Investors Service = A1 (Good)
- Standard & Poor's = AA- (Very Strong)
- A.M. Best Company = A+ (Superior)

14 million members
4th largest U.S. health insurer

WHAT’S HAPPENED TO ATTACHMENTS?

ACA Administrative Simplification has a Compliance Date of January 1, 2016.

We will cover:
- The status of the regulation on Attachments
- The proposed Standards
- Types of Attachment requested / sent
- Different uses for Attachments
- What’s new or related to Attachments
- Where you can pick up more information
Status on Regulation for Attachments?

- NCVHS
    - Strong Industry Support for Adoption
    - Be Consistent with Clinical Information Exchange
  - Feb 2013 Testimony, Letter of Recommendation June 2013
    - Need Convergence of Clinical and Administrative Data
      - Attachment Standard is the 1st Bridge
    - Need Roadmap to Align Clinical/Administrative Initiatives
    - Continue Collaboration between Standards and Operating Rules
    - Definition - "supplemental documentation needed about a patient(s) to support a specific health care-related event (such as a claim, eligibility, prior authorization, referrals, and others) using a standardized format."

Status on Regulation for Attachments?

- NCVHS Feb 2013 Testimony = Letter of Recommendation June 2013
  - Recommendations:
    - Standards = 1) Query  2) Response  3) Acknowledgement
      - HL7 Consolidated – CDA 1.1 and HL7 Supplemental Guide; LOINC codes
      - X12 275, 277, 278 and 999
      - NCPDP
      - No Transport
      - Solicited and Unsolicited (as recommended in 2004)
      - TPA must pre-define criteria for unsolicited
      - No Unspecified Attachments
      - Do not allow 'Continued' Requests
        - Repeating or Chaining (one at a time)
      - Phased Implementation
      - Defined Meta-data to re-associate
      - NPRM (not IFR)
      - Obey Minimum Necessary
      - Industry Needs Education

Status on Regulation for Attachments?

  - Recommendations:
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      - HL7 Consolidated – CDA 1.1 and HL7 Supplemental Guide; LOINC codes
      - X12 275, 277, 278 and 999
      - NCPDP
      - No Transport
      - Concerns:
        - Level of maturity of the Standards
        - Level of industry readiness
        - New Medicare specification – CDP1
        - Number of other initiatives mandated
        - Industry Needs Education

- Sept 2015 NCVHS Agenda – Review Committee Report from June
  - February 2016 next Standards Subcommittee – probable Attachment Agenda
  - Recent publication for HL7 CDPI and Consolidated-CDA R2.1
What’s changed for Attachments?

  - To give providers one common standard to implement
  - Health Story consolidates CCD, HITSP C32 and Attachments
  - Changed to use CDA version 3 Templates

- Templates Re-usable building blocks
  - Imposed at three levels within a CDA
  - Document-level: applies to entire document
  - Section-level: applies to the document section
  - Entry-level: applies to entries within a document section

Examples:
- Document level = Discharge Summary, CCD, Progress Note
- Section level = Payer, Medications, Allergies, Problem Lists, Providers
- Entry level = Name, Number, Address.
- Consolidated CDA is an IG of different Document Templates, and each Document Template has a defined set Sections
- CDA changed, C-CDA IG changed, and the publication of CDP1

What is CDA? …C-CDA? …CDP1? …LOINC?

- Clinical Document Architecture (CDA)
  - XML based std, constrained by HL7 Reference Information Model
- Consolidated CDA (C-CDA)
  - Implementation guide that defines discrete data for specific clinical documents
  - Documents built from templates of Sections
  - Primarily developed to support MU-EHRs and Attachments
- Clinical Documents for Payers – Set 1 (CDP1)
  - Implementation guide that defines discrete data for specific clinical documents with testable conformance statements
  - Requires HIT vendor to fill every section with the data or null value
  - Provider is responsible for the content
  - Initially developed for prior authorization, pre-payment review and post payment audit for Medicare FFS

- Logical Observation Identifiers Names and Codes (LOINC)
  - Value set that identifies the document being requested/sent

CDA Structure

Every CDA Document is composed of two parts:
- Header
  - Contains information about the document, establishes context for the details found in the Body:
    - Who: Participants such as patient, physician, author...
    - What: Document Title, encompassing encounter...
    - Where: Location
    - When: Creation date
    - And much more...
- Body
  - Contains clinically relevant information
    - Either Unstructured; such as a pdf, jpg, tiff
    - Or Structured, as defined in the Consolidated CDA or CDP1 (XML/CDA)
Required Sections
- Allergies and Intolerances
- Immunizations
- Medications
- Problem
- Procedures
- Results
- Vital Signs

Optional Sections
- Advance Directives
- Encounters
- Family History
- Functional
- Medical Equipment
- Mental Status
- Nutrition
- Plan of Treatment
- Social History
**Compare C–CDA and CDP1**

Consolidated–CDA R1.1

- Continuity of Care Document,
- Consultation Note,
- Diagnostic Imaging Report,
- Discharge Summary,
- History & Physical,
- Operative Note,
- Procedure Note,
- Progress Note,
- Unstructured

C–CDA R2 Clinical Notes adds 4 docs:
- Care Plan
- Referral Note
- Transfer Summary
- Patient Generated Document

Clinical Document for Payers 1

- Re-packages C–CDA sections
- Changes Conformance Statements to require all Sections in each document to allow for vendor conformance testing
- Using Null values, if the provider has no information to report or choses not to report

INTO

5 new document types:
- Enhanced Encounter,
- Enhanced Hospitalization,
- Enhanced Operative Note,
- Enhanced Procedure Note,
- Interval

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**esMD Goals and Policy Issues**

- **PCG/esMD Goals**
  1. Reduce improper payment ($45.8 B in 2014) through
     - prior authorization (e.g. PMD)
     - pre-payment review
  2. Minimize provider burden through
     - electronic communication of medical information (esMD)
     - structured data to facilitate review process
     - digital signatures to establish data integrity and provenance

- **Medicare FFS policy**
  1. No limitations on providers right to submit documentation
     - NCDs/LCDs policies allow providers to submit any documentation they deem required to support that the service was/is medically necessary and appropriate
  2. Medicare cannot limit submission to specific information (e.g. H&P)

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**esMD Project > CDP1**

Phase 1 – provider sends document images electronically to Medicare
- Unstructured documents (PDF’s, jpg, tiff)
- Using NwHIN – CONNECT through a Health Information Handler

Phase 2 – e-Determination of Coverage work group (ONC)
- Medicare sending a secure eMDR (Request for information) to a ‘registered’ provider
  - Provider Profile Authentication IG (IHE HDR or X12 274)
  - eMDR and Structured Content IG (IHE XD* or X12 277 and CORE 270)
  - Digital signature for Author of Record
    - Author of Record IG
    - HL7 Digital Signature DSTU
  - Define and support structured documentation
    - Clinical Documents for Payers Set 1 (Balloted HL7 CDA based on C-CDA)
    - Companion Guides for X12 275 and X12 278
CDP1 Documents

1) Enhanced Encounter Document requires all:
   a. C-CDA R2 Progress Note Document sections
   b. C-CDA R2 Consult Document sections
   c. C-CDA R2 History and Physical Document sections
   + New Sections: Additional Document, External Defined CDE, Orders Placed, Transportation

2) Enhanced Hospitalization Document requires all:
   a. C-CDA R2 Discharge Summary Document sections
   b. C-CDA R2 History and Physical Document sections
   + New Sections: Additional Document, External Defined CDE, Orders Placed, Transportation

3) Enhanced Procedure Document requires all:
   a. C-CDA R2 Procedure Document sections
   + New Sections: Additional Document, External Defined CDE, Orders Placed

4) Enhanced Operative Note Document requires all:
   a. C-CDA R2 Operative Note Document sections
   + New Sections: Additional Document, External Defined CDE, Orders Placed

Interval Document has no equivalent templates?

Descriptions of new CDP1 Documents
(reference)

- Enhanced Encounter - support the entire contents of the medical record related to a specific encounter with a patient for the administrative or clinical exchange with a third party
- Enhanced Hospitalization - to support a complete synopsis of the admission and discharge portion of the medical record related to a specific admission of a patient for the administrative or clinical exchange with a third party
- Enhanced Op Note - to support the entire contents of the medical record related to a specific operative procedure performed on a patient for the administrative or clinical exchange with a third party
- Enhanced Proc. Note - to support the entire contents of the medical record related to a specific procedure performed on a patient for the administrative or clinical exchange with a third party
- Interval - to capture the complete activity for the period covered. It may exclude anything that is covered in one of the other Clinical Document Templates (e.g. Enhanced Procedure Note).

Descriptions of new CDP1 Sections
(reference)

- Additional Documentation - This section contains additional documentation captured by the provider related to care provided or planned for the patient that is not supported in any other section of the document. (example – physicians rationale for decision)
- External Defined CDE - This section contains additional documentation captured by the provider related to care provided or planned for the patient that is not supported in any other section of the document. (example – physicians rationale for decision)
- Placed Orders - This section contains data that defines orders for observations, interventions, encounters, services, and procedures for the patient. It includes orders that have been entered into an EHR. These are distinguished from observations, interventions, services, and procedures by the entries within this section. The entries in this section represent the details of the orders and not the acts involved in the processing and fulfillment of the order. The process of and fulfillment of the order is represented by other entries.
- Transportation - The Transportation Section describes in a narrative format the transportation method (such as emergency transport), other than the patient’s or caregiver’s personal transportation, that was used to bring the patient to the location for the current encounter. This information is normally provided as a summary by the entity that provides the transportation service.
Attachments on FHIR

- FHIR Standard Specification
  - Uses 'Resources' as modular building blocks
    - Resources - define XML for a common use (for reuse and interoperability)
    - Combine Resources into 'Profiles'
    - Standalone Resource for messaging or document
  - Specification has three parts
    - General documentation on How to Define Resources
    - Implementation - How to use with REST, Messaging, as clinical documents
    - Resource Lists - Clinical, Administrative, and Infrastructure

- Possible Use Cases
  - FHIR resources for building the Consolidated CDA document types
  - FHIR / Structured Data Capture to create forms, such as consent forms, etc
  - Use PHR Profile to push/pull PHR data
    - Blue Button based on CCD, P2PPHR (HL7 Standard)
    - Build Blue Button Plus collaboration with HL7 Financial Management WG

Procedure Resource

The resource is referenced by CarePlan and Condition

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<FHIR

 PHR Use Case

2.11.1: Personal Health Record (PHR)

- In the PHR scenario, an Electronic Medical Record system (EMR, though many other names and acronyms are also used) provides a RESTful API that allows patients to access their own medical records via a common web portal or mobile application.
- The EMR scenario can be extended to allow consumers to federate their records with the PHR provider.
- This is done by linking the patient records to an external identity provider (e.g. OpenID, OAuth, Facebook, Google, etc.)
- The consumer integrates the EMR API into their own web portal or mobile application to provide a federated view of both the EMR and PHR.
- The PHR provider (e.g. an organization providing virtual clipboard or document management services) can offer access to general patient documents in a common portal or mobile application.
- The PHR Use Case for PHR scenarios is intended to provide access to general patient documents in the form of PDFs etc.
- The provider can offer access to specific resources such as Encounter, Procedure, DocumentReference, Condition, etc.
- The PHR provider can support the search and read operations on the following resources:

NATE = National Association of Trusted Exchange

NATE initiatives:

- Task Force developing a Data Provenance Implementation Guide to improve workflow upon receipt of messages from consumers
- Governance of the Trust Bundle, revisiting the eligibility criteria of the NBB4C
- Discovery regarding Consumer sharing of clinical data with Qualified Research Organizations (PCORI related NATE users)
- Virtual Clipboard – pilot support
WEDI EHR Vendor Survey

What are the findings from the Survey to the EHRA?
What CDA Documents are being created from C-CDA?
  - About 30 members
  - Most Vendors are producing CCDs
  - Some are creating Dis-Summary
  - Limited support for optional sections
What’s Next
  - Look for more details from WEDI
  - Possible follow up survey
  - Updates on the status of MU3 requirements
  - Pilot from Medicare

Considerations

- What do payers need for Claim Payment, or Prior Authorization? Is it same for value based care?.....
- Is the CDP1 ‘re-packaging’ of the C-CDA sections into different documents a value for all payers?
  - For all purposes?
- Are there any issues having both; CDP1 and C-CDA?
- Which of the newly developed CDP1 Documents/Sections are of value?
- Will providers (their vendors) be willing and able to produce the C-CDA and the CDP1?
- Would you want to have both the C-CDA and CDP1 named in the regulation for Attachments?

For Further Reference

NCVHS.gov
For Letters of Recommendation and future calendar events:
  http://www.ncvhs.hhs.gov/subcommittees-work-groups/subcommittee-on-standards/

HL7.org
To join or browse the HL7 Payer User Group activities
  http://www.hl7.org/Special/committees/pug/

WEDI
To review the webinar on CDA (and C-CDA)
  http://www.wedi.org/forms/store/CommercePlusFormPublic/search?action=Feature

ONC B8+

Or contact Durwin Day: dayd@bcbsil.com
Important Note:

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- Thank you.