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Issue Brief

Keeping it together

Lack of uniformity for exchanging medical documentation costs the industry time, money and frustration.

INTRODUCTION

For more than a decade the healthcare industry has been guided by the triple aim: the goal to deliver an improved patient experience, at lower costs, while improving the overall health of a population. But as providers are expected to deliver more value and take on more financial risk, a fourth aim has been added — avoiding physician burnout.[1] A 2019 national survey reported that over 44% of physicians experience some type of burnout. Of these physicians, 59% identified administrative tasks as the number one contributor.[2] The exchange of clinical and administrative information is an essential component to healthcare delivery; however, the administrative burden associated with these tasks causes significant provider stress and detracts from time spent caring for patients.

DATASPRING SURVEY ON EXCHANGING MEDICAL DOCUMENTATION

DataSpring is committed to supporting electronic standards, accelerating interoperability, and aligning administrative and clinical activities across stakeholders, to administrative burden.

Electronic transaction standards have been federally adopted under HIPAA to support most components of the healthcare revenue cycle including eligibility, claims, prior authorization, and payments, and implementation

is well underway. However, the healthcare industry continues to wait for an electronic attachments standard that can simplify the exchange of necessary medical information and supplemental documentation.

Attachments or additional medical documentation are a bridge between clinical and administrative data. They give health plans vital information for adjudication of a subset of claims, prior authorizations, referrals, post-adjudication appeals, audits, and more. In value-based payment, attachments can be used for sharing clinical information and quality measure reporting documentation between health plans and providers.

According to the CAQH Index Report, the attachments workflow, however, is primarily manual with ~75% of attachments transmitted via mail and fax,[3] largely because no federal standard has been adopted. On average, it takes medical providers 10 minutes to submit an attachment manually by mail or fax compared to using some type of electronic method.[4]

DataSpring conducted an industry survey to better understand how health plans and providers are currently exchanging attachments for four use cases: prior authorization, healthcare claims, quality measurement, and value-based payment to inform the development of operating rules to support a more standardized workflow.

Figure 1. Survey respondents by stakeholder type

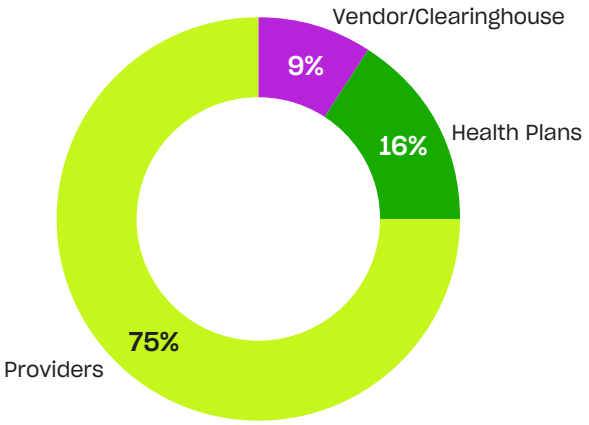
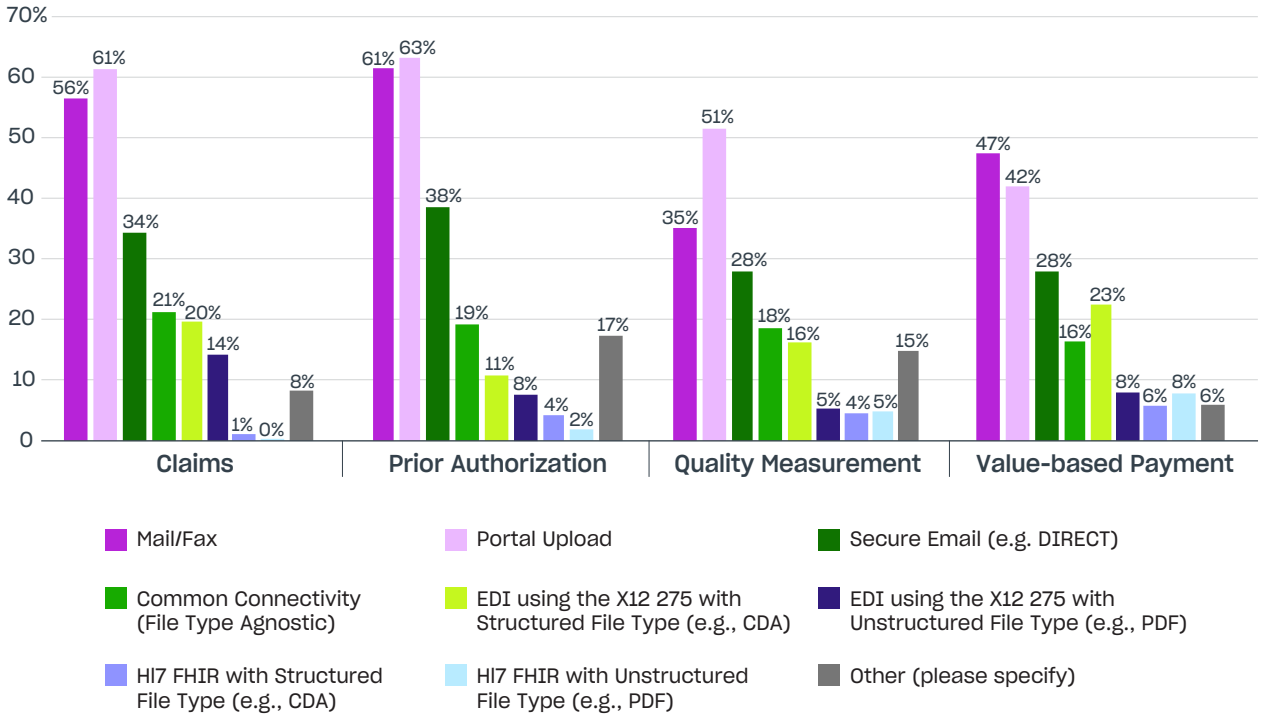


Figure 2. Exchange mechanisms and formats used by providers by use case



Note: Providers had the option to select multiple exchange formats and mechanisms.

The survey also sought to understand which service lines consistently require the highest volume of attachments and therefore most significantly contribute to administrative burden. CAQH received surveys from over 340 organizations across three stakeholder types: providers, health plans, and vendors/clearinghouses (Figure 1).

The results, which show wide variability in how attachments are exchanged and the prevalence of mail and fax (the most time consuming of methods), illustrate the opportunities of moving to an electronic standard which would substantially reduce the time and costs associated with attachments.

KEY FINDINGS

Providers report that web portal uploads and mail/fax are the most prevalent attachment exchange mechanisms across use cases, followed by secure email (Figure 2). Partially electronic, web portal uploads require providers to log into disparate systems with different requirements and re-enter information from the EHR and/or PMS, realizing limited time or cost savings over more manual methods. Fully electronic methods to exchange attachments (e.g., X12 275[5], HL7 CDA[6] and FHIR[7]) allow the exchange of structured data types which can be integrated into an electronic health record (EHR) or practice management system (PMS).

Provider use of EDI outpaces use of APIs; however, newer use cases such as value-based payment and quality measurement are seeing higher use of APIs (Figure 2). While less than 6% of providers reported using HL7 FHIR APIs for exchanging attachments for the purpose of submitting claims or prior authorizations, over 14% of respondents are currently using HL7 FHIR APIs for data exchange related to value-based payment. It is important to recognize that HIPAA-mandated electronic transactions exist for submitting healthcare claims and requests for prior authorization. Where no HIPAA-mandated electronic transactions exist, providers and health plans have often built proprietary mechanisms to exchange medical documentation.

Across service lines, providers and health plans agree that hospitalizations consistently require some of the highest volumes of medical documentation of prior authorizations and healthcare claims (Table 1 and Table 2). Hospitalizations represent 15% of provider medical documentation volume and 17% of health plan volume for the exchange of prior authorization information. For claims,

Table 1. Total prior authorization medical documentation volume by service line

% of Total Prior Authorization Medical Documentation Volume

	Providers	Health Plans
1	Radiology and other Imaging (16%)	Hospitalization (17%)
2	Hospitalization (15%)	Orthopedics (17%)
3	Behavioral Health (13%)	Post-acute Care (13%)
4	Cardiovascular (10%)	Oncology (6%)
5	Neurology (6%)	Neurology (6%)
6	OB/GYN (5%)	Cardiovascular (5%)
7	Orthopedics (5%)	OB/GYN (4%)
8	Dental (5%)	PT/OT (4%)
9	Oncology (4%)	Behavioral (4%)
10	PT/OT (4%)	Laboratory Services (3%)

Table 2: Total claims payments medical documentation volume by service line

% of Total Claims Payments Medical Documentation Volume

	Providers	Health Plans
1	Emergency (13%)	Hospitalization (18%)
2	Hospitalization (13%)	Post-acute Care (13%)
3	Behavioral Health (11%)	Oncology (11%)
4	OB/GYN (8%)	PT/OT (8%)
5	Radiology and other Imaging (7%)	Cardiovascular (7%)
6	Post-acute Care (6%)	Emergency (5%)
7	Cardiovascular (5%)	Dental (5%)
8	Neurology (5%)	Dialysis (5%)
9	PT/OT (5%)	Orthopedics (5%)
10	Pediatrics (4%)	Neurology (4%)

hospitalizations represent 13% of provider medical documentation volume and 18% for health plans. The top ten service lines for attachment burden are generally consistent across both stakeholder groups for the purpose of submitting healthcare claims and prior authorization. Discrepancies across stakeholder types may be partially explained by the differences in how health plans and providers interpret service lines. For example, orthopedics ranked second in attachment burden for health plans but seventh for providers for prior authorizations. As radiology and imaging make up a large component of orthopedic services it is possible that health plans may not distinguish radiology as a separate line item related to orthopedics in the same way that providers do.

CONCLUSION

The results from the DataSpring Medical Documentation Survey provide valuable insight into the variation in the methods for exchanging medical documentation today and the need for more standardized technical approaches and supporting operating rules. The survey results also highlight the services for which standardization can have the greatest impact on reducing administrative burden.

The current state of the exchange of attachments indicates substantial opportunity for cost and time savings for both providers and health plans. By shifting away from manual methods and adopting standardized, fully electronic formats and operating rules, the healthcare industry can streamline data exchange and reduce burden.

To substantially reduce administrative burden is to reduce provider burnout and enable better care for patients across the health care system.

Healthcare leaders have long worked to more closely align administrative and clinical systems. While many believe the capacity for greater interoperability is now within reach, data in clinical and administrative systems has remained siloed.

CMS and the Assistant Secretary of Technology Policy, Office of the National Coordinator (ASTP/ONC) have repeatedly exercised regulatory authority calling for healthcare data to be accessed, exchanged, and used "without special effort" as provisions of the 21st Century Cures Act,[8] showing a strong capacity to break down barriers and stimulate interoperable exchange of clinical information.

Standardizing the electronic exchange of attachments to communicate medical information and supplemental documentation between health plans and providers is an opportunity to change this in a significant way. Electronic attachments open a line of communication between administrative and clinical systems and hold the key to unlocking the next level of interoperability by making the use of integrated data routine. This vision can be achieved through industry collaboration to standardize electronic formats and align on business expectations for use through common operating rules.

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1. http://www.annfammed.org/content/12/6/573.full
2. https://www.medscape.com/slideshow/2019-lifestyle-burnoutdepression-6011056
3. https://www.caqh.org/insights/caqh-index-report
4. Ibid.
5. X12 275: Transaction used by the provider to respond to the health plan with requested information embedded in the transaction such as .pdf or CDA.
6. HL7 CDA: Standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare stakeholders.
7. HL7 FHIR: Use of profiles and APIs to establish real-time communication and data transference.
8. https://healthit.gov/regulations/cures-act-final-rule/

