A New Approach to Claims Attachments

Use of the proposed XML-based messages might hasten selective use of autoadjudication.

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Health Level 7 (HL7), Ann Arbor, Mich., and ANSI's Accredited Standards Committee (ASC) X12, Alexandria, Va., are cooking up a revision to the proposal for Health Insurance Portability and Accountability Act (HIPAA) claims attachments. The proposal will be useful to more care delivery organizations (CDOs) and easier for payers to implement than the current approach. But its most immediate benefit is that it provides an easy way for all participants to start using electronic data exchange (EDI) or the Web to pass human-readable text and document images. It also provides a path to gradually increase the structure and rigor of attachment data so autoadjudication and other processes can be improved.

The current approach

The current approach (see September 2002, page 67) includes definitions for six kinds of attachments: ambulance, rehabilitation, emergency, medications, lab results and general clinical reports. It also assumes a regulatory mechanism whereby the industry can create additional attachments for voluntary use that ultimately become mandatory under HIPAA. The choice of new attachments is left to the industry; ultimately, 30 or more may be defined.

From the CDO point of view, the most important benefit of this approach is that attachment contents are predefined. For example, under the proposal, an ambulance attachment consists of 14 questions, such as "How far did the ambulance drive?" and "What is the weight of the patient?" (used to justify an extra attendant). Because each attachment has a specified set of questions, CDOs can collect the information in advance of an attachment request.

The current approach calls for attachment data to be sent as an
HL7 version 2.4 message embedded in an ASC X12N 275 EDI message. The message structure and use of LOINC codes are believed necessary to allow payers to achieve maximum efficiency by autoadjudicating claims that include attachments. Many payers see specific kinds of claims that could be easily adjudicated with attachments. With periodontal claims, for example, many payers look at a single item in the attachment--the depth of pockets.

On the other hand, payers will continue to keep people in the loop for many years while adjudicating most kinds of claims with attachments. This shows the fundamental dilemma facing standards organizations and policy-makers. Should they write standards for sending unstructured or structured data?

Permitting unstructured data would allow more CDOs to make immediate use of the HIPAA attachments specification and would lower implementation costs for payers. But it would also prevent payers that want to autoadjudicate from doing so. Sending unstructured data is characterized as a "walk before you run" approach. However, if the standards don't support structure, there is no path to autoadjudication. Using unstructured data is really a "walk, don't run" approach.

Specifying structured data is a "start off running" approach that requires a higher investment of payers, regardless of whether they plan to do autoadjudication. Furthermore, it requires a computer-based patient record or sophisticated HL7 capabilities. Since HIPAA is a "payers must, CDOs may" proposition, payers are justifiably afraid that they would make the investment to build it and few CDOs would come.

**The new approach**

The new approach solves this dilemma. Technically, it's simple. It continues to use the X12 275 transaction but replaces the HL7 version 2.4 message with an XML document formatted according to the HL7 Clinical Document Architecture (CDA), an ANSI standard.

The CDA standard defines XML tags to represent clinical documents. Although it's primarily designed for text documents, such as transcribed dictation, CDA has options to support coded information and images, including scanned medical record pages.

Booklets that will be available from the HL7 organization list the standard questions for each of the six defined attachments and describe how to prepare CDA documents. They also describe two variants for each attachment. As shown in Table 1, the human decision-making variants require a minimum of structure since the information will ultimately be read by a person. They can be implemented by sending free-text answers to the questions or by using a scanner to copy images of the medical record pages that answer the questions.

**Table 1. Variant Attachment Formats**

The computer decision-making variant requires the use of codes and structure sufficient to support autoadjudication. Payers can accept attachments in both formats: Using an Extensible Stylesheet Language (XSL) stylesheet, they can render the XML document and associated images on a screen into an electronic image for an image-based workflow system or on paper so the electronic submission can be handled using existing paper workflows. HL7 supplies a stylesheet or payers may develop their own.

### Getting to the computer-decision variant

The problems with the one-size-fits-all HIPAA approach have proven that using regulations to move from the human-decision variant to the computer-decision variant would be very difficult. Not all payers will be interested in autoadjudication of a specific attachment in the same time frame, and not all CDOs will be able to create the computer-decision variant due to limitations of their in-house systems. The new proposal relies on a system of incentives that would allow payers and CDOs to make business decisions to move to the computer-decision variant, one attachment type at a time:

- A payer would offer to autoadjudicate claims associated with a specific attachment when the attachment is received in the computer-decision variant. It would contend that autoadjudicated claims would be paid sooner.
- CDOs would make business decisions on whether to take advantage of the offer. They'd be able to decide sooner if they have the necessary software to create the computer-
decision variant.
- If the economics are strong enough, CDOs that don't have the capability to create computer-decision variants would bring pressure on their software vendors to support a specific attachment. This is a far more manageable challenge than attempting to create all attachments in the computer-decision format.

Getting to the smaller CDOs

Some in the industry doubt that small CDOs will have even the minimum capability necessary to create a human-decision attachment. It'll be easier for vendors serving this market to adapt their systems to create XML than to create HL7. For example, at the April HL7 meeting, a vendor demonstrated the feasibility of creating a user interface that enables the data for a specific attachment to be accepted from a user, validated and produced in a compliant XML format using InfoPath, a component of Redmond, Wash.-based Microsoft's Office 2003.

For the least technically able CDOs, the new proposal also supports bypassing the practice management vendor and EDI channel altogether. At the same HL7 meeting, another vendor demonstrated a Web-based entry system for a claims attachment based on the draft HL7 CDA-attachments specification. In this demo, a user could type in the information required by attachment specifications directly with a browser or upload a scanned page from the medical record using an $80 scanner attached to a personal computer.

The demonstration showed that payers could easily construct e-health Web sites that accept attachment information using the "direct data entry" exception under HIPAA. Such a site would produce the same XML documents as those coming in through EDI, so downstream processing in the payer organization would be the same.

Next steps

The Department of Health and Human Services has indicated that it will revise its draft Notice of Proposed Rulemaking (NPRM) to follow this new approach and hopes to publish it in February 2004. Allowing some time for a final rule and the 26-month latency period, the approach could become mandatory in late 2006. However, there is sufficient excitement about this approach in the industry that we expect to see voluntary implementations sooner.

Covered entities should learn about the approach (see Attachments Special Interest Group area at www.hl7.org) and provide comments to HHS when the NPRM is published. Health plans and large CDOs that work well together should consider being early adopters. This approach is a winner for both.

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