Electronic Submission of Medical Documentation

Additional Attachment Templates

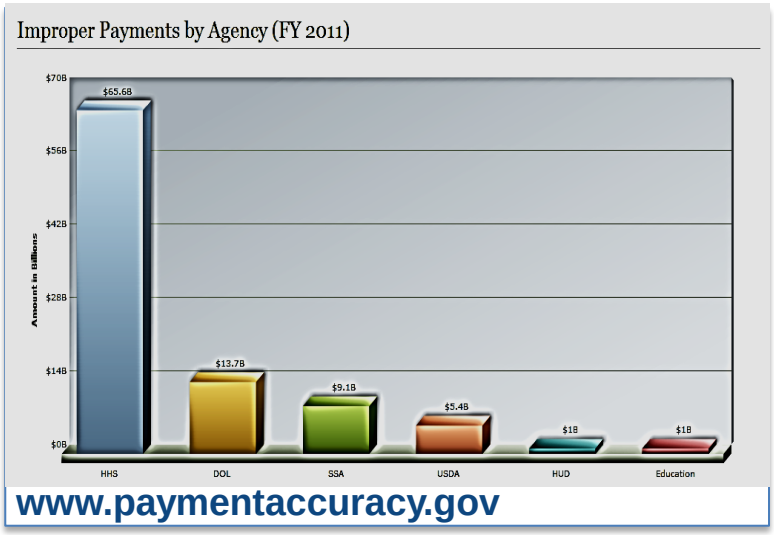
Attachments Workgroup

December 31, 2013

Updated January 8, 2013

Improper Payment

- Medicare receives **4.8 M** claims per day.
- CMS' Office of Financial Management estimates that each year
  - the Medicare FFS program issues more than **$28.8 B** in improper payments (error rate 2011: **8.6%**).
  - the Medicaid FFS program issues more than **$21.9 B** in improper payments (3-year rolling error rate: **8.1%**).
- Most improper payments can only be detected by a **human** comparing a **claim** to the **medical documentation.**



- **Medical Documentation Requests are sent by**:
  - Medicare Administrative Contractors (MACs) Medical Review (MR) Departments
  - Comprehensive Error Rate Testing Contractor (CERT)
  - Payment Error Rate Measurement Contractor (PERM)
  - Medicare Recovery Auditors (formerly called RACs)
- Claim review contractors issue over **1.8 million** requests for medical documentation each year.
- Claim review contractors currently receive most medical documentation in **paper** form or via fax.

C-CDA R2 Document Templates

1. 12 Structured Document Templates
2. 1 Unstructured Document Templates
3. 79 Section Level Templates
4. 108 Entry Level Templates

5. Document Types "Require" only a limited number of Sections
    1. Consultation (3 required)
    2. Discharge Summary (4 required)
    3. H&P (10 required)
    4. Op Note (7 required)
    5. Procedure Note (4 required)
    6. Progress Note (none required)
6. Certification tests only for "Required" components

Sections in C-CDA R2	Src	Consultation Note	Discharge Summary	H&P	Op Note	Procedure Note	Progress Note
Section-Level Templates							
	SHALL	3	4	10	7	4	
	SHOULD	3	1	1			
	May	19	21	10	8	24	15
Advance Directives Section (entries optional)	V2	[0..1]					
Allergies Section (entries optional)	V2		[1..1]	[1..1]		[0..1]	[0..1]
Allergies Section (entries required)	V2	[1..1]					
Anesthesia Section	V2				[1..1]	[0..1]	
Assessment and Plan Section	V2	[0..1]		[0..1]		[0..1]	[0..1]
Assessment Section	V1.1	[0..1]		[0..1]		[0..1]	[0..1]
Chief Complaint and Reason for Visit Section	V1.1	[0..1]	[0..1]	[0..1]		[0..1]	
Chief Complaint Section	V1.1	[0..1]	[0..1]	[0..1]		[0..1]	[0..1]
Complications Section	V2				[1..1]	[1..1]	
Family History Section	V1.1	[0..1]	[0..1]	[1..1]		[0..1]	
Functional Status Section	V2	[0..1]	[0..1]				
General Status Section	V1.1	[0..1]		[1..1]			
History of Past Illness Section	V2	[0..1]	[0..1]	[1..1]		[0..1]	
History of Present Illness Section	V1.1	[1..1]	[0..1]	[0..1]		[0..1]	
Hospital Admission Diagnosis Section	V2		[0..1]				
Hospital Admission Medications Section (entries optional)	V2		[0..1]				
Hospital Consultations Section	V1.1		[0..1]				
Hospital Course Section	V1.1		[1..1]				
Hospital Discharge Diagnosis Section	V2		[1..1]				
Hospital Discharge Instructions Section	V1.1		[0..1]				
Hospital Discharge Medications Section(entries optional)	V2		[0..1]				
Hospital Discharge Medications Section (entries required)	V2		[0..1]				
Hospital Discharge Physical Section	V1.1		[0..1]				
Hospital Discharge Studies Summary Section	V1.1		[0..1]				
Immunizations Section (entries optional)	V2	[0..1]	[0..1]	[0..1]			
Instructions Section	V2			[0..1]			[0..1]
Interventions Section	V2						[0..1]
Medical (General) History Section	V1.1					[0..1]	
Medical Equipment Section	V2	[0..1]					
Medications Administered Section	V2					[0..1]	
Medications Section (entries optional)	V2			[1..1]		[0..1]	[0..1]
Medications Section (entries required)	V2	[0..1]					
Mental Status Section	New	[0..1]					
Nutrition Section	New	[0..1]	[0..1]				
Objective Section	V1.1						[0..1]
Operative Note Fluid Section	V1.1				[0..1]		
Operative Note Surgical Procedure Section	V1.1				[0..1]		
Physical Exam Section	V2	[0..1]		[1..1]		[0..1]	[0..1]
Plan of Treatment Section	V2	[0..1]	[1..1]	[0..1]	[0..1]	[0..1]	[0..1]
Planned Procedure Section	V2				[0..1]	[0..1]	
Postoperative Diagnosis Section	V1.1						
Postprocedure Diagnosis Section	V1.1					[1..1]	
Preoperative Diagnosis Section	V2				[1..1]		
Problem Section (entries optional)	V2		[0..1]	[0..1]			[0..1]
Problem Section (entries required)	V2	[1..1]					
Procedure Description Section	V1.1				[1..1]	[1..1]	
Procedure Disposition Section	V1.1				[0..1]	[0..1]	
Procedure Estimated Blood Loss Section	V1.1				[1..1]	[0..1]	
Procedure Findings Section	V2				[1..1]	[0..1]	
Procedure Implants Section	V1.1				[0..1]	[0..1]	
Procedure Indications Section	V2				[0..1]	[1..1]	
Procedure Specimens Taken Section	V1.1				[1..1]	[0..1]	
Procedures Section (entries optional)	V2	[0..1]	[0..1]	[0..1]		[0..1]	
Reason for Referral Section	V2	[0..1]					
Reason for Visit Section	V1.1	[0..1]	[0..1]	[0..1]		[0..1]	
Results Section (entries optional)	V2			[1..1]			[0..1]
Results Section (entries required)	V2	[0..1]					
Review of Systems Section	V1.1	[0..1]	[0..1]	[1..1]		[0..1]	[0..1]
Social History Section	V1.1						

C-CDA R2/R1.1 Document Templates

1. Continuity of Care Document
2. History and Physical
3. Consult Note
4. Discharge Summary
5. Diagnostic Imaging Report
6. Procedure Note
7. Operative Note
8. Progress Note
9. Unstructured Document
10. Care Plan (new)
11. Referral Note (new)
12. Transfer Summary (new)

Note: Document Templates 1-8 were updated in R2

C-CDA R2

- 12 Document Templates
- 79 Section Templates
- 108 Entry Templates
- **1 PDF Document** 1

C-CDA R1.1

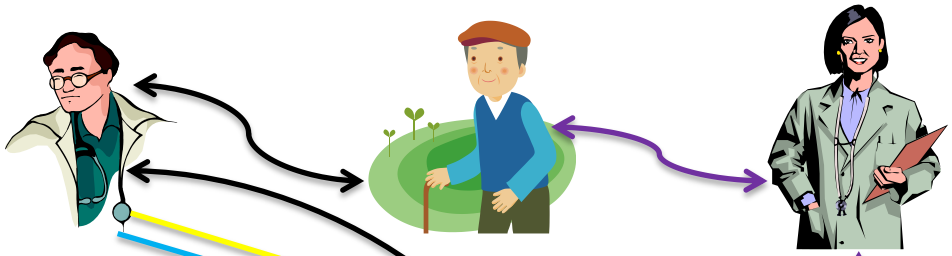
- 9 Document Templates
- 60 Section Templates
- 66 Entry Templates
- **1 PDF Document** 1

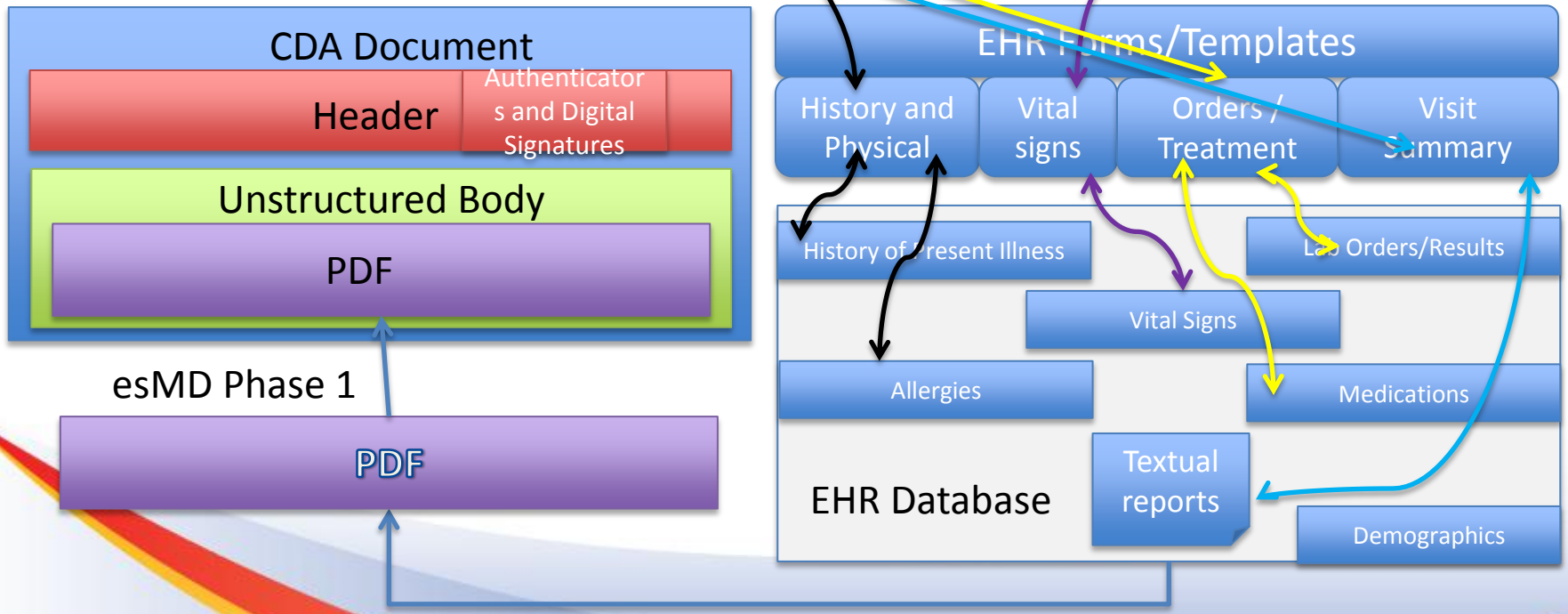
CDA R2

- ~110 Section Templates
- ~200 Entry Templates
- 17 PDF Documents

Today – Typical Response to CMS request for Documentation

Documentation collected via EHR forms and templates and stored in the EHR Database



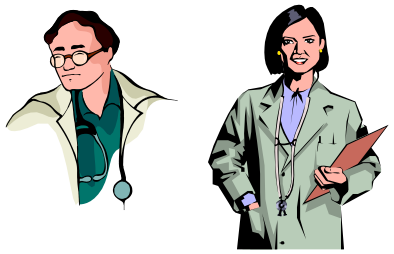


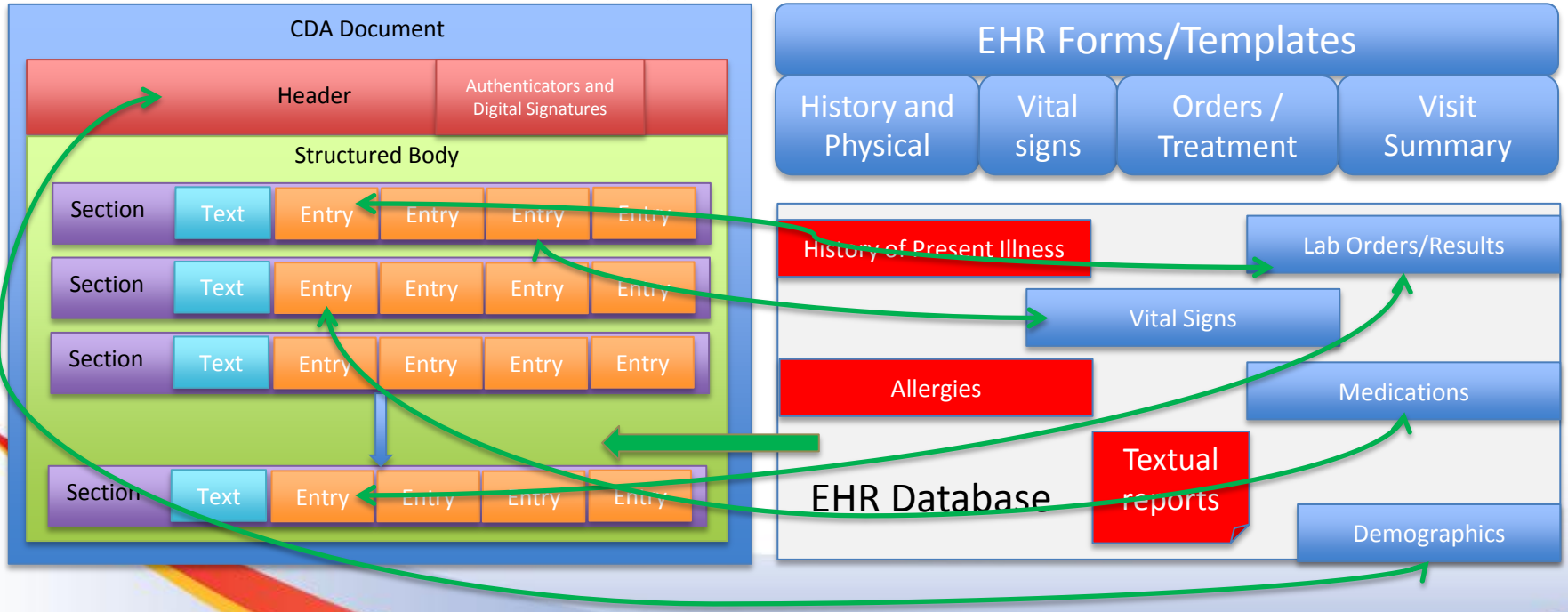
Current Templates

Use of Current Templates

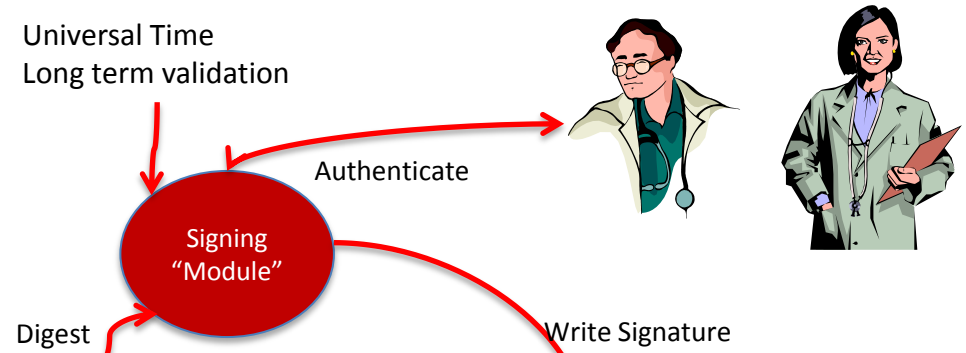
Create Structured CDA

1) Works for all sections and entry templates defined as SHALL or, depending on the certification requirements, SHOULD
2) Sections and entry templates defined as MAY are supported to various degrees, or not at all, by each EHR vendor
3) How does the provider meet documentation requirements?
4) Recipient of the document does not know if data does not exist, data is being withheld, or the implementation does not support the section/entry



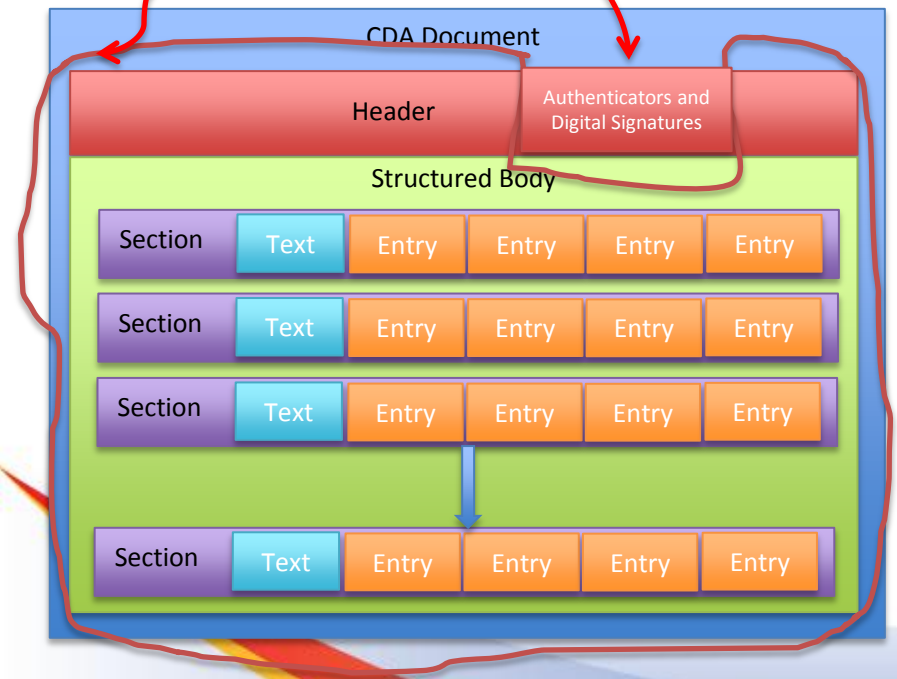


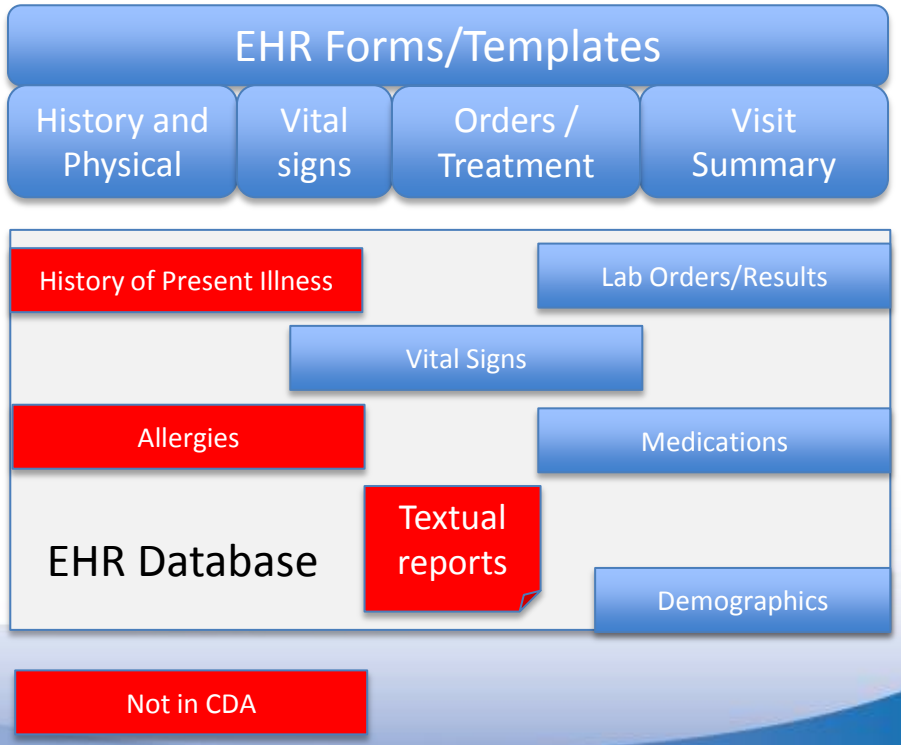
Sign CDA



Notes:

1) Signer may authenticate and then review/sign multiple documents at one session
2) Authentication via acceptable two factors -- something you know, something you hold, something you are (e.g. biometric), etc.
3) CDA typically contains a subset of the encounter information





Business Case

PCG/esMD

1) Expanding use of medical review (prior-auth, pre-payment, audit)
2) Moving to electronic communication of medical information
3) Moving to structured data to facilitate review process
4) Need to deal with provider burden and inappropriate payments
5) Moving to digital signatures

Medicare policy limitations

1) NCD/LCD written to allow provider to submit any documentation they deem necessary to support medically necessary and appropriate
2) Cannot require specific information (e.g. a specific assessment tool)

Other Issues

1) C-CDA R1.1/R2 documents require very few section/entry templates
2) EHR vendors frequently support only required section/entry
3) Certification requires support only for the CCD and some sections
4) Provider experience large variability in support for C-CDA optionality
5) Digital signatures fix content at time of signing

Business Case

Regulatory

1. Attachments rules may affect ability to use structured information if document types do not support documentation rights under NCDs/LCDs

Approach to solution

1. Ensure that we do not impact the commercial payer requirements by creating a separate IG to avoid any impact on the existing C-CDA R2 effort – **this guide requires C-CDA R2**
2. Add new templates to existing C-CDA R2 set to accommodate providers need for more documentation to support services – **include nullFlavors to declare if no information is available or withheld**
3. Include the new templates in EHR certification to ensure they are available to all providers
4. Include new templates as part of allowed attachments

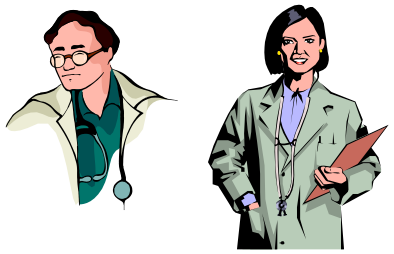
The combination of C-CDA R2 and AAT is a solution for **all payers**

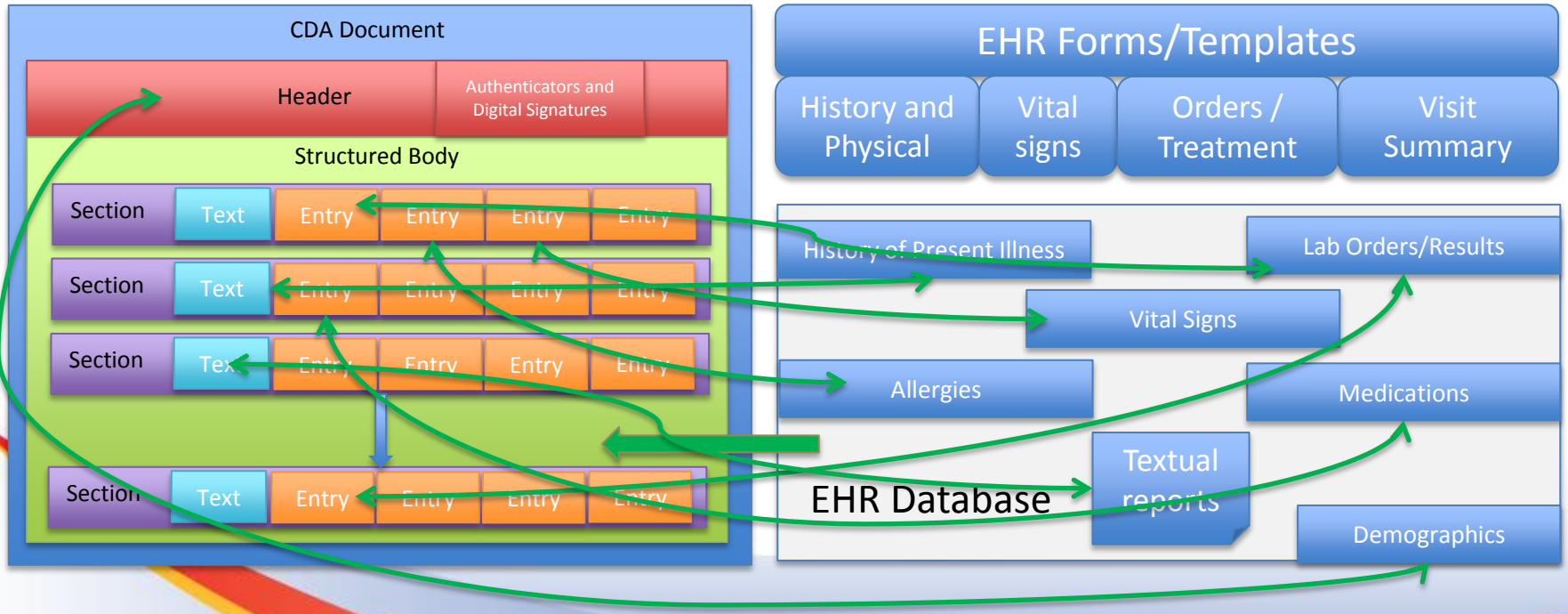
Create Complete CDA

Prior to or at time of signing – create CDA from Complete Document Template

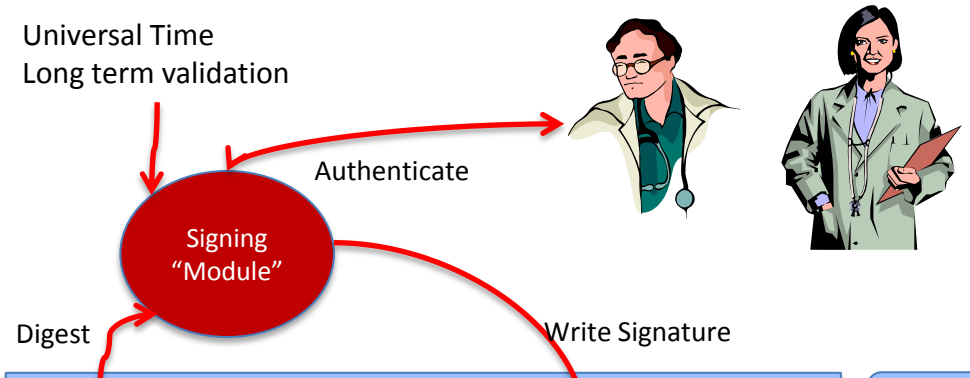
Create Structured CDA from Complete Document Template

1) All Document sections and constrained entries are populated or use appropriate nullFlavor
2) Ensures that all captured documentation is in the CDA prior to signing





Sign CDA



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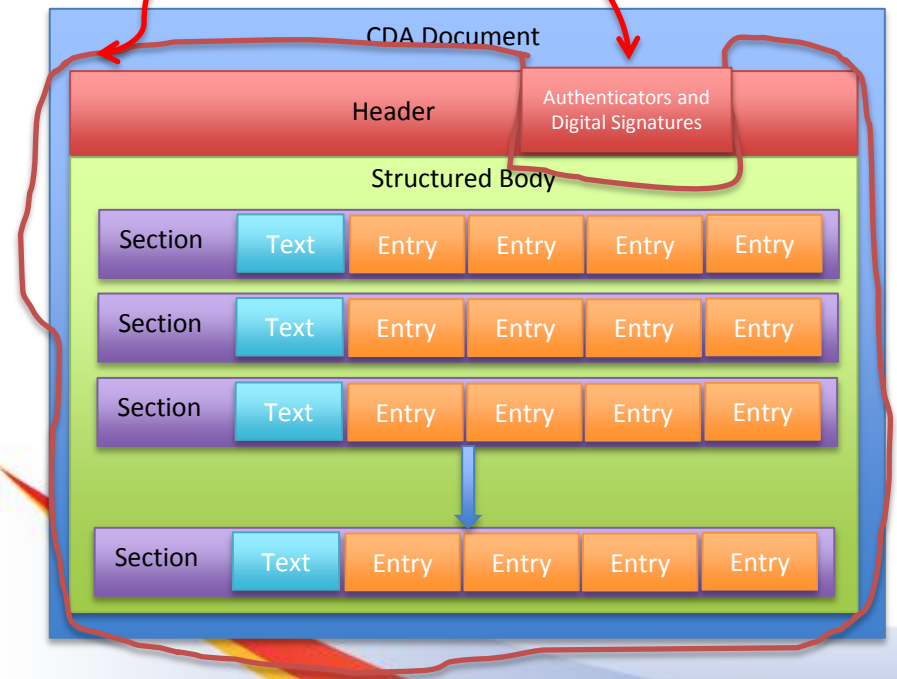

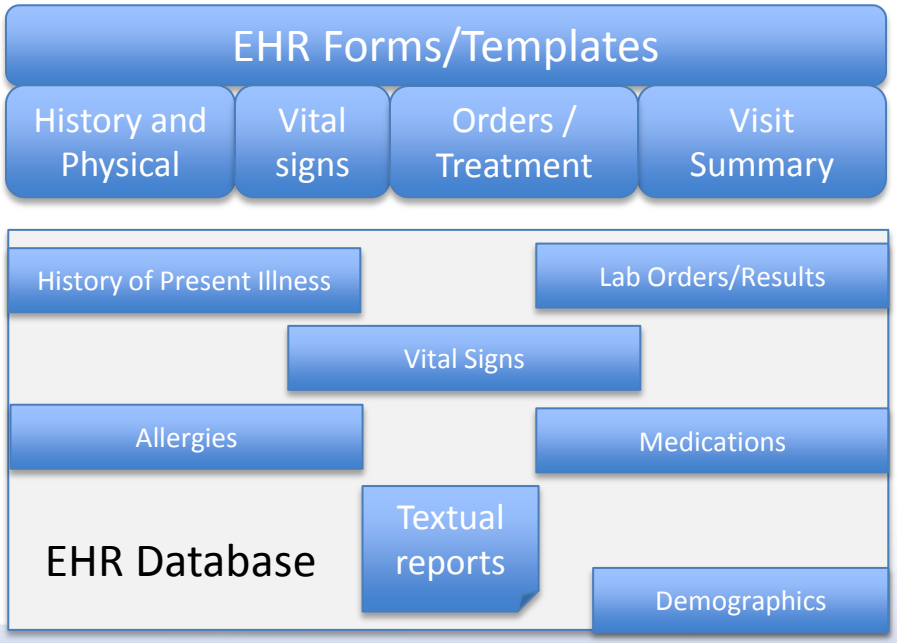

New Templates

Documents

1) Complete Encounter Document (office visit, consult, home health)
2) Complete Hospitalization Document (hospital admit and discharge)
3) Complete Operative Note Document (operative note)
4) Complete Procedure Document (procedure note)
5) Time Boxed Document (shift, day, period) (for acute / long term care)

Sections

1) Additional Documentation Section (documents that do not have a place in the existing sections)
2) Externally Defined CDE Section (data collection using externally defined templates that produce name value pairs defined by external standards (NLM ...))
3) Orders Placed Section (orders that are instantiated (moodCode RQO))
4) Transportation Section (provider copy of transportation documentation)

C-CDA R2 Additional Attachment Templates

1. Complete Encounter
2. Complete Hospitalization
3. Complete Operative Note
4. Complete Procedure Note
5. Time Boxed

New

- 5 Document Templates
- 4 Section Templates
- 4 Modified Section Templates
- 8 Entry Templates

Structured Templates

- All **structured** C-CDA Document and Section Level templates are "**open**" – which means that under the HL7 Standard
  - Any section can be included in any document
  - Any entry template can be included in any section
- Any recipient of a C-CDA document **must** :
  - "Accept" all included Sections and Entry Templates
    - Can support all Sections and Entry Templates (suggested)
    - Can find only the Sections and Entry Templates you want and ignore the balance.
  - "Display" Sections and Entry Templates (all are suggested, but not required)
    - Can display all – standard for most CDA viewers
    - Can display some and "hide" others (useful for rapid review with "drive down" to additional information
    - Can display only the Section and Entry templates of interest

Notes – Medicare NCD/LCD

Electronic Submission of Medical Documentation

1) Provider is not required to use a specific Document Template or even use a CDA at this time
2) Attachments rule may change this to require a CDA document
3) Provider is responsible for submitting all documentation required to justify that the services is medically necessary and appropriate
4) Signatures must be applied prior to billing -- based on policy

We are:

1) Not changing the content or use of the existing templates in C-CDA R1.1 or R2
2) Not requiring new data collection by provider – they should be documenting based on medical best practice (embodied in NCD/LCDs)
3) Creating templates that ensure that the C-CDA document signed by a provider contains everything documented in the encounter. Provider can withhold information if provider deems appropriate and technology supports.
4) Creating Additional Attachment Templates that meet Medicare requirements and can be used by other payers or providers as they deem appropriate.

Status – Work to Complete

- Updates based on this Attachments WG review

- Final updates to examples
- Final editorial review
- Identification and correction of any incorrect OIDs