2015

Electronic Submission of Medical Documentation

Introducing Electronic Submission of Medical Documentation (esMD) to Clearinghouses

The Centers for Medicare & Medicaid Services (CMS)

Office of Financial Management (OFM)
Provider Compliance Group (PCG)
Division of Compliance Projects and Demonstrations (DCPD)

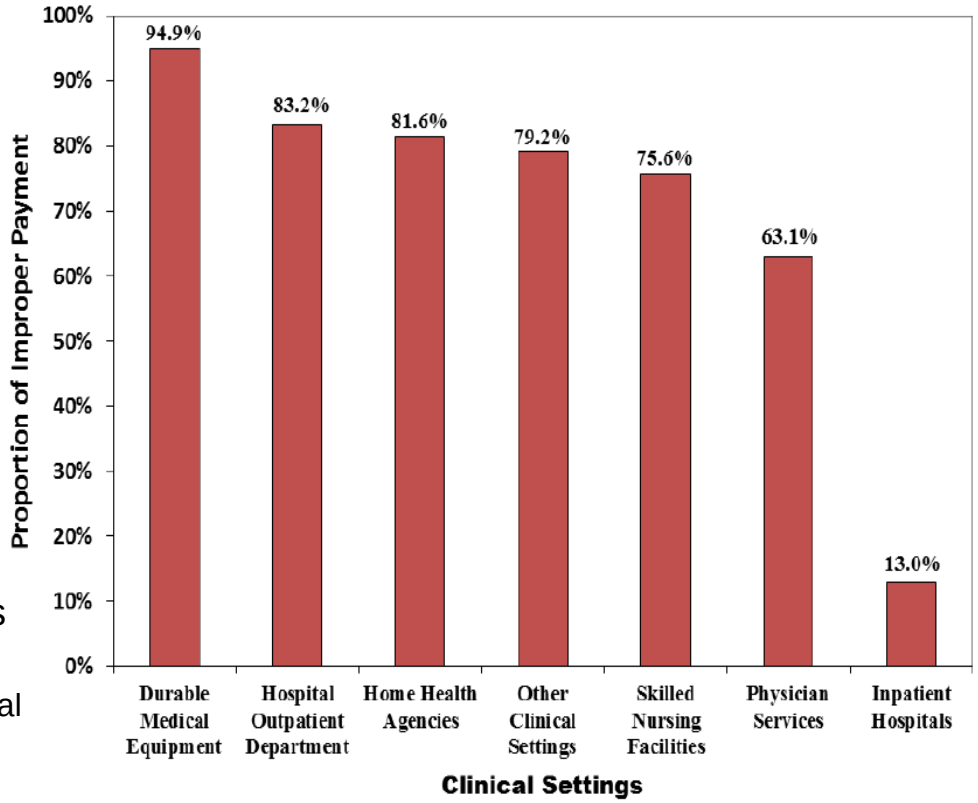
Background facts about improper payments

The CMS Office of Financial Management estimates that:

- The fiscal year (FY) 2014 Medicare Fee-for-Service (FFS) program improper payment rate was **12.7 percent**, representing **$45.8 billion** in improper payments.
  - **$29.5 B** of improper payment is due inadequate documentation to support payment for services billed
  - **$12.9 B** of improper payment is due to services that were not medical necessary based on Medicare coverage policies

- Over 2 million Medical Documentation Requests are sent annually 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)
  - Supplemental Medical Review Contractor (SMRC)

Figure 1: Proportion of Improper Payment Attributed to Insufficient Documentation in 2013, by Clinical Setting

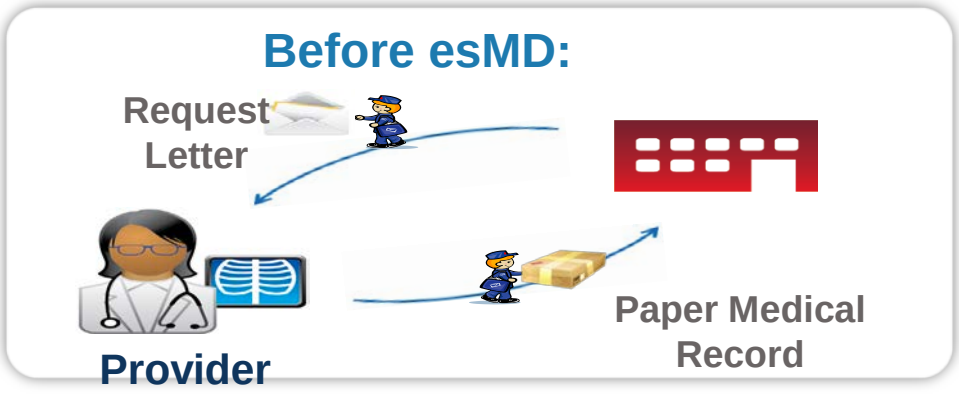


- Most improper payments can only be detected by a **human** comparing a **claim** to the **medical documentation.**

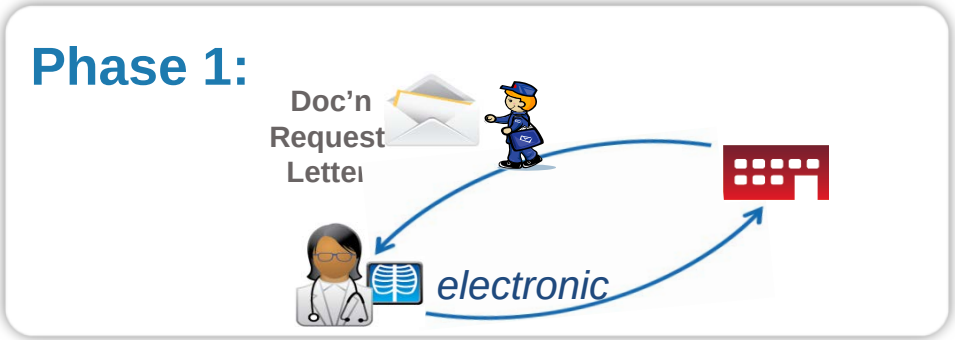
PCG / esMD Goals

- ✓ ***Reduce improper payment through***
  - ➢ prior-authorization (e.g. PMD)
  - ➢ Encourage better documentation (e.g. Electronic clinical templates, “Probe & Educate” programs)
- ✓ ***Minimize provider burden through***
  - ➢ electronic communication of medical information (esMD)
  - ➢ structured data to facilitate review process (e.g. CCDA and CDP1)
  - ➢ digital signatures to establish data integrity and provenance
- ✓ ***Adopt/promote standards to facilitate information exchange***
  - ➢ Messaging/Metadata standards (278 for prior auth requests)
  - ➢ electronic transaction standards (CMS exploring accepting Direct transactions)
  - ➢ Content standards (Now: pdf only…. Future: CCDA and CDP1)
  - ➢ Digital Signature standards

esMD Background

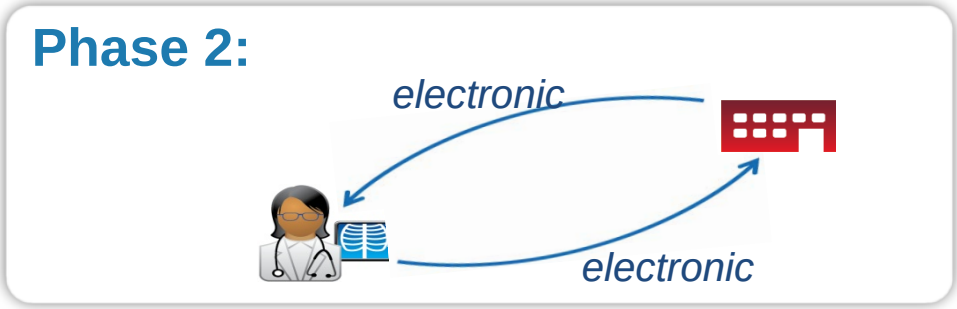


Healthcare payers frequently request that providers submit additional medical documentation to support a specific claim(s). Until recently, this has been an entirely paper process and has proven to be burdensome due to the time, resources, and cost to support a paper system.

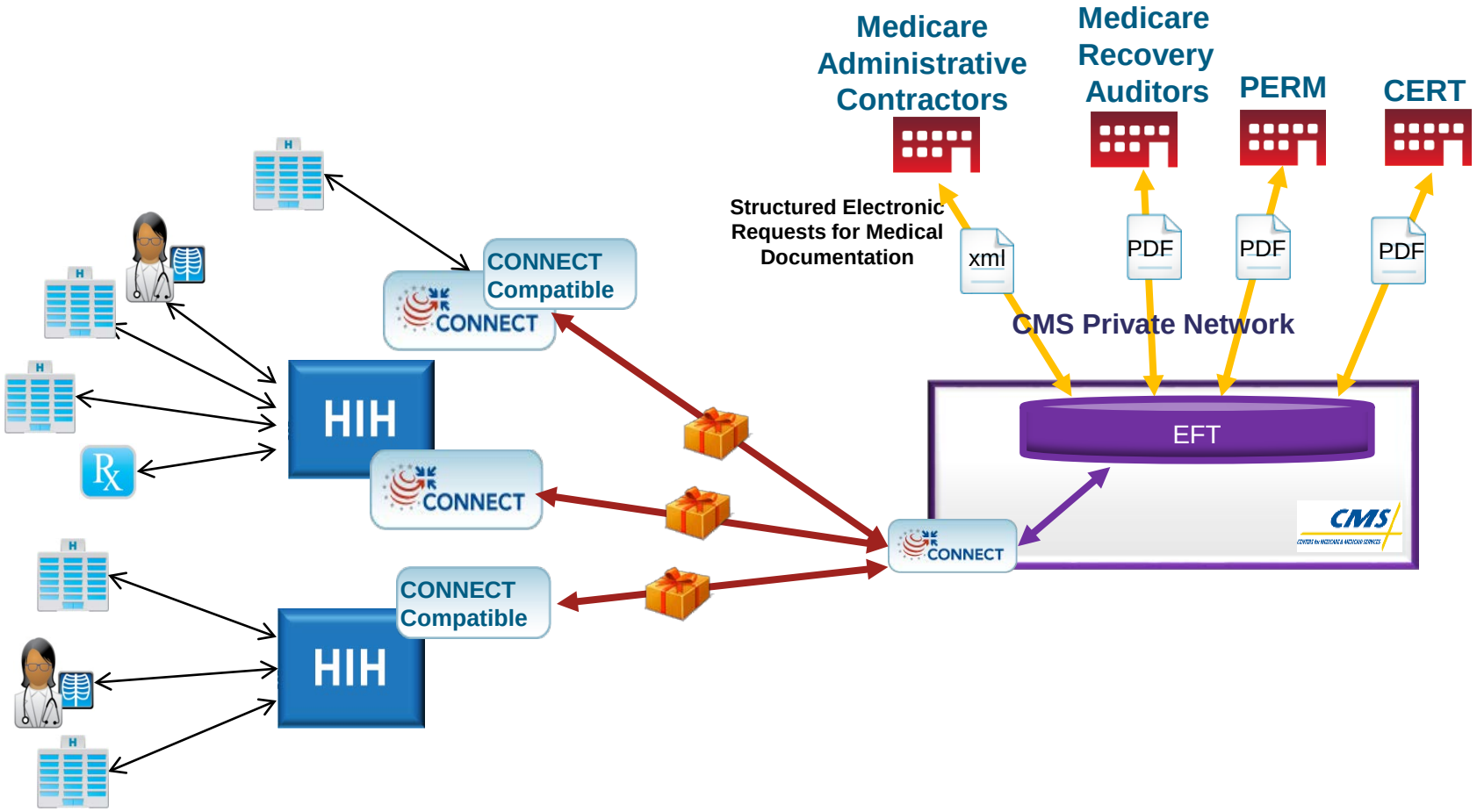


Phase I of esMD was implemented in September of 2011. It enabled Providers to send Medical Documentation electronically

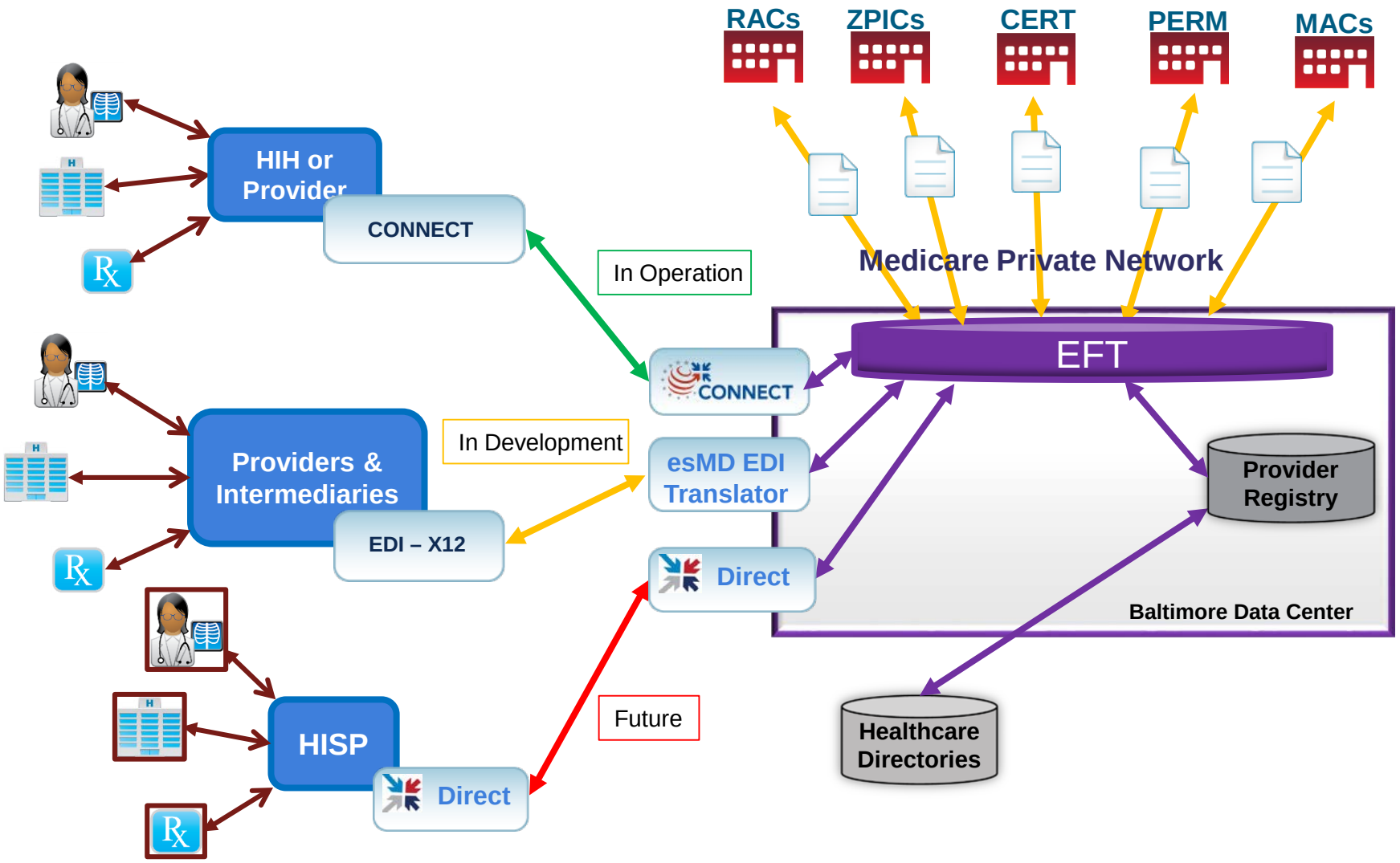
The ONC S&I Framework Electronic Submission of Medical Documentation (esMD) initiative has developed implementation guides to support an entirely electronic documentation request.



CMS esMD Utilizes CONNECT



esMD Interoperability Direction



Current and future use cases for esMD

INBOUND Use Cases Submitted through esMD (esMD Phase 1)

- Responses to Documentation Request Letters in PDF
- Power Mobility Device (PMD) Prior Authorization Requests in PDF
- 1st level Appeal Requests in PDF
- Advance Determination of Medicare Coverage
- Prior authorization request for ambulance in PDF
- Prior authorization request for HBO in PDF
- Prior authorization request in X12 278
- Structured Orders, Progress Notes
- Structured esMD Phase 2 Registration

We Are Here

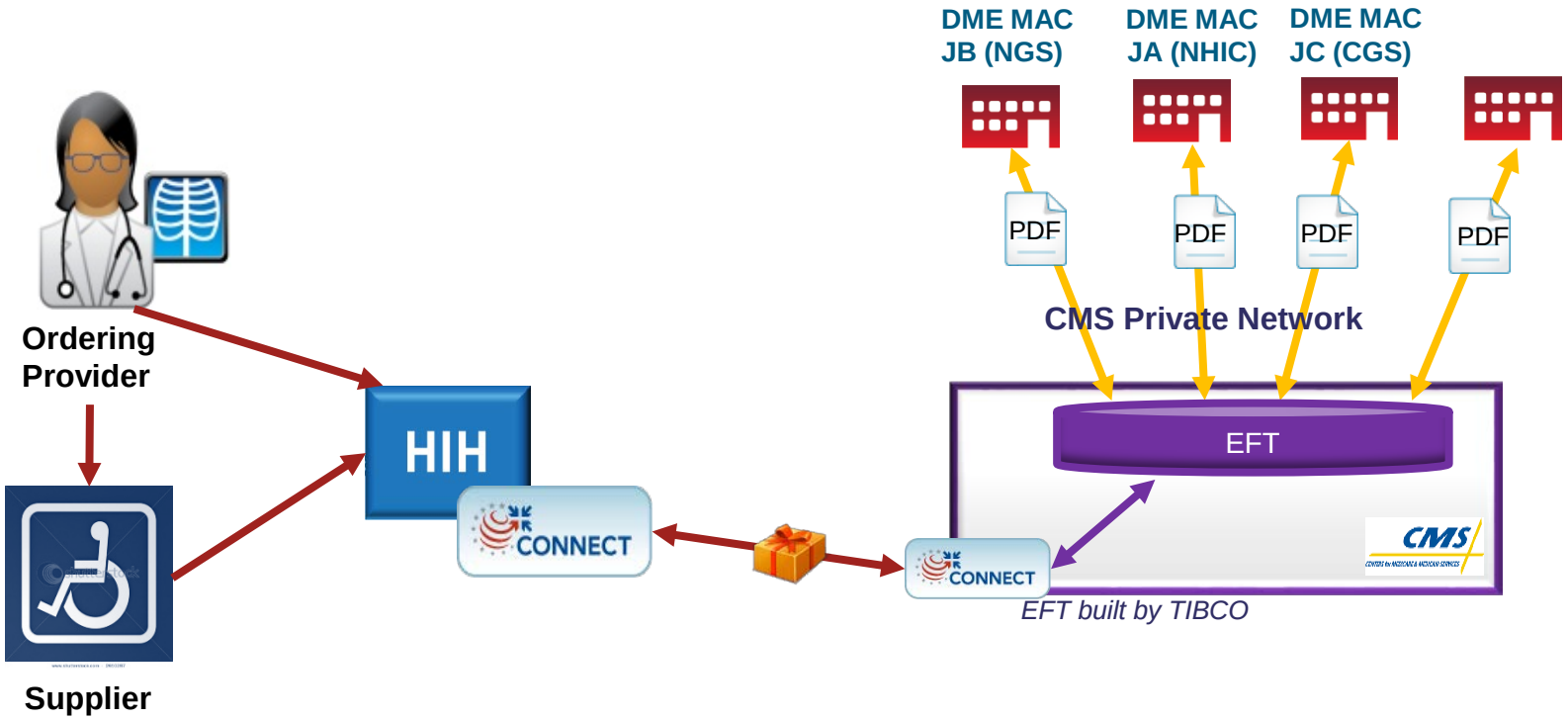
OUTBOUND (esMD Phase 2)

- Structured Outbound Documentation Requests
- Power Mobility Device (PMD) Prior Authorization Responses
- Prior authorization responses
- Review Results Letters
- Demand Letters

LOOKUP (Future Phase)

- Request\Receive Documentation Status
- Request\Receive Claim Review Status
- Request\Receive Appeals Status
- Request\Receive Procedure Level eligibility Info

Prior Authorization (PA) of Power Mobility Devices (PMD) submissions through esMD



Definition of an esMD package

A portion of a patient's medical record in esMD format which will contain:

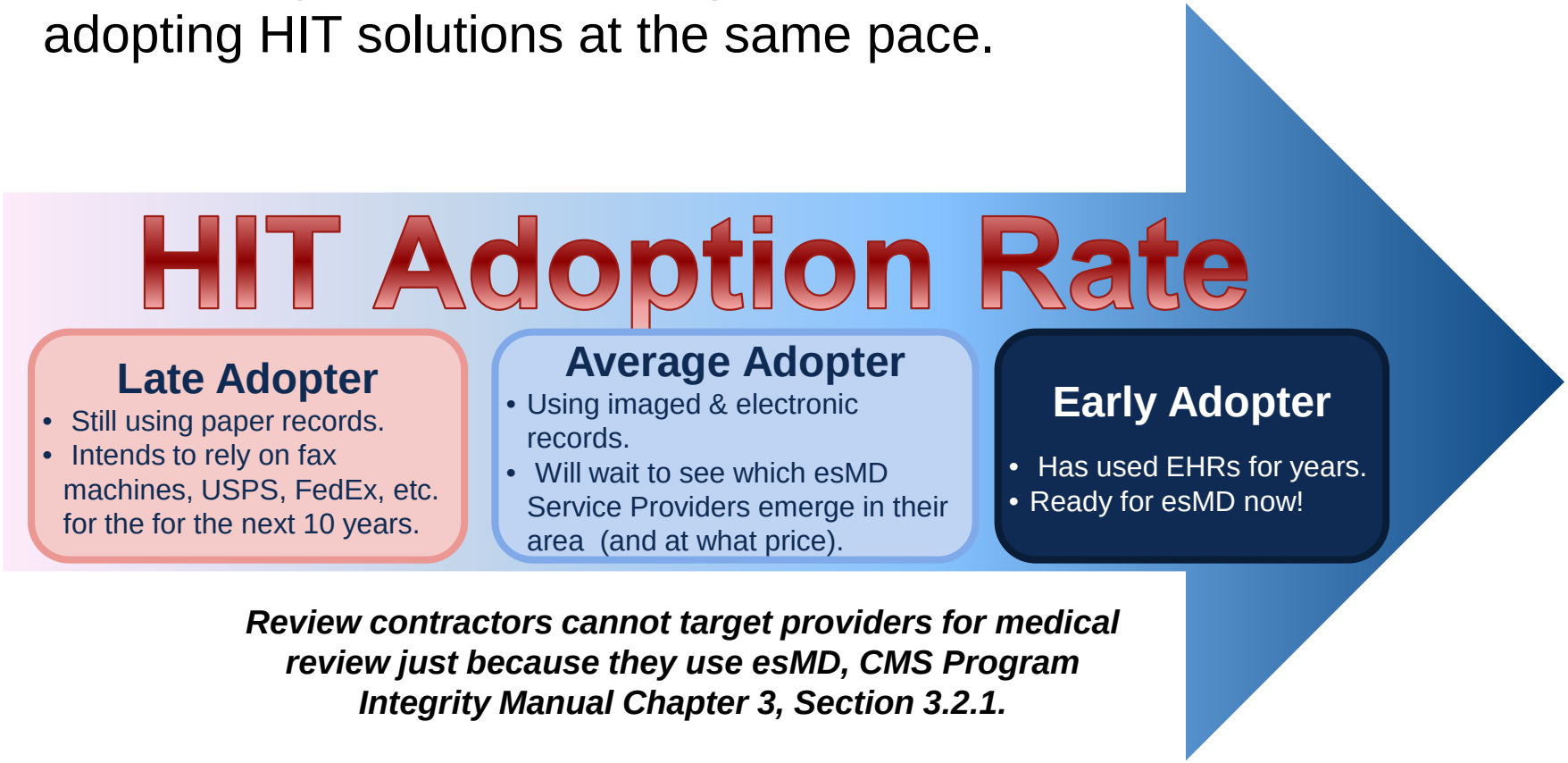
- Imaged documents (PDF)
- Important Metadata Fields:
  - Intended Recipient – Required field
  - Claim ID – Required field for ADRs only
    - optional for First Level Appeals requests
    - not used for Prior Authorization Requests
  - NPI – Required field
  - Case ID – Required field, if known
  - Document Type Code – Required field
    - Response to Additional Documentation Request (PDF)
    - Power Mobility Device (PMD) Prior Authorization Requests (PDF)
    - Advance Determination of Medicare Coverage (ADMC)
    - First Level Appeal Requests (PDF)
    - Non-Emergent Ambulance Transport

Detailed description for each field can be found in:

- the esMD XDR Profile.**(http://www.connectopensource.org/product/connect-NHIN-specs)**
- the esMD Implementation Guide**(www.cms.gov/esMD)**

esMD is not mandatory for providers

CMS recognizes that not all providers are adopting HIT solutions at the same pace.



Review contractors cannot target providers for medical review just because they use esMD, CMS Program Integrity Manual Chapter 3, Section 3.2.1.

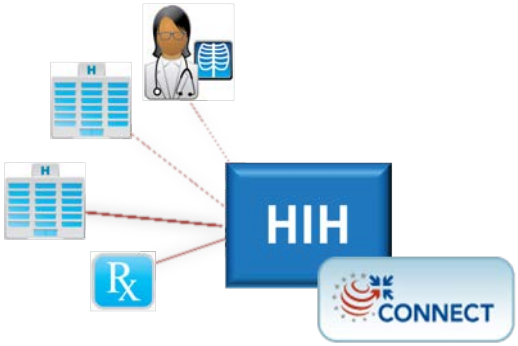
esMD statistics

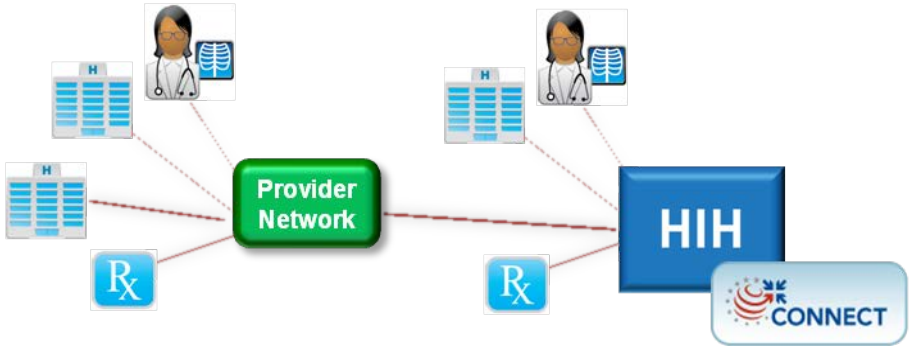
- As of February 20, 2015, over **84,477** providers have signed up with an esMD HIH.

- As of February 20, 2015, over **1,199,038** medical records have been submitted through the CMS esMD Gateway.

esMD is open to providers and provider networks:

- May communicate directly with providers, or





Medicare and Medicaid review entities can join esMD

- Option 1: Build your own Gateway
- Option 2: Use a technology partner's Gateway
- Option 3: Hire a Health Information Handler (HIH)

CMS Review Contractors that accept esMD

Approved CMS Review Contractors	
Region A Medicare Recovery Auditor	JA DME Durable Medical Equipment MAC
Region B Medicare Recovery Auditor	JB DME MAC
Region C Medicare Recovery Auditor	JC DME MAC
Region D Medicare Recovery Auditor	JD DME MAC
J5 Medicare Administrative Contractor (MAC)	Zone 1 Zone Program Integrity Contractor (ZPIC)
J6 MAC	Zone 2 ZPIC
J8 MAC	Zone 3 ZPIC
J10MAC	Zone 4 ZPIC
J11MAC	Zone 5 ZPIC
J15 MAC	Zone 7 ZPIC
JE MAC	U.S. Railroad Retirement Board (RRB)
JF MAC	Supplemental Medical Review Contractor (SMRC)
JH MAC	Comprehensive Error Rate Testing (CERT)
JK MAC	Program Error Rate Measurement (PERM)
JL MAC	
JN MAC	

For updated list, visit: **www.cms.gov/esMD**

- Obtain connectivity to the Electronic File Transfer system
- Successfully onboard and test with the CMS esMD team

CMS Certified esMD HIHs
IVANS / ABILITY Network
Bluemark, LLC
Cobius Healthcare Solutions
Craneware
Dorado Systems
Episode Alert
eSolutions, Inc.
HealthPort
IOD Incorporated
LOISS, Ltd.
Medical Electronic Attachment (MEA)
MedFORCE Technologies
MRO
Proficient Health
Rycan Technologies, Inc.
RISARC
SSI
SunCoast RHIO, Inc.
Verisma Systems

For an updated list, visit:

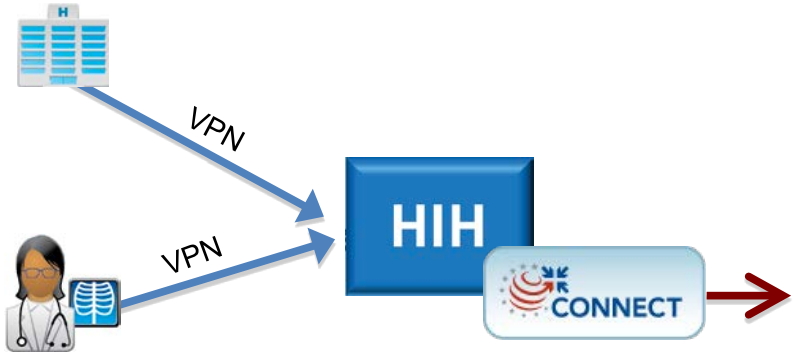
ww.cms.gov/esMD

esMD HIHs:

- Participate voluntarily
- Receive no funding from CMS or ONC (Note: they may bill providers)
- Attend calls with CMS (scheduled)
- Build a CONNECT-Compatible Gateway
- Obtain a certificate, IP address, and share key with CMS Gateway Contractor
- Successfully onboard with the CMS esMD team and test with CMS Gateway Contractor
- Recruit providers to join

CMS does not dictate how an HIH communicates with providers

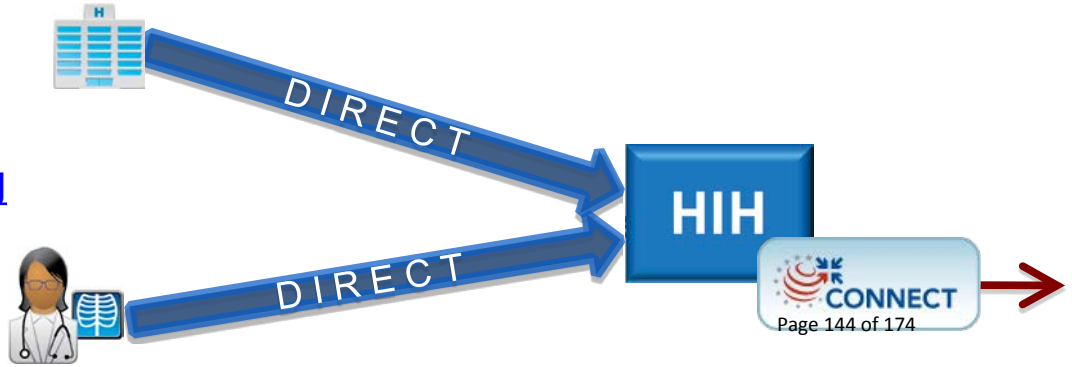
- Some esMD HIHs plan to ingest a provider's medical records and metadata by:
  - going onsite to the provider's facility
  - using a Virtual Private Network (VPN)
  - using a secure web portal



- Some esMD HIHs are using DIRECT.

http://directproject.org

http://wiki.directproject.org



Using Health Information Handlers to provide Gateway services

A Health Information Handler (HIH) is any company that handles health information on behalf of a provider. Examples include:

(1) Health Information Exchange (HIE)/Regional Health Information Organization (RHIO)

(2) Release of Information (ROI) Vendor

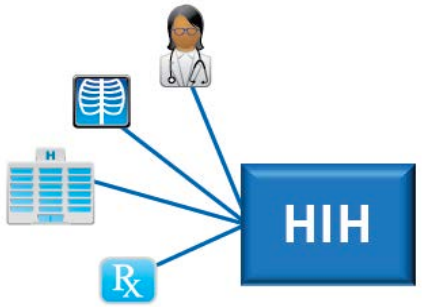
A company that manages the release of information for providers. Their services may include logging and tracking the request, retrieving the patient record from multiple locations in multiple formats, identifying the information needed to fulfill the request, requesting additional authorization, if needed, copying, packaging and mailing, and invoicing.

(3) Electronic Health Record (EHR) Vendor

(4) Clearinghouse

(5) Health Internet Service Provider (HISP)

An entity that provides services that enable providers or health organizations to exchange health information using the internet.



Process to become a HIH

1) Read and understand the documentation
2) Attend calls with CMS (scheduled)
3) Build or acquire a CONNECT-Compatible Gateway
4) Obtain a certificate, IP address, and share key with CMS Gateway Contractor
5) Successfully onboard with the CMS esMD team and test with CMS Gateway Contractor

Total time for a well prepared HIH to complete certification with esMD – 21 days

Typical time: 60-90 days

6) Recruit providers to join

Benefits of becoming an HIH

- Provide current clients with HIH Gateway services to allow submission of medical documentation to Medicate for:
  - Prior-Authorization programs
  - Claims review (pre and post pay)
  - Program Integrity reviews
    - CERT
    - SMRC
  - Quality Programs

- Providers have reported the payment turnaround when using esMD is 6 days as opposed to the paper process which is approximately 3 weeks.
- esMD helps to reduce the amount of labor required to fulfill these requests by no longer having to print and mail paper, feed a fax machine or burn CD's.
- esMD can also reduce hard costs like shipping and handling expenses.

Standards

esMD Standards Efforts

- ***Work through ONC S&I Framework to encourage broad stakeholder participation***
  - Provider Registration (for payer services)
  - Author of Record (data provenance and integrity)
  - Electronic Determination of Coverage (documentation, content and messaging standards)
- ***Work with Standards Organizations to adopt current and emerging standards***
  - ASC X12N – Message/Metadata -- 270/271, 274, 277, 278, 275, ...
  - HL7 -- Digital Signatures, Data Provenance, Clinical Document Architecture and Structured Data Capture -- FHIR
  - IHE/W3C -- Digital Signatures -- DSG / DigSig
- ***Work with ONC/NIST to adopt the standards for EHR Certification***
  - Digital Signature
  - Clinical Documents for Payers

Electronic Determination of Coverage (eDoC) Limitation of C-CDA

- ***Consolidated Clinical Document Architecture (C-CDA)***
  - C-CDA documents "require" a limited number of sections
  - EHR vendors frequently support inclusion of only required sections even if information exists in the medical record for "optional" sections
  - Testing and Certification only verify EHR support for required information
- ***Consequences for Providers***
  - Large variability in C-CDA ability to support submission of existing medical documentation to support a specific service
  - Inability to submit "complete" documentation may inappropriately
    - increase denial rates,
    - force providers to use unstructured documentation, and/or
    - require additional requests for documentation
  - thereby substantially increasing error rate and administrative costs

Solution

esMD open forum solution to protect beneficiary and provider rights

- Clinical Documents for Payers – Set 1 (CDP1) to support providers right to submit documentation to justify proposed or completed services
- Constraints allow certification of EHR support for C-CDA optional sections when information exists
- CDP1 templates are available for both administrative and clinical purposes where exchange of more complete documentation is appropriate

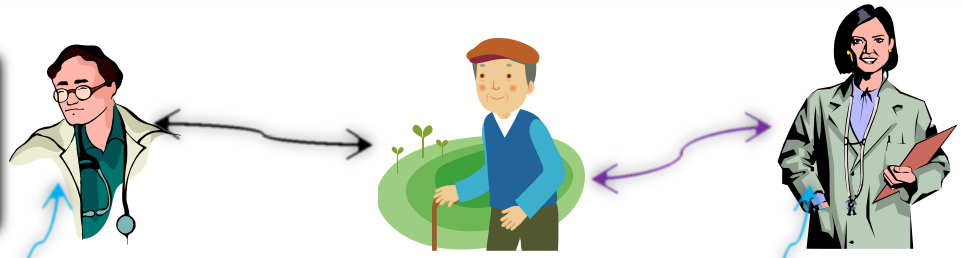
without impacting existing use cases

- Leverages C-CDA R2 templates – does not replace them
- Does not require providers to perform additional documentation
- Does not impact any payer or clinical user's ability to request C-CDA R2 templates

The combination of the C-CDA R2 and CDP1 templates provide a solution for all providers and payers

Providers Document Patient Encounters

CDA Generator populates document based on template constraints



EHR Screen(s)

Demographics | Subjective | Objective | Assessment | Procedure | Plan

Demog raphics | History of Past Illness | Allergies | History of Present Illness | Social History | Vital Signs | Meds | Diagnos es | Procedure Notes | . . . | Lab Orders / Results

EHR Database

CDA Generator

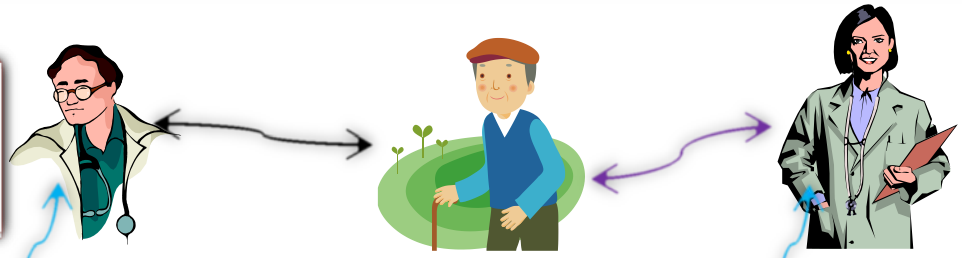
Header | 5 required sections | 21 optional sections | Other C-CDA Sections | Open Template Sections

Support varies by vendor -- not required

Create C-CDA R2 Procedure Note

Providers Document Patient Encounters

CDA Generator populates document based on template constraints



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Demographics | Subjective | Objective | Assessment | Procedure | Plan

Demog raphics | History of Past Illness | Allergies | History of Present Illness | Social History | Vital Signs | Meds | Diagnos es | Procedure Notes | . . . | Lab Orders / Results

EHR Database

CDA Generator including ACT1 Templates

Header | 29 RENW sections | Other C-CDA Sections | Open Template Sections

Sections not supported or with no data – use NI
Sections where data is not applicable – use NA

Create CDP1 – Enhanced Procedure Note

Selection of Documents

- Payer or provider may request a document by LOINC code or template ID
- Provider may produce a document based on intended use
- All documents are made from the same set of sections
- Header is the same for all documents

C-CDA R2 Procedure Note

CDP1 – Enhanced Procedure Note

RENW – Required if Exists and Not Withheld

CDP1 and Minimum Necessary

Does the use of CDP1 violate Minimum Necessary regulations?

- **Absolutely Not!**

- Payers (including Medicare FFS) are not required to ask for CPD1
- Providers are not required to use CDP1
- If CDP1 is used, the provider is in complete control of what information is exchanged
- CDP1 is just a vehicle to reliably exchange as much or as little information as required to satisfy a specific clinical or administrative need.

If a provider chooses to send a complete record of the encounter to a payer is this a violation of Minimum Necessary

- **Absolutely Not!**

- The information is clearly covered and allowable as payment operations. 164.502(a)(1)(ii) is an explicitly permitted use covering payment activities under minimum necessary in 502(b)(2)(ii).
- Policy determines what is required/permitted and not CDP1

Frequently Asked Questions

1. **Will providers be required to use the CDP1 documents?**

   No. Providers may use any standards allowed by the attachments rule to submit documentation -- the CDP1 documents provide for a more complete submission when providers deem it is appropriate

2. **Are the CDP1 documents significantly larger than C-CDA documents?**

   A CDP1 document is between 1% and 5% larger than a typical C-CDA document when the same information is included in both. ***However, CDP1 documents are typically <10% the size of a PDF.***

3. **Will providers need to do additional work documenting a patient visit?**

   - The provider is not required to collect any additional information when using the CDP1 documents -- CDP1 just ensures that desired information can be reliably submitted
   - EHR vendors can provide the capability to use the default indicators when no information is present or the provider believes that specific patient information is not applicable as part of their exchange standard.

Summary

- Medicare FFS improper payment rate exceeds $45 billion / year
- Movement to prior-authorization for certain categories of benefits with high improper payment rate coupled with improved clinical documentation will substantially reduce improper payment and minimize the burden of post payment audit
- To simplify the administrative process CMS and providers need:
  - Ability to report medical documentation in structured electronic format
  - Digital signatures to ensure data integrity and provenance (applies to both C-CDA R2 and CDP1)
- To ensure beneficiary and providers rights are supported
  - Need uniform support of structured reporting by certified EHR vendors
  - Need templates that support the reporting of all information the provider wishes to submit to demonstrate services are medically necessary and appropriate (incomplete information may result in increased denial rates)

Goals of esMD

- Reduce inappropriate payments to improve management of the Medicare FFS trust fund for all beneficiaries
- Ensure Medicare FFS beneficiaries receive covered services
- Promptly pay providers for covered services that are medically necessary and appropriate

SSI Group Presentation

SSI esMD Gateway

A Health Information Handler (HIH) on the CMS esMD Connect Network

Deborrah Short Rodrick
COO & VP
The SSI Group, Inc.

SSI Product and HIH Integration

- ClickON® Audit Management
  - Documentation request letters from RAC, MAC, etc.
    - ADR (Additional Development Request)
    - Documentation requests for RAC and other Government Audits
    - Sending Appeal Package documentation
- ClickON® Attachments Portal
  - Upload the documentation and manually check status.
- ClickON® Billing Module
  - Attach the documentation to the claim (837)

Active esMD Transactions

Content Type	Code	SSI Status	SSI Usage
Response to Additional Documentation Request(ADR)	1	Supported/Active request	Audit Management and Attachments to send ADR and RAC Audits to Contractors
PMD Prior Authorization (PA)	8	Supported/ Limited request	
Appeal Request	9	Supported/Active request	Audit Management to send Appeal Package documentation to Contractors
ADMC (Advance Determination of Medical Coverage)	10	Supported / Limited request	
RA Requests	11	Supported / Limited request	
Non-Emergent Ambulance Transport	8.1	Supported/ Limited request	
Hyperbaric Oxygen (HBO) Therapy	8.2	Supported/ Limited request	
Supporting Documentation for the unsolicited X12N 278 Request	12	Not developed	
Supporting Documentation for the X12N 278 Request	13	Not developed	

Active esMD Contractors

Contractor	Type	SSI Status
Performant Recovery (RAC Region A)	RAC	Active
CGI Federal (Region B)	RAC	Active
Connolly (Region C)	RAC	Active
Health Data Insights (Region D)	RAC	Active
MAC J5 (WPS)	MAC	Active
MAC J6 (NGS)	MAC	Active
MAC J8 (WPS)	MAC	Active
MAC J11 (Palmetto GBA)	MAC	Active
MAC J15 (CGS)	MAC	Active
MAC JE (Noridian)	MAC	Active
MAC JF (Noridian)	MAC	Active
MAC JH (Novitas Solutions)	MAC	Active
MAC JJ (Cahaba)	MAC	Active
MAC JK (NGS)	MAC	Active
MAC JL (Novitas Solutions)	MAC	Active
MAC JN (First Coast)	MAC	Active – limited customers sending
DME MAC JA (NHIC)	DME	Active – limited customers sending
DME MAC JB (NGS)	DME	Active – limited customers sending
DME MAC JC (CGS)	DME	Active – limited customers sending
DME MAC JD (Noridian)	DME	Active – limited customers sending
ZPIC 1 (SafeGuard Services)	ZIPC	Active – limited customers sending
ZPIC 2 (Advance Med)	ZIPC	Active – limited customers sending
ZPIC 3 (Cahaba)	ZIPC	Active – limited customers sending
ZPIC 4 (Health Integrity)	ZIPC	Active – limited customers sending
ZPIC 5 (Advance Med)	ZIPC	Active – limited customers sending
ZPIC 6	ZIPC	Active – limited customers sending
ZPIC 7 (SafeGuard Services)	ZIPC	Active – limited customers sending
Retirement Board – RRB (Palmetto GBA)	CERT-PERM	Active – limited customers sending
Supplemental Medical Review Contractor (Strategic Health Solutions)	CERT-PERM	Active – limited customers sending
Comprehensive Error Rate Testing – CERT	CERT-PERM	Active – limited customers sending
Program Error Rate Measurement – PERM	CERT-PERM	Active – limited customers sending

The Certification Process

The certification process was challenging for SSI and took about 6 months, ultimately it came down to a couple significant issues:

We were in the second set of HIHs and were connecting to a new Server Pool at CMS. CMS had configuration issues which had to be researched during the setup. Mainly invalid certificates and ports open.

We under estimated the time needed to complete the Setup and Configuration of the Connect Gateway. The Connect Gateway is a Java implementation using GlassFish. We didn't have much expertise in Java and GlassFish at that time.

More development was needed that we anticipated integrating with the Connect Gateway. We didn't have expertise in the XDR document format at that time. (moving to AGILE development at same time)

Other Opportunities

- Initially we had to wait 2 minutes between submissions which meant it couple take a couple days to send a large RAC audit. This has been fixed and we can send with no pausing between documents.
- There was initially a 19MB size limitation for transactions which meant that PDFs frequently had to be split in to multiple transactions. This has been extended to 50MB and has helped.
- Missing the pickup messages from the Review Contractors. This is still an ongoing problem and all the HIHs experience it. We can request a status via email and they will send us a spreadsheet. This can take 3+ weeks sometimes to get the status. They are implementing a daily email with current status's in version 4.0.
- Education of Providers (We are working with our RAC and DME clients but it has been slow getting the value out to all the other providers)

Closing Information

Want to be an esMD HIH but don't know how to build a Gateway?

- Consider contacting the esMD HIHs
- Consider contacting one of the esMD HIH subcontractors

  http://www.cms.gov/ESMD/04_b_IT_Vendors_Assisting_HIHs.asp#TopOfPage
- Consider contacting one of the IT vendors

  http://www.connectopensource.org/partners
- Visit the CMS and QSSI websites

  http://www.qssinc.com/esmd/index.html

  http://www.cms.gov/esMD
- Before HIHs can begin esMD onboarding, they need to complete the tasks within the specified timeframes as explained in the HIH Onboarding Manual

  http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information_for_HIHs.html

For more information

To contact the esMD Team:

esMD@cms.hhs.gov

CMS esMD Website:

www.cms.gov/esMD

CONNECT Website:

http://www.connectopensource.org

Follow Us on Twitter:

@CMSGov (Look for #CMS_esMD)

Next Steps

Collaboration Opportunities

Round Table Discussion

Questions