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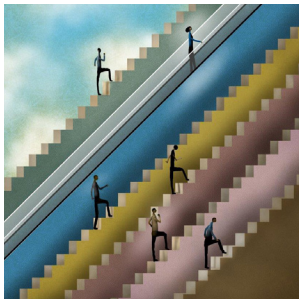

Exchanging Clinical Documentation—Misaligned Expectations

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Introduction

Additional medical documentation, or attachments, may be required by a health plan when a provider requests or bills a medical procedure for their patient.[1] Attachments consist of documents and forms that support various clinical decisions and administrative transactions including prior authorizations and claim submissions (claims). For prior authorizations and claim submissions, plans often need clinical information such as lab results, imaging scans, discharge summaries or other supplemental documents from a provider to verify that the service being requested or billed is consistent with the health plan's medical policies.[2]

A goal of exchanging attachments is to ensure correct patient treatment and accurate processing and payment of medical services; however, providers often struggle with knowing the specific clinical attachments required often causing delays in care and resubmission of information. In addition, the lack of a federally mandated standard for attachments[3,4] has deterred vendors, health plans and providers from investing in automated solutions, resulting in incomplete electronic solutions and manual workarounds which can create complexity and administrative burden.[5,6]

While the exchange of clinical information has often resulted in unnecessary burden due to a lack of clarity and standardization surrounding requirements, it is an essential component to healthcare delivery. Understanding how health plans and providers exchange clinical attachments can help the industry identify pain points and target specific areas for improvement. Working together, stakeholders can move towards a clearer, more succinct and automated approach to patient care, reducing overall healthcare complexity and burden.

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Survey Findings

To better understand how health plans and providers interact with clinical documents and challenges associated with exchanging them, the 2021 CAQH Index asked health plans and providers the percent

of prior authorizations and claims requiring additional clinical information. Knowing this can provide insights into the quality and understanding of the guidelines and requirements associated with submitting clinical documentation.

Additional Clinical Documentation – What is Needed

The percent of prior authorizations and claims requiring additional clinical documentation varied by health plans and providers. Regardless of how the information is exchanged (i.e., mail, fax, web portal or automated transaction) providers were over three times more likely to submit additional clinical documentation related to prior authorizations and claims than health plans required, suggesting a disconnect between what health plans require and what providers think they should send. Providers may be spending unnecessary time and effort gathering and sending documents that are not required or needed.

Given the lack of standardized requirements and formats associated with attachments, providers are often unsure what information to send health plans resulting in multiple resubmissions and added burden. Outdated, varied and changing guidelines and codes related to prior authorizations and claims also result in resubmissions and follow-up.[7,8,9] Opportunities exist to help providers better understand requirements related to clinical attachments and make available current guidelines.

Additional Clinical Documentation Required

	Prior Authorizations	Claims
Health Plans	12%	5%
Providers	38%	24%

Avenues for Improving Clinical Attachment Burden

As the industry awaits a mandated electronic attachments standard, health plans and providers continue to wrestle with exchanging clinical documentation often through costly and time-consuming manual processes. According to the 2021 CAQH Index, attachments are the most manual administrative transaction studied with only 21 percent exchanged electronically.[10] To help reduce the burden associated with exchanging clinical attachments, provider education is needed to clarify and convey what clinical information is needed and required. Additionally, it is essential to push for the adoption of an electronic standard as well as develop operating rules and requirements to foster the consistent exchange of information.

In support of these efforts, in 2021, the CAQH CORE Attachments Subgroup developed new operating rule requirements[11,12] aimed at enabling providers to send documentation to support a prior authorization or claim electronically in a uniform format to health plans — clarifying and speeding up the adjudication of prior authorizations and claims. These operating rules establish infrastructure and data content requirements for attachments and support both existing and emerging standards including the X12 275, HL7 CDA and FHIR.[13]

Through provider guidance and adoption of an attachment standard and operating rules, the industry can simplify and improve the lines of communication between administrative and clinical systems. Helping to clarify, align and integrate processes not only improves interoperability, but also reduces administrative burden ultimately benefiting the quality and cost of care for the patient.

Methodology

The 2021 CAQH Index included questions related to clinical administrative workflow for medical health plans and providers. The measurement period represented January 1 to December 31, 2020. Results from this survey have been weighted to represent a national distribution of physicians by practice size as reported by the American Medical Association (AMA)[14] and the total number of U.S. covered lives reported by the AIS Directory of Health Plans.[15]

Endnotes

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