National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards

Hearing on Attachments
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Testimony from the American Medical Association

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The American Medical Association (AMA) thanks the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards (Subcommittee) for the opportunity to provide our written comments on the proposed attachment standard. Administrative hassles such as the submission of supporting clinical documentation are a top-of-mind concern for our physician members, and we strongly advocate for reduction in these uncompensated paperwork burdens through automation and standardization of work processes. We urge the Subcommittee to consider the following comments regarding the attachment standard and also refer you to our oral testimony slides on this topic.

The critical importance of attachments in today's health care environment is clear, as there has been a steady increase in health plans' requests for supporting clinical documentation from providers to support utilization management and cost containment programs. Whether this information is requested prospectively, as in the case of prior authorization, or retrospectively, as with audits, the end result is always increased administrative work for physician practices. Furthermore, these documentation requests can delay patient care or payment for provided services. Due to these negative impacts on physicians and patients, the AMA strongly objects to the current widespread, broad-based application of these programs and believes that any such systems should be restricted to outliers, rather than globally applied to all providers.

While the AMA would ultimately prefer to see an overall and significant reduction in clinical documentation requests, we acknowledge that the originating utilization management and cost control programs will be in place for the foreseeable future. Given this reality, the AMA advocates for the industry-wide adoption of an **automated, standardized, efficient process for clinical documentation submission** to replace today's manual system of mailing and faxing medical records. Elimination of these manual processes would offer significant efficiency improvements and cost savings for all stakeholders and would be in line with industry-wide goals to promote interoperability and improved data access.

Before detailing our recommendations regarding attachment standards, we would like to highlight the consequences of the current lack of guidance on clinical documentation exchange. In the absence of an attachment standard, the industry has evolved into a "wild west" environment where stakeholders have created a wide variety of electronic tools to exchange

clinical data. Current methodologies in place include standard electronic transactions, secure email, facsimile, and ever-proliferating health plan portals, which, while offering automation to the payer, burden practices with workflow disruptions and the unique logins and passwords required for each health plan. The myriad of options impose significant hardships on providers, who must accommodate all of the different methods of clinical data exchange currently being employed by health plans. This lack of standardization also runs counter to the spirit of administrative simplification and the goal of reducing burdens across the industry through standardized processes. **Our health care system must establish one uniform method of clinical information exchange to promote consistency and reduce ambiguity**—goals that will ultimately reap benefits across stakeholder groups.

The exchange of clinical data requires the standardization of several supporting functionalities (information requests, envelopes, and clinical content) for both claim and prior authorization attachments. The AMA supports attachment standardization using the following elements:

- **Request for additional information**
  - ASC X12 278 Services Review Response (prior authorization)
  - ASC X12 277 Request for Additional Information (claim)
- **Envelope**
  - ASC X12 275 Additional Information to Support a Health Care Claim (claim)
  - ASC X12 275 Additional Information to Support a Health Care Services Review (prior authorization)
- **Clinical Content**
  - HL7 C-CDA R2 Consolidated Clinical Document Architecture Release 2

The AMA urges the Subcommittee to recommend adoption of the standards listed above to support the uniform exchange of clinical documentation for both claims and prior authorization. We would underscore the importance of standardizing both the administrative and clinical aspects of attachments, as the industry will need uniformity in both to improve efficiency and reduce processing costs.

Clinical content has emerged as one controversial area in attachment standardization. Some have proposed that both the HL7 C-CDA R2 and the Clinical Document for Payers 1 (CDP1) should be mandated as attachment standards for clinical content. We are first concerned that allowing two options defeats the purpose of having a standard, which is to achieve administrative simplification through uniform electronic data interchange. Allowing use of both the C-CDA R2 and the CDP1 would also be associated with increased physician administrative burdens, as clinicians and vendors would essentially have to create two different forms for encounter documentation (one to be sent to other providers for care transitions and another to be sent to health plans). The AMA firmly believes that a single encounter document should be able to meet the needs of **both** other providers **and** health plans.

The AMA urges the Subcommittee to recommend adoption of the HL7 C-CDA R2 as the single standard for attachment clinical content. We believe that inclusion of the CDP1 in the attachment standard could increase provider administrative hassles, as the CDP1 requires completion of significantly more templates than the C-CDA R2 and use of "null flavors" to

reflect uncollected data or information that the provider does not wish to exchange. We are concerned that required use of null flavors will both negatively impact physicians' documentation time and encourage sending of more clinical data than what is needed for a particular situation—thus violating the "minimum necessary" principle of protected health information exchange under the Health Insurance Portability and Accountability Act (HIPAA). For these reasons, the AMA advocates for the adoption of the HL7 C-CDA R2 as the standard for attachment clinical content.

We recognize that some valid concerns have been raised during the industry discussion of the HL7 C-CDA R2 and CDP1. First, the CDP1includes additional sections and templates beyond what is included in the C-CDA R2. Since the CDP1 has not been tested or used, we urge the industry to further examine these additional templates and determine if they would be valuable additions to clinical documentation and data exchange. If so, these additional capabilities should be considered for the next release of the HL7 C-CDA standard. **Again, we firmly maintain that there must be only one standard for clinical content, and that any enhancements to clinical documentation must be captured within that single standard.**

Concerns have also been expressed surrounding vendor implementation of the C-CDA R2. Some fear that vendors will not develop the C-CDA R2's optional sections and templates, particularly since current testing methods do not evaluate vendors' support for optional capabilities. **While physicians and other providers may not use all of these sections and templates for every patient or even in the regular course of their practice, vendors must fully support the maximum potential information content of the standard and include all elements—both required and optional—in their implementation of the C-CDA R2 so that these data can be reported when appropriate.** To ensure vendor conformance with these development needs, we urge the Subcommittee to recommend adjustments in vendor testing methodologies that will allow for evaluation of vendors' support of all optional templates and sections in the C-CDA R2.

In addition to the adoption of the previously listed attachment standards, the AMA also advocates that restrictions be placed around clinical information requests to protect physician practices from undue administrative burdens. We would argue that supporting documentation requests should be the exception, not the norm, as clinical data exchange increases administrative burdens and costs for both physicians and health plans. In addition to the judicious use of attachments, we believe that there should be uniformity across health plans as to which specific situations require attachments so that physicians can proactively send this information with certain types of claims in an unsolicited workflow model. Health plans should also be prohibited from requesting the same clinical data multiple times from providers. We urge the Subcommittee to consider recommending incorporation of these principles in the attachment operating rules.

Finally, we must emphasize the **urgent need** for an attachment standard. Twenty years have passed since the original HIPAA legislation that listed attachments as a transaction requiring standardization. A mandate regarding clinical documentation exchange is long overdue. We point the Subcommittee to testimony from its June 2014 hearing on attachments, during which a vendor stated that the **"uncertainty in the area has had a paralyzing effect"** and serves as a disincentive for vendors to allocate resources to attachment development. Unless the industry is

provided with clear direction via an attachment standard, the fragmented “wild west” situation of today—with its associated administrative burdens and costs—will continue.

The AMA again thanks you for the opportunity to present our feedback on the adoption of an attachment standard. We urge you to consider the recommendations outlined above and in our oral testimony, as we believe that standardization in the electronic exchange of clinical documentation has the potential to reap substantial administrative savings for all stakeholders and allow those dollars to be more prudently invested in patient care. We hope that the Subcommittee will take swift action in this area so that vendors, providers, and health plans will all have the clear direction needed for attachment development and implementation.