Comments on Standards for Claims Attachments

These comments follow on the testimony provided on February 16, 2016, to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards, Hearing on HIPAA and ACA Administrative Simplification — Phase IV Operating Rules and Attachment Standard — specifically, to Part 2 on Attachments[1].

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General Comments

Thank you for the opportunity to provide comments in response to testimony presented to the sub-committee during the hearing last week which we attended by teleconference.

We concur with the unanimous recommendation of those who spoke at the hearing to adopt Consolidated CDA[2] (C-CDA) as the primary vehicle to submit additional information needed to adjudicate a claim, and to address many other use cases where attachments are required.

We agree wholeheartedly with the sentiment presented at the hearing that the time is right to move to a national standard for electronic attachments.

Specific Comments

In the following sections, we provide some suggestions to simplify the process of specifying and implementing the program and raise a risk which may not have been articulated to the sub-committee.

Simplifying Implementation

We have several suggestions we would like the sub-committee to consider that may simplify implementation of a national program for electronic attachments.

1. Semi-structured notes: We agree with the many comments urging a low bar for initial compliance, to be raised over time in accordance with industry readiness. The semi-structured option would include an XML note that may or may not contain semantic coding. The C-CDA itself specifies how to create an unstructured document consisting of a C-CDA compliant set of metadata in the header and an unstructured body that could contain any type of clinical report. C-CDA also specifies structured and coded requirements for twelve types of clinical notes, including Discharge Summary, Consult Note, and so on. C-CDA does not include guidance for using this consistent set of metadata along with a semi-structured report. We believe this intermediate level of report would provide a significant advantage over the unstructured report and yet be easier to achieve than the structured reports. Addressing this gap would provide an important increment in an incremental adoption roadmap.

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[1] http://www.ncvhs.hhs.gov/meeting-calendar/agenda-of-the-february-16-2016-ncvhs-subcommittee-on-standards-hearing/

[2] *HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Release 2.1,* DSTU. (August 2015) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=408

2. Guidance on document types for C-CDA and non-C-CDA clinical notes: The LOINC Ontology[3] is a hierarchy that classifies documents by type and applies unique, industry standard codes. C-CDA uses a selection of these codes, expressed as value sets and housed in the National Library of Medicine Value Set Authority Center (VSAC)[4]. We suggest that guidance for a national electronic attachments program:
    a. For document types specified within C-CDA, drop the mention of the RELMA HIPAA document types and rely on the VSAC value sets referenced in C-CDA.
    b. For other document types, reference the LOINC Ontology, in preference to RELMA.

    RELMA contains a large number of document type codes, many highly pre-coordinated and many specific to the VA. Expanding the HIPAA Panels to cover the non-C-CDA types would be redundant with the existing LOINC Ontology.
    These suggestions simplify and unify the path for implementers, promoting greater consistency with Meaningful Use.
3. Non-clinical document types: The LOINC Ontology contains high-level codes for non-clinical (administrative) document types. Some additional work is required to determine the level of specificity needed and fill out the code set appropriately.
4. The option to send/receive CDP1[5]: We concur with those giving testimony who recommended against inclusion of the option to send/receive CDP1 conformant documents. We believe that the level of semantic coding that would make CDP1 valuable is far distant as a national capability and at the time when it is viable, the question of how to do so should be reexamined. At present, CDP1 represents a clear divergence from C-CDA. Even though based on its templates, CDP1 creates new types of documents and would precipitate changes/redundancies in clinical workflow. Finally, it remains unimplemented and untested.
5. Publication format: Our final suggestion to simplify implementation is to support a move to online/electronic publishing of the C-CDA specification. An electronic form of the standard could support a view tailored to attachments implementation or specific to unstructured or semi-structured documents. At present, the print form of the specification is over 1,100 pages over two volumes. The online format for CDA implementation guides has been piloted for Healthcare Associated Infection (HAI) Reports and supports single-report-type views to the requirements and implementation guidelines[6].

Understanding Risks

Several of those providing testimony pointed to challenges and risks in the indicated pathway including the need for cross-training of clinical and administrative IT staff as well as outreach and education.

An additional risk we would like to bring to the sub-committee's attention is the apparent absence of a sponsoring or stewardship body for the combined work published under C-CDA. To date, portions of the work have had various champions and sponsors including the Health Story Project, ONC, ASPE, and many volunteers. The whole, consolidated body of work, however, has no single

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[3] *HL7 Implementation Guide: LOINC Clinical Document Ontology, Release 1,* DSTU. (June 2015) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=402

[4] https://vsac.nlm.nih.gov/

[5] HL7 CDA® Release 2 Implementation Guide: Additional CDA R2 Templates - Clinical Documents for Payers - Set 1, Release 1, DSTU. (August 2015) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=410

[6] Distributed for ballot, not posted on hl7.org.

sponsor or steward today, apart from the volunteer coordination provided by the HL7 Structured Documents Work Group (SDWG). Other CDA guides under the SDWG have clear sponsorship including CDC for HAI Reports and ASCO for oncology reports. The contents of C-CDA today are so general and wide-reaching and the size of the collection is so large that volunteer hours cannot address the needs of a national implementation timetable. No single professional group today has a clear mandate and responsibility for updating and maintaining the specification[7].

It may be desirable, in future, to distribute responsibility along the lines taken by the FHIR Management Group or to consider if there is an industry body or stakeholder group appropriate to take on its management, with ballot and procedural responsibility remaining within HL7 and the SDWG.

About Lantana

Lantana Consulting Group provides services and software for standards-based health information exchange. We have built our expertise through more than a decade of involvement in standards development and deployment. Lantana has had a seminal role in the introduction of XML to healthcare, the development and implementation of the CDA, CCD, the Health Story Project, Consolidated CDA, and the basic standards used for EHR quality and public health reporting. Today, we support providers and developers implementing these standards in both commercial and governmental applications.

[7] See our blog on this topic: https://www.lantanagroup.com/2016/02/17/consolidated-cda-pursuing-continuous-improvement/