AHIMA
American Health Information Management Association®

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WHITE PAPER

Medical Record Retrieval and Procurement: Challenges and Solutions

Summary

Medical record retrieval is a vital component of risk adjusted programs and remains a resource-intensive process for payors and providers alike. Efficiency is a must, especially given rigorous Centers for Medicare and Medicaid Services submission deadlines and retrieval targets that are difficult to achieve. A comprehensive data intake and analytics process is essential to optimize retrieval and ensure records are accurate, complete, and timely. Delays and inaccuracies can result in significant under or overpayments, impact quality reporting, and impede population health initiatives.

With this in mind, the American Health Information Management Association (AHIMA) and CERiS convened an expert panel of health information management (HIM) and medical records retrieval and integrity experts to explore how payor organizations and others can address provider friction and procurement challenges to successfully navigate the task of getting necessary medical records for review and how to improve payor-provider relationships and ensure payment integrity.

Expert Panel

James Contos
Senior Vice President, Operations
CERiS
FORT WORTH, TX

Jeannie Hennum
CEO
ChartFast
LAWRENCEVILLE, GA

Julie Pursley
Senior Director, Thought Leadership
AHIMA
CHICAGO, IL

"One of the biggest challenges we see is the multiple points of entry when it comes to requesting medical records for payment integrity."

— JEANNIE HENNUM, CHARTFAST

Challenges in Medical Record Retrieval

The shift to Electronic Health Records (EHR) has significantly improved medical record retrieval and procurement, which previously relied upon a strictly manual process to locate, retrieve, copy, and fax or mail the medical record. Significant challenges, however, remain to medical record retrieval. The panel highlights lack of data integrity and lack of clarity on where to send record requests as top barriers to timely retrieval. Additionally, payor-provider friction remains a problem as hospital HIM departments and physician practices are overwhelmed by large volumes of requests from payors for payment and HEDIS audits and risk-adjustment reviews. Specifically, the panel notes, payors are faced with significant variability in how providers receive and process release of information (ROI) requests, with many provider organizations having multiple points of entry for these requests. This decentralized approach creates not only confusion for payors and delays their ability to conduct audits and comply with reporting quality requirements, but it can also impact provider revenue. Payors may withhold payment or request reimbursement for suspected overpayments if the provider fails to comply to the request within a 30-day period or as otherwise specified in the contract.

In addition to multiple points of entry for requests, changes in workflows and staffing can lead to delays in record retrieval. Requests sent to the wrong vendor or person can result in weeks-long delays. Other delays stem from lack of interoperability and standardization, which can corrupt files and make them unusable for the end-user. From a provider perspective, the high volume of medical records retrieval requests from payors presents a significant financial risk and resource burden that distracts from patient care. The resulting disconnect between payors and providers inhibits the ability to access accurate, complete records in a timely manner.

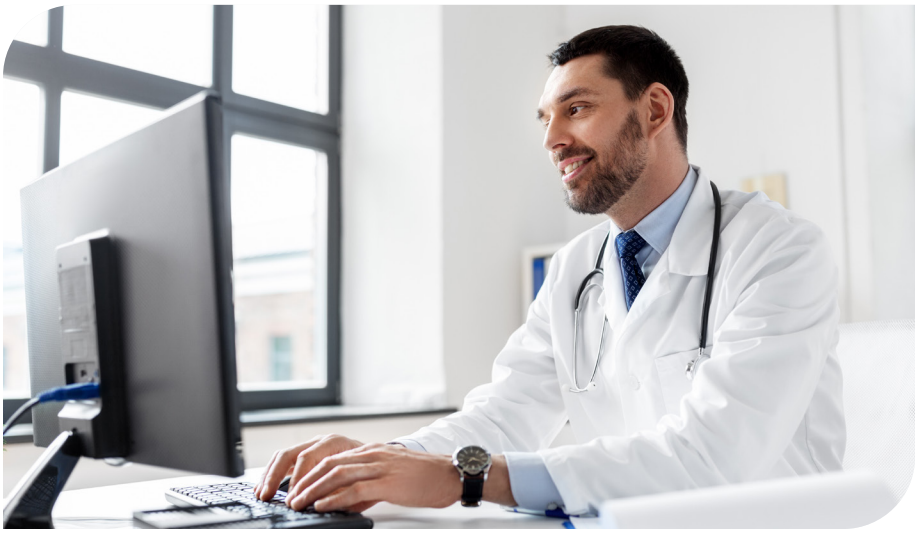
"You have to have cooperation from all the parties involved. Everyone needs to be on the same page."

— JAMES CONTOS, CERiS

Payors and providers must find common ground to overcome the barriers to the efficient and secure procurement of medical records. A **complete, accurate bill benefits all stakeholders:** payors, providers, and patients. Yet too many inaccuracies remain in the medical record that impede accurate payment and impact quality measures and clinical outcomes, the panel suggests. This adds another layer of complexity to the retrieval reprocess. Reconciling the medical record takes time and resources that could otherwise be directed towards supporting patient care delivery and quality improvement. Better data and information technology governance are needed to ensure **the right information is sent in the right format** to payors, patients, and others granted access to patient information.

Technological advances, including artificial intelligence (AI), are helping streamline workflows and have the potential to address many existing and future challenges. Automating ROI supports providers by helping reduce missed deadlines and the need to ask for extensions, keeping providers in line with their contract agreements and regulatory requirements and reducing payor-provider friction.

Automation can also enhance patient matching, helping ensure disparate patient data is linked to the right patient at the right time. Currently, due to the lack of a standard demographic data set, patient records are often not being linked together, resulting in health information being unavailable to providers at the point of treatment. Again, the panel emphasizes the importance of having an accurate patient record and its implications on payment integrity, quality reporting, and clinical care. AI will play a greater role in catching medical record errors. It won't, however, negate the need for human intervention and the need for checks and balances to ensure clinical documentation integrity and that all the necessary information is identified and shared.



Data quality begins with patient identification and matching. If an individual is not matched to their historical records, data quality could be compromised."

— JULIE PURSLEY, AHIMA

A Patient-centric Solution

The panel cites the **need for greater patient access to medical records** going forward. The ability of individuals and their caregivers to access, exchange, and use their health information is paramount to informed decision making and care management. Although most hospitals and provider organizations today provide patients with the ability to view and download their health information electronically, many patients continue to struggle with accessing their health information in a way that is seamless and timely. National policies are needed to address these challenges and should encourage the adoption and implementation of standards to provide patients seamless electronic access and control of their health information. This will result in significant benefits to patients, providers, and payors through improved patient and population health outcomes and enhanced patient safety.

Younger patients, in particular, will expect on-demand access to their health information similar to what they experience in other aspects of their lives, the panel notes. Younger patients expect convenience, speed, and accuracy, as well as privacy. Development of an e-commerce-type platform, similar to Amazon and other retail sites, would help patients access the information they need when they need it, the panel suggests. For example, patients could access the platform and request, pay, and download X-rays or other, specific portions of their medical record.

The Benefits of Prepay

The shift to prepayment reviews has the potential to eliminate many of the challenges payors and providers face with data quality and the timeliness of medical records retrieval. Prepayment reviews can detect inaccuracies in the patient record and coding errors, among other things. It can also eliminate excessive touchpoints in reconciling patient records post-pay that delay record retrieval and payment. The reduction of payor-provider friction is another benefit as claims are paid correctly the first time; providers and payors benefit because fewer resources are required to handle pre-pay reviews.

Conclusion

Medical record retrieval and procurement remains a challenge for payors, providers, and patients. Delays and noncompliance result in excessive costs and the unnecessary allocation of resources that could be directed toward population health initiatives and patient care. The solution is not simple; it will require regulatory changes and overcoming long-standing friction between payors and providers. Improving access to medical records, however, is a win-win for all stakeholders. Payors can be assured of payment integrity; providers are paid correctly and have fewer denials and re-payments; and patients benefit from the provision of safe, effective care. Technological advancements, including AI, can significantly reduce turnaround times and ensure records are complete and accurate. Finally, prepayment offers payors and providers the opportunity to ensure payment integrity upfront, rather than spending time reconciling claims, tracking down overpayments, and ultimately achieve greater claims accuracy.

KEY FINDINGS

1. **Provider organizations should consider a more centralized approach** to medical record requests, eliminating the multiple entry points that lead to significant delays.
2. **Patients need greater access to their health information** to support informed decision making and to ensure the delivery of safe, effective care.
3. **Improved access to medical records** benefits both payors and providers by eliminating waste and the unnecessary allocation of resources that can be better directed towards population health and patient care.
4. **Enhancing consumer access to their health records** is fundamental to value-based care delivery.

About AHIMA

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

www.ahima.org

About CERiS

CERiS, a leader in both prospective and retrospective claims review and repricing, combines clinical expertise and cost containment solutions to ensure the accuracy and transparency in healthcare payments. Accuracy and validation services include itemization review, DRG validation, facility repricing, contract and policy applications, review of implants and devices, and primary payor cost avoidance. Its universal chargemaster contains billions of charge items from more than 97% of the nation's hospitals, helping to ensure the accuracy and objectivity of each claim review.

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