Managing Data Content: Clinical Data Management Programs Improve Reimbursement

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by Harry Rhodes, MBA, RHIA, CHPS

Although we've made progress in advancing the EHR initiative, we continue to struggle with data content management. The data content management crisis is not unique to healthcare, according to Ruth Stanat, global business consultant. All businesses —not just healthcare—are "drowning in data, yet starved of information."[1] Unstructured content is growing at an increasingly rapid rate, and it has been since the advent of the Internet and e-commerce.

Unstructured data are any data residing unorganized outside of a database. These can be text, audio, video, images, or graphics. It is estimated that as much as 85 percent of the information that currently flows through businesses is unstructured. The capturing and use of this unstructured data has proven to be difficult to manage. Unstructured data are not easily searchable. As a result, the typical office worker spends increasing amounts of time looking for and managing information.

HIPAA to the Rescue?

The recent publication of the proposed rule for HIPAA administrative simplification reinforces the need to address the unstructured data problem. The summary statement of the proposed rule recommends the adoption of standards that will facilitate the electronic exchange of clinical and administration data to further improve the claims adjudication process when additional documentation (also known as healthcare claim attachments) is required.

Under the proposed rule, claims will be processed quicker, and the process will become more efficient with the introduction of standardized communication formats and code sets for the identification of supplemental clinical information.

The introduction of electronic data interchange technologies and standardized formats will allow providers and payers to exchange medical, billing, and other claims processing information more expeditiously and cost effectively. The improvements made to the claims adjudication process will reduce manual handling, processing time, and eliminate claims processing delays that result from lost documents.

Yet the recommended technological and transaction code set improvements outlined in the proposed rule will not improve the clinical documentation needed to support the positive adjudication of healthcare claims. None of the process improvements will ensure that healthcare providers are able to justify their healthcare claims, meet medical necessity requirements, and reduce or prevent claims denials that could have been prevented by adequate clinical documentation.

Needed: Clinical Data Management Standards

Along with the proposed claims attachments standards, successful healthcare providers need to implement clinical data management standards that will result in clinical documentation that justifies reimbursement for the care provided.

Contained within the HIPAA claims attachment proposed rule is an overview of a white paper titled "HIPAA and Claims Attachments: Preparing for Regulation" published by the Attachments Special Interest Group at Health Level Seven (HL7). The document highlights the possible workable electronic healthcare claims attachments requests and response scenarios between health plans and healthcare providers. It also envisions a best-practice future where claims attachments are provided in machine-readable structured data format; these claims are then efficiently auto-adjudicated and promptly paid at the lowest possible administrative cost.

Yet even if this scenario is successfully implemented, poor data management standards will rob the successful healthcare provider of the reimbursement it rightfully deserves. The proposed rule only addresses standardizing the process for submitting

claims information and ignores the need for structured data content. If the data content submitted does not adequately reflect what the payer requires to adjudicate the claim, electronic submission will not improve payment turnaround time for the provider and only provide limited value for the payer. If the provider and payer have different definitions or values for data, the lack of standardization can lead to misunderstandings, incorrect data interpretation, incorrect metrics for outcome measures, and inability to compare results and outcomes.

For the immediate future, healthcare providers that comply with the HIPAA standards for electronic healthcare claims attachments will most likely opt to scan medical record documents as claims attachments, which will be submitted for manual review. Initially the claims attachment submission process will remain essentially unchanged. Now is the opportune time for healthcare providers to begin developing their clinical data management programs.

Strategies for Managing Your Clinical Data

A strategy that incorporates clinical physician documentation guidelines into a hospital's concurrent utilization or DRG management process is an effective way to improve clinical documentation. A concurrent review process that focuses on the specific clinical document required for correct diagnoses and treatment will result in the appropriate documentation needed to support proper ICD, CPT, and DRG code assignment.

The current process employed by most healthcare providers to check whether medical necessity requirements have been met is a back-end check performed just prior to claims submission. It is estimated that approximately 50 to 60 percent of providers use some sort of claim scrubber or clearinghouse to edit for medical necessity just prior to electronic submission of the claim. The problem with employing postservice medical necessity checking is that it allows little opportunity to correct missing documentation.

To improve data content, the medical staff must be made aware of claims denials and actively involved in the appeals process where improved documentation could have prevented the denial from ever being issued. Continuing education programs should be established to keep the medical staff abreast of Medicare's DRG, APC, and medical necessity documentation requirements.

Preparing for the Future

To prepare for the day when structured data submission is commonplace, the medical staff should be encouraged to:

- Be consistent in the use of terminology
- Document all diagnoses that are actively being treated
- Clearly indicate in the medical record all disease relationships
- Document all diagnoses that are identified by a consultant and are actively treated during hospitalization
- Clearly document clinical techniques used in the outpatient setting[2]

Healthcare entities should also inventory existing data sets for possible incorporation into the organization's data content management system. Data sets provide a structured means to capture, record, and communicate the most significant and timely facts about a patient's diagnosis and course of treatment.

Organizations should establish policies and procedures that ensure that common data elements are used in the patient history and physical, problem list, operative note, progress notes, and other clinical documentation. Use of common data elements will ensure consistency in data transfer, consistent information submission for reporting agencies, and easy data exchange without increasing costs associated with manual data keying and human rework.

Healthcare entities should educate their staffs about standard clinical vocabularies and work to incorporate them in their processes. The lack of standard clinical vocabularies is considered to be a major barrier to successful EHR interoperability.

The healthcare industry is actively developing comprehensive data sets that map back to EHR functions. Healthcare providers should ensure that their content management efforts relate to the work of:

- HL7 Clinical Data Architecture (CDA) Standard—a standard structure for the data interchange of narrative clinical documents.

- American Society for Testing and Materials (ASTM) Continuity of Care Record (CCR)—a standard patient health summary based on an XML-formatted data set. (Recently ASTM and HL7 announced plans to collaborate on the synchronization of HL7 CDA and CCR.)
- HL7/HIMSS EHR Interoperability Collaborative—a collaborative standardization of medical summaries and clinical templates coordinated between HL7, HIMSS EHR Vendors Association, and Integrating the Healthcare Enterprise.
- SNOMED CT—the National Library of Medicine signed a five-year contact with the College of American Pathologists to license SNOMED CT and offer it without cost to US healthcare providers. This action was seen as a first step in establishing a standardized medical vocabulary.

The healthcare industry is driven by information; unfortunately most of the information currently exists in the form of unstructured free text. The introduction of standardized EHR data content is paramount to the successful transformation to an interoperable EHR.

To achieve an environment where electronic health information, regardless of its source, is universally defined, consistently accurate, and trusted it must be precisely defined, recorded, retained, and communicated in a timely manner.

Notes

1. Quoted in Chandler, Steve. *100 Ways to Motivate Others*. Franklin Lakes, NJ: Career Press, 2004.
2. Parsons, Roger, Monica Lenahan, and Julie Micheletti. "Strategic Approaches to Data Management and Documentation Improvement." 2004 IFHRO Congress and AHIMA Convention Proceedings, October 2004. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

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