

Submitter : Dr. Michael Maves
Organization : American Medical Association
Category : Health Care Provider/Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-115-Attach-1.PDF



Michael D. Maves, MD, MBA, Executive Vice President, CEO

January 23, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

Re: *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule; 70 Fed. Reg. 184, 55990 (Sept. 23, 2005; File Code CMS-0050-P)*

The American Medical Association (AMA) appreciates the opportunity to provide its views on the Centers for Medicare and Medicaid Services' (CMS) proposed rule concerning *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments 70 Fed. Reg. 184, 55990 (Sept. 23, 2005)*.

GENERAL

We appreciate CMS's efforts to develop a proposal to implement national standards for electronic health care claims attachments, and want to reiterate our longstanding interest in working to improve the efficiency and effectiveness of the health care system through implementation of certain health information technology. We believe that the inclusion of clear standards, comprehensive provisions, and strong safeguards, will facilitate the electronic transmission of relevant health information, thus improving quality of care, reducing errors, and improving communication between payers and providers.

As CMS continues to develop national standards for electronic health care claims, the AMA wants to express its long-standing concern regarding the confidentiality, integrity, and security of patient medical record information. The AMA believes that it is critical that any electronic attachment information submitted by physicians to health plans, either directly or indirectly through intermediaries, is protected throughout the transaction process by safeguards designed to limit access to, and use of, patient information.

American Medical Association 515 North State Street Chicago Illinois 60610
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The AMA also remains concerned about excessive and unnecessary requests for additional information, as well as unexplained delays in processing and payment by third party payers, where a completed standard claim form for reimbursement has been submitted. For this reason, the AMA believes that this rule should provide protection from unnecessary and excessive requests for additional information.

In addition, the AMA is concerned about the lack of specificity as to time frames associated with health plan requests for additional electronic attachment documentation. To date, 49 states and the District of Columbia have state laws requiring the timely payment, and in some cases, processing, of health care claims submitted by physicians, other providers of medical care, and even patients, to health plans and other entities. The AMA feels that clarification is needed regarding how the electronic attachment standards and provisions might impact these state-based patient and provider protections.

MISCELLANEOUS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), “[a] health plan that operates as a clearinghouse or requires the use of a clearinghouse may not charge for the clearinghouse service.” The AMA believes that the HIPAA provisions regarding clearinghouses should apply equally to electronic attachments. Where an electronic attachment is required for claims processing, adjudication, and payment, by a health plan that operates as a clearinghouse, or operates its own clearinghouse that must be accessed in order to submit claims and associated information to the health plan for processing, said health plan should be barred from charging for the clearinghouse service.

The AMA believes that more information regarding the result of the pilot study performed by Empire Blue Cross should be shared and assessed. Findings from the study can assist in anticipating and addressing problems that are likely to arise among physicians, transmission entities, and health plans. It will provide insight into important issues such as; the frequency with which documentation is requested both initially, and as follow-up; how easily information is shared; and how difficult it is for physicians and health care entities to implement the process. Although the study was preliminary in many ways, the AMA believes that it can offer some important insights into how the electronic attachment requirements will impact the interoperability of physician practices, as well as connectivity with clearinghouses and health plans.

II. PROVISIONS OF THE PROPOSED REGULATIONS

A. DEFINITIONS

3. CLINICAL REPORTS (pp. 55994)

With respect to the definition of Clinical Reports, the AMA proposes that Clinical Reports be changed to “Clinical Information,” as this terminology is more appropriate given that the physician is generally not required to provide the entire clinical report for the patient

encounter. Rather, the physician is being asked for, and is providing, certain limited clinical information deemed necessary to appropriately adjudicate the claim.

Although not included in the definitions section of the proposed regulations, the AMA believes that in order to encourage transparency in the process of requesting additional documentation, the term "minimum necessary" must be defined through regulation. The AMA is very concerned that absent definition, some health plans may take advantage of the electronic attachment standard to unduly burden physicians with unnecessary and attainable requests for clinical patient information.

Under HIPAA "The health plan must request no more information than it determines necessary for the purpose of the request. The physician may rely on the health plan determination and is not required to make independent determination of what information the health plan needs, unless the request is clearly unreasonable." HIPAA *does not* require physicians to give the health plan the information it requests. However, HIPAA does not provide a basis for physicians to deny requests for information either. Therefore, the AMA believes that the United States Department of Health and Human Services (DHHS) should provide some guidance to ensure health plans make appropriate requests to physicians.

Consistent with the DHHS Privacy Brief, which states that "the major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities," and the DHHS Fact Sheet: Protecting the Privacy of Patient's Health Information, which dictates that "...covered entities may use or share only the minimum amount of protected information needed for a particular purpose," the AMA believes that an entire medical record should never be requested using the electronic attachment approach and format. A report or specific question regarding a report, however, would be acceptable. Furthermore, the AMA thinks that DHHS should monitor the types, and frequency, of requests for information issued by health plans via the electronic attachment regulation.

Similarly, the AMA feels strongly that the term "one request" should be defined and clarified by regulation. The AMA is concerned that under the current proposed rule, health plans could dispense to participating physicians, via website or other means, information regarding necessary electronic attachments, which would not be considered the "one request," subjecting physicians to the possibility of a second request upon claim submission. The AMA believes that where health plans have well-documented, well-established policies regarding documentation requirements, these policies should constitute, "one request," and health plans should be restricted to "one response" to the attachment information originally submitted by the physician; rather than an additional request unrelated to the submitted documentation.

B. EFFECTIVE DATES (pp. 55994)

Under the proposed rule, covered entities, other than small health plans that have 36 months, must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule. The AMA believes that these time frames are longer than

necessary and would advocate a shorter implementation period, so long as the approved electronic attachment mediums remain as proposed.

C. OVERVIEW OF KEY INFORMATION OF ELECTRONIC HEALTH CARE CLAIMS ATTACHMENTS

6. FORMAT OPTIONS (pp. 55998)

Listed in Table 1 – Human vs. Computer Variants for Electronic Attachments, are three options available to physicians for the transfer of medical information. The options include, scanned images of pages from the medical record, natural language text with captions that match specified questions, and natural language text with captions identified by LOINC® codes and supplemented by coded information. The AMA judges that all of the aforementioned options should remain available to physicians. Solo and small physician group practices may need to rely on the faxed and/or scanned image option indefinitely due to the unavailability, for financial, staffing, or geographic reasons, of sophisticated information technology. The AMA is also concerned with the suggestion that small physician practices will adopt electronic medical records (EMR) in the near future. Decreasing reimbursements and increasing administrative costs are preventing physicians from acquiring the capital needed to invest in EMR technology, notwithstanding the establishment of pay-for-performance incentives by payers. Such flexibility, accompanying standardization, will ensure a smooth transition to the use of electronic attachments.

D. ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT BUSINESS USE (pp. 55998)

The proposed rule states that post-adjudication processes are not part of the electronic attachment requirements process. The AMA agrees with this approach. The AMA also believes that health plans should be prohibited from requesting additional information tied to post-adjudication processes when physicians have submitted additional documentation for the claim in an electronic attachment format. Any request and subsequent provision of information that meets the minimum necessary requirement should prevent a health plan from post-adjudication requests for additional information. Likewise submission of such information should limit a health plan's ability to deny or retract payment based on deficient documentation.

2. SOLICITED vs. UNSOLICITED ATTACHMENTS (pp. 55999)

Pursuant to HIPAA, “[a] health plan may not reject a transaction because it contains data that the health plan does not need.” The AMA believes that this prohibition should apply with equal force to electronic claims transactions. Furthermore, the AMA believes that what has been defined as “unsolicited requests” should be acceptable when a health plan routinely requests additional information for certain claims and/or when a health plan disseminates information regarding required documentation. When physicians know what documentation is required they often submit the necessary documentation in advance of a request. Such efforts

should be encouraged rather than penalized, as they will facilitate the exchange of claim information and expedite the adjudication and payment process. In fact, the AMA believes that health plans should be required to request, in advance, that additional documentation (electronic attachments) accompany certain types of claims and should provide this information initially or whenever a change is made regarding required documentation.

The AMA further believes that requests for additional documentation should be required in only certain limited circumstances and should be narrowly tailored. The AMA is concerned that health plans, under the proposed rule, will fail to be judicious in their requests for additional documentation, causing enormous burdens on physicians. Payers should recognize and respond to all claims and should be permitted to ask for additional information only when such information is deemed necessary based upon the physician's response to the first request. Failure to prohibit payers from continually and repeatedly requesting additional information from a physician for a single claim will undoubtedly result in significant delays in claims adjudication and payment, as well as untoward administrative hassles. Health plans should be permitted one request for information and then a second request if, and only if, the second request is based upon information garnered from the response to the first request. However, the AMA cautions that even this proscription could lead to situations in which an initial request and response generates dozens of follow-up requests and responses. Thus, the AMA feels that there needs to be a definitive point at which no additional information can be requested and/or has to be provided.

Finally, the AMA is concerned by the provision that indicates physicians can send only one attachment per request. In situations where some, but not all, of the information requested is available, physicians should be permitted to submit the accessible information initially in order to commence the adjudication process. Such a procedure has the potential to lesson any unnecessary delays associated with the request for additional information.

3. COORDINATION OF BENEFITS (pp. 55999)

The AMA believes that as suggested above with regard to primary health plans, secondary health plans should be required to inform physicians on its physician Web site or through other means of information dissemination, what its documentation requirements are for certain claims. The AMA does not believe that the primary health plan should receive the secondary health plan's requested information either directly from the physician or indirectly from the secondary health plan. Requested information and the responses to these requests should remain separate when a coordination of benefits issue ensues. The AMA believes that even if the primary health plan and the secondary health plan request the same information be sent via electronic attachment, the physician needs to directly provide each of the plans the requested information in a separate claims transaction.

4. IMPACT OF PRIVACY RULE (pp. 55999)

The AMA strongly believes that physicians own all claims data, transactional data and de-identified data created, established, and maintained by the physician practice, regardless of how and/or where such data is stored. The AMA deems physician ownership of health data to transcend claims data, and to include any data derived from a physician's medical records,

electronic health records, or practice management system. It is the physician, acting as the trusted steward of protected health information, who is required to maintain and safeguard patient health information that is submitted as part of an electronic attachment response to a health plan request for additional documentation. For this reason, the AMA strongly advocates that this rule include prohibitions against using the additional information submitted as a result of electronic attachments, for any purposes other than adjudication and payment. Such prohibitions would protect against third parties establishing and maintaining medical records and/or databases.

Moreover, the AMA thinks that CMS should provide guidance regarding when, and how much, information needs to be blacked out on electronic attachments. While the AMA is cognizant that certain information should not be submitted as part of an electronic attachment, it cautions that blacking out or otherwise trying to extract certain information can often create additional barriers to electronic transactions and further burden physicians.

In addition, under section 1178(a)(2)(B) of the Social Security Act and section 264(c)(2) of HIPAA, provisions of state privacy laws that are contrary to and more stringent than the corresponding federal standard, requirement, or implementation specification are not preempted. The effect of these provisions is to let the law that is most protective of privacy control. To the extent that these conflicts are implicated by implementation of the electronic attachment rule, the AMA would appreciate clarification from CMS on this issue.

The AMA also feels that included in the proposed rule should be a requirement that covered entities turn on their electronic audit trails in their practice management, EMR systems, etc., in order to allow for tracking of individuals access to the clinical record and PHI information. Typically, a vendor can easily comply with this request, as it is usually built into the software application.

Finally, as part of the Impact of Privacy Rule section, the rule states that “[f]or health care physicians who choose to submit attachment information in the form of scanned documents, efforts will need to be made to ensure that those documents do not contain more than the minimum necessary information.” The AMA believes that CMS should clarify that “more than the minimum necessary information,” should not include information that was previously transmitted by the physician.

5. CONNECTION TO SIGNATURES (pp.56000)

The AMA requests that any consideration of how to handle electronic signatures include guidelines and definitions that would ensure that the appropriate person in physician practice has the authority to submit responses to the health plan inquiries. This added security will help physicians monitor information submitted to the health plan. Assistance with monitoring information submitted is of particular importance as physicians will ultimately be liable for any misinformation, violations of minimum necessary requirements, unsolicited requests, and/or other adverse events that can result from submission of an electronic attachment.

G. PROPOSED STANDARDS

1. CODE SET (pp. 56004)

The AMA believes that standard implementation guidelines for code sets are essential for uniform national application of the code sets. If standard guidelines for medical code sets are adopted, many attachments would be eliminated. If health plans and physicians are permitted to implement and interpret medical data code sets as they see fit, the purpose of Administrative Simplification will not be achieved. An important part of Administrative Simplification and reduced regulatory hassle includes the simplification of instructions for the coding of health care services. The overwhelming amount of paperwork to which physicians are subject could be significantly reduced if coding is standardized and electronic transactions are facilitated. Thus, the AMA believes that the CPT guidelines and instructions should be specified as a national standard for implementing CPT codes.

The AMA believes that it is difficult for the industry to submit thoroughly comprehensive comments on the attachment standard, given the number of issues for which the Notice of Proposed Rulemaking (NPRM) is soliciting guidance and assessment. As such, the AMA is of the opinion that HHS should issue an interim final rule (or its equivalent), that includes the comments submitted in response to the NPRM's solicitations. Issuing an interim final rule that includes the submitted comments, and affording a comment period, would provide the industry with an opportunity to react to a more specific set of recommendations

We are pleased that CMS is moving forward with the adoption of standards for certain attachments to electronic health care claims and we support CMS in this effort. We appreciate the opportunity to provide our views on the implementation of the electronic attachment rule and look forward to working further with CMS on this important matter. Should you have any questions regarding these comments, please contact Carolyn Ratner, Washington Counsel, by phone, 202-789-8510, or by email, Carolyn.Ratner@ama-assn.org.

Sincerely,



Michael D. Maves, MD, MBA

Submitter : Ms. Cynthia Korman
Organization : Healthcare Financial Management Assoc, NJ Chapter
Category : Health Care Provider/Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

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See Attachment

CMS-0050-P-116-Attach-1.DOC

Healthcare Financial Management Association
New Jersey Chapter
PO Box 6422
Bridgewater, NJ 08807
January 20, 2006

Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Re: File Code CMS-0050-P

Dear Sir/Madam:

The New Jersey Chapter of the Healthcare Financial Management Association (HFMA-NJ) is submitting the following comment to the **Proposed Rule for 45 CFR Part 162 HIPAA Administrative Simplification Standards for Electronic Health Care Claims Attachments**, as published in the Federal Register, dated September 23, 2005.

HFMA-NJ is an HFMA Chapter consisting of 1059 employees at New Jersey hospitals, integrated delivery systems, nursing homes, and other health care organizations. While we have not had the chance to thoroughly review the proposed rule and develop specific comments, an executive review by HFMA-NJ raised the following significant concern:

FORMAT OPTIONS: (p 55997 middle column item 6). The proposed rule, combined with the definition of electronic media that is contained in the original HIPAA transactions final rule* gives cause for much concern. The proposed rule suggests that 24 months after the effective date of the Claims Attachment Final Rule, health care providers will in some cases no longer be able to fax paper claims attachments to health plans. This is because many entities' fax functionality allows incoming faxes to be received directly into computer systems, instead of onto paper.

Claims attachment faxing is commonly used between provider and payer organizations, especially for complex claims that are difficult and time-consuming to settle. We therefore ask that faxes from fax machines to computers be **excluded** from Section 162.1925 of the final rule. (Section 162.1925 is "Standards and Implementation specifications for the electronic health care claims attachment response transaction")

Requiring providers to convert to using computer systems rather than fax machines to support settlement of all claims will place an immediate expensive and unfair burden on them. It will also complicate what is currently a very simple and secure process. Providers that lack the financial resources to completely implement computer systems should not be prohibited from faxing paper attachments just because some of their payers have had the resources to implement greater sophistication.

We look forward to your response to this comment.

Sincerely,

John Manzi, President

**Section 162.103 of 45 CFR Parts 160 and 162 Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice defines "Electronic media" to mean "the mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dialup lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media."*

Submitter : Ms. Esther Scherb
Organization : Latham & Watkins, LLP
Category : Attorney/Law Firm

Date: 01/23/2006

Issue Areas/Comments

GENERAL

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See Attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Q. Michael Ditmore
Organization : Missouri Division of Medical Services
Category : State Government

Date: 01/23/2006

Issue Areas/Comments

GENERAL

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The Missouri Division of Medical Services is pleased to submit the attached comments in response to proposed rule CMS-0050-P entitled "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments." This rule was published in the September 23, 2005 Federal Register.

Thank for your consideration of our comments and suggestions. Please feel free to contact Joel Schnedler at 573/751-7996 if you have any questions.

CMS-0050-P-118-Attach-1.DOC

CMS-0050-P-118-Attach-2.DOC

Missouri Medicaid Comments for Claims Attachment NPRM

Commenting Organization: Missouri Medicaid
 Date Comments Submitted: 1/23/2006
 Contact Person Name: Betty Emmerich
 Contact Person Telephone: (573)751-7996
 Contact Person Email: Betty.Emmerich@dss.mo.gov

#	Document Number and Issue Identifier	Page #	Par/Fed Reg Column	LOINC	Comment or Suggested change	Business Justification
1	Federal Register Vol. 70, No. 184	55998	3		<p>COMBINED USE OF DIFFERENT STANDARDS Section D. Electronic Health Care Claims attachment Business Use – “Therefore, post-adjudication processes are not covered by this proposal.”</p> <p>Suggest adding a ‘nor are they prohibited’.</p>	If we have policies that indicate attachments are required to be sent for certain claims, regardless of whether those attachments are reviewed prior to payment or after payment we want them sent in the standard as unsolicited.
2	Federal Register Vol. 70, No. 184	56001	1		<p>PROVIDER VS PLAN PERSPECTIVE ‘, a health care provider may direct a health plan to send any request for additional documentation to it or its business associate in standard form, for those attachment types for which a standard has been adopted here, and the health plan must do so.’</p> <p>This negates the unsolicited discussion in section SOLICITED VS. UNSOLICITED ATTACHMENTS, which states ‘Health plans may also request, in advance, that additional documentation (the attachment) accompany a certain type of claim for a specific health care provider, procedure or service.’</p>	If the health plans’ policy states an attachment is required, the provider should not have the ability to require the health plan to request the information with a 275 request before they’ll send it.
3	Federal Register Vol. 70, No. 184	56001	2		<p>ATTACHMENT CONTENT AND STRUCTURE ‘One transaction is a health plan’s request for health care claims attachment information, and the other is the health care provider’s response, which includes submission of the attachment information’.</p> <p>Because unsolicited attachments are not response transactions either a third type of attachment should be listed or rewording to indicate the provider side is a response OR unsolicited submission.</p>	Health plans’ need it to be clear that unsolicited attachments are allowed and covered as a transaction within this rule.

Missouri Medicaid Comments for Claims Attachment NPRM

#	Document Number and Issue Identifier	Page #	Par/Fed Reg Column	LOINC	Comment or Suggested change	Business Justification
4	Federal Register Vol. 70, No. 184	56006	2		<p>G. Proposed Standards 3. Electronic Health Care Claims Attachment Response Transaction 'We solicit comments regarding which other attachments most impact the health care industry with respect to the exchange of clinical and administrative information, specifically for the purpose of claims adjudication.'</p>	We would like to see an 'Invoice of Cost' attachment created.
5	Federal Register Vol. 70, No. 184	56012	1		<p>H. Requirements (Health Plans, Covered Health Care Providers and Health Care Clearinghouses) 'Health plans would be required to be prepared to receive and send only the standards specified in 162.1915 and 162.1925 for the identified transactions. <u>No other electronic transaction format or content would be permitted for the identified transactions.</u>'</p> <p>This appears to exclude the ability to do Direct Data Entry (DDE) attachments, unlike previous HIPAA transactions that allowed the transaction's content only to be used for DDE methods. It appears a health plan could be over-sophisticated, as this is written, if they have DDE capability for attachments.</p> <p>Where does DDE fall into these electronic attachment transactions guidelines?</p>	We understand the need to have a batch method of submitting the attachments, however, being asked to accept an image of a paper attachment, that happens to have an X12 envelope around it, is backwards progress. It would require us to go back to manual review of attachments. If a health plan currently provides direct data entry (DDE) capability for certain attachment information, we understand that we might, at a minimum, need to modify our current DDE screens to meet standards. But, the idea that we can no longer use this functionality which truly allows automated processing of attachment fields that are entered into the DDE, is against administrative simplification.
6	Federal Register Vol. 70, No. 184	56024	1		<p>PART 162 – ADMINISTRATIVE REQUIREMENTS Subpart S – Electronic Health Care Claims Attachments - Section 162.1910 Electronic health care claims attachment request transaction. '(3) Through instructions for a specific type of health care claim which permit a health care provider to submit attachment information on an unsolicited basis each time such type of claim is submitted.'</p> <p>May these instructions be applied on a case-by-case basis rather than across the board?</p>	We require the unsolicited submission of an Ambulance Service attachment only from ambulance providers on pre-payment review status. Not <u>all</u> ambulance claims submitted to require submission of the Ambulance Service attachment. Also, we require the unsolicited submission of Clinical Notes attachment (consultation report) for all consultation services. These services are submitted on the CMS-1500. However, not all CMS-1500 claim forms submitted to us require submission of the Clinical Notes attachment.

AMBULANCE SERVICE ATTACHMENT – Pages 1 - 3

EMS Transport		Ambulance Trip Ticket		Attachment/Claim Type	Notes/Comments	
Components	Value	Card	Field	Card		
18584-3	Body weight at transport (composite)	0,1	Weight	0,1	Ambulance Attachment - Medical	Value not on all Ambulance Trip Tickets and not needed by MO Medicaid
3141-9	Body weight (measured)	0,1				
3142-7	Body weight (stated)	0,1				
8335-2	Body weight (estimated)	0,1				
15517-6	Transport Direction	1,1	Narrative/assessment are sometimes in the impression field	1,1	Ambulance Attachment - Medical	MO Medicaid relies on claim modifiers and written information on attachment
15517-6	I - initial trip	1,1		1,1		
	R - return trip					
	T - transfer trip					
	X - round trip					
15509-3	Rationale for Choice of Destination	1,1	Narrative/assessment	1,1	Ambulance Attachment - Medical	
15509-3		1,1		1,1	ER Records - Outpatient, Medical, Inpatient	
15510-1	Distance Transported	1,1	Patient Destination Actual Mileage To Scene: Mileage From Scene to Destination	1,1	Ambulance Attachment - Medical	
15510-1	Number of miles traveled during this ambulance service.	1,1		1,1		MO Medicaid covers scene to destination. Mileage needs to be separated out.
15511-9	Origination Site Information (composite)	1,1		1,1	Ambulance Attachment - Medical	
					ER Records - Outpatient, Medical, Inpatient	

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Page 2

Code	Field Name	Length	Description	Length	Notes
18580-1	Origination site name	0,1	Location of Pickup, Name of Hospital, Nursing Home, Clinic	0,1	
18581-9	Origination site address	1,1	Location of Pickup Street, Route, Highway #, City, County, State, Zip	1,1	
15512-7	Destination site Information (composite)	1,1		1,1	Ambulance Attachment - Medical ER Records - Outpatient, Medical, Inpatient
18582-7	Destination site name	0,1	Patient Destination Name of Hospital, Nursing Home, Clinic, Ambulance Service, Home, etc.	1,1	Card opposite
18583-5	Destination site address	1,1		0,1	Card opposite
15513-5	Reason for Scheduled Trip	0,1	Narrative	0,1	Ambulance Attachment - Medical ER Records - Outpatient, Medical, Inpatient
15513-5		1,1		1,1	
18815-1		0,1		0,1	
18588-4	Purpose of Stretcher	0,1			MO Medicaid Med Policy doesn't use this information
18588-4	Describing the need for a stretcher	1,1			
18589-2	Admitted at Destination Facility on Transfer	0,1			MO Medicaid Med Policy doesn't use this information
18589-2	N - No	1,1	Patient admitted to 2nd facility Y or N		
	Y - Yes		Patient admitted to 2nd facility Y or N		
15514-3	Ordering Practitioner (Composite)	0,1			MO Medicaid Med Policy doesn't use this information

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

18813-6	Ordering practitioner name	0,1			
18812-8	Ordering practitioner identifier	1,1			
18591-8	Confined to Bed Before Transport	0,1	Narrative	0,1	Ambulance Attachment - Medical ER Records - Outpatient, Medical, Inpatient
18591-8	N - No	1,1		1,1	
	Y - Yes				
18592-6	Confined to Bed After Transport	0,1	Narrative	0,1	MO Medicaid Med Policy not sui information is needed
18592-6	N - No	1,1		1,1	
	Y - Yes				
18593-4	Discharge From Originating Facility on Transfer		Narrative		MO Medicaid Med Policy not sui information is needed
18593-4	N - No				
	Y - Yes				
15515-0	Medical Reason For Unscheduled Trip	0,1	Narrative, trauma assessment, illness assessment	0,1	Ambulance Attachment - Medical ER Records - Outpatient, Medical, Inpatient
15515-0		1,n		1,n	
15516-8	Justification for Extra Attendants	0,1			MO Medicaid doesn't pay for ext attendants
15516-8	Statement justifying the use of extra attendants	1,1			

EMERGENCY DEPARTMENT ATTACHMENT – Pages 4 - 9

Deeds

Components	Value	Card	Ambulance Trip Ticket	Card	Attachment Claim Type	Notes/Comments
18710-4	Provider, Primary Practitioner (composite)	0,1		0,1	ER Records - Medical, Outpatient, Inpatient	
18711-2	Name	1,1		1,1		
18600-7	Identifier	1,1		1,1		
18601-5	Profession	0,1		0,1		
18699-9	Provider, Ed Practitioner (composite)	1,1		1,1	ER Records - Medical, Outpatient, Inpatient	
18602-3	Identifier	1,1		1,1		
18700-5	Name	1,1		1,1		
18701-3	Profession	0,1		0,1		
18702-1	Role	1,1		1,1		
18693-2	Provider, Ed Consultant Practitioner (composite)	0,n		0,n	ER Records - Medical, Outpatient, Inpatient	
11298-7	Identifier	1,1		1,1		
18694-0	Name	1,1		1,1		
11299-5	Profession	0,1		0,1		
18704-7	Provider, Ed Referring Practitioner (composite)	0,1			ER Records - Medical, Outpatient, Inpatient	
18706-2	Identifier	1,1				
18705-4	Name	1,1				
18707-0	Profession	0,1				
11288-8	Date and Time First Documented in the Emergency Department	1,1		1,1	ER Records - Medical, Outpatient, Inpatient	

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

			Run Report and Times		
			Date of Run		
11288-8		1,1	Arrive at Destination	1,1	
11459-5	Mode of Transport to Emergency Department	1,1		1,1	ER Records - Medical, Outpatient, Inpatient
11459-5		1,1	Narrative	1,1	Ambulance - Included in procedure code
11319-1	Identifier of EMS Unit Transporting Patient to Emergency Department	0,1	Crew Paramedic	Amb 1,n ER 0,n	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11319-1		1,1			? If this information is for paramedic, MO Medicaid Medical Policy uses. Card for Ambulance and ER is different.
11318-3	Identifier of EMS Transport Agency	0,1	Run Report	0,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11318-3		1,1		1,1	? If this information is for Ambulance service name and number, MO Medicaid Medical Policy uses
11293-8	Ed Referral, Source	1,1	Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11293-8		1,1		1,1	
8661-1	Patient's Chief Complaint	1,1		1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
8661-1		1,1	Crew - Chief Complaint Chief Complaint	1,1	
11371-2	Initial Encounter for Chief Complaint	1,1		1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

11371-2		1,1	Narrative	1,1	
11283-9	First Acuity Assessment	0,1	Type of Run Narrative	0,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11283-9		1,1		1,1	
11454-6	First Responsiveness Assessment	1,1	Assessment and Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11454-6		1,1		1,1	
11324-1	First Glasgow Eye Opening Assessment	1,1	Assessment and Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11324-1		1,1		1,1	
11326-6	First Glasgow Verbal Assessment	1,1	Assessment and Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11325-8		1,1		1,1	
11325-8	First Glasgow Motor Assessment	1,1	Assessment and Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical, Inpatient
11325-8		1,1		1,1	
18684-1	First Blood Pressure (composite)	1,1	Assessment and Narrative	1,1	Ambulance Attachment - Medical ER Records - Outpatient Medical,

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Inpatient

11378-7	First Systolic Pressure	1,1		1,1
11377-9	First Diastolic Pressure	1,1		1,1
18685-8	First Blood Pressure Special Circumstances	0,1		0,1

**Ambulance
Attachment - Medical
ER Records -
Outpatient Medical,
Inpatient**

18708-8	First Heart Rate (composite)	0,1	Assessment and Narrative	0,1
11328-2	Rate	1,1		1,1
11327-4	Rate Method	0,1		0,1

**Ambulance
Attachment - Medical
ER Records -
Outpatient Medical,
Inpatient**

18686-6	First Respiratory Rate (composite)	0,1	Assessment and Narrative	0,1
11291-2	Rate as Breaths per Minute	1,1		1,1
18687-4	Rate Special Circumstances	0,1		0,1

**Ambulance
Attachment - Medical
ER Records -
Outpatient Medical,
Inpatient**

18688-2	First Temperature Reading (composite)	0,1	Narrative	0,1
11289-6	First Temperature Reading	1,1		1,1
11290-4	Reading Route	0,1		0,1

**Ambulance
Attachment - Medical
ER Records -
Outpatient Medical,
Inpatient**

18690-8	First Measured Body Weight	0,1	Weight	0,1
18833-4	Measured Body Weight	1,1		1,1

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Code	Activity Associated with	Count	Category	Count	Attachment - Medical ER Records -	Attachment - Medical ER Records -
11372-0	Injury	0,n	Place of Incident	0,1	Ambulance	Ambulance
11372-0		1,1		1,1	Attachment - Medical ER Records -	Attachment - Medical ER Records -
					Outpatient Medical,	Outpatient Medical,
					Inpatient	Inpatient
11457-9	Safety Equipment in Use During Injury	0,1	Narrative	0,1	Ambulance	Ambulance
11457-9		1,n		1,n	Attachment - Medical ER Records -	Attachment - Medical ER Records -
					Outpatient Medical,	Outpatient Medical,
					Inpatient	Inpatient
18605-6	Current Medication (composite)	0,n	Narrative	0,n	Ambulance	Ambulance
18606-4	Identifier	1,1		1,1	Attachment - Medical ER Records -	Attachment - Medical ER Records -
18607-2	Dose and Unit	1,1		1,1	Outpatient Medical,	Outpatient Medical,
18608-0	Timing and Quantity	1,1		1,1	Inpatient	Inpatient
18609-8	Route	1,1		1,1		
						Prefer name over NDC
18698-1	Ed Clinical Finding (composite)	0,n	Narrative	0,1	Ambulance	Ambulance
see note	identifier and value	1,1		1,1	Attachment - Medical ER Records -	Attachment - Medical ER Records -
18697-3	Data Source	1,1		1,1	Outpatient Medical,	Outpatient Medical,
					Inpatient	Inpatient
18610-6	Ed Medication Administered (composite)	0,n		0,n	Ambulance	Ambulance
18611-4	Name and Identifier	1,1		1,1	Attachment - Medical ER Records -	Attachment - Medical ER Records -
18615-5	Dose and Units	1,1		1,1	Outpatient Medical,	Outpatient Medical,
18616-3	Strength	0,1		0,1	Inpatient	Inpatient
18614-8	Timing	1,1		1,1		

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

18612-2	Route	1,1	1,1	
18617-1	Ed Discharge Medication (composite)	0,n	0,n	ER Records - Outpatient Medical, Inpatient
18618-9	Name and Identifier	1,1	1,1	
18619-7	Dose and Units	1,1	1,1	
18620-5	Timing and Quantity	1,1	1,1	
18621-3	Route	1,1	1,1	
18622-1	Quantity Dispensed	1,1	1,1	
18623-9	Number of Refills	1,1	1,1	
19012-4	Substitution Instructions	0,1	0,1	
18624-7	ED Practitioner's Problem Statement	1,n	1,n	ER Records - Outpatient Medical, Inpatient
18624-7		1,n	1,n	

MEDICATION REPORT – Page 10

Medication
Attachment

Subject ID Code	Response Codes	Report Subject	Claim Type	Notes
34483-8		Current, Discharge, or Administered Medications	Medical, Outpatient, Inpatient, Home Health	MO Medicaid Medical Policy does not review Medication. If present on attachment, may use for claim determination.
19013-2		Medications Current Report	Medical, Outpatient, Inpatient, Home Health	MO Medicaid Medical Policy reviews information per system edits.
	19009-0	Medications Current (Narrative) (Reported)		
	18605-6	Medication Current (Composite) (Reported)		
19014-0		Medications Discharge Report		MO Medicaid Medical Policy does not review.
	19010-8	Medication Discharge (Narrative)		
	18617-1	Medication Discharge (Composite)		
19015-7		Medications Administered Report	Medical, Outpatient, Inpatient, Home Health Claims. Ambulance Trip Ticket	Med. Policy doesn't review Medication. If present on attachment, may use for claim determination.
	19011-6	Medication Administered (Narrative)		
	18610-6	Medication Administered (Composite)		

LABORATORY RESULTS – Page 11

Lab Result

Code	Report Subject	Claim Type	Notes
26436-6	All Laboratory Studies (Set)	Medical, Outpatient and Inpatient	All laboratory tests MO Medicaid Medical Policy is required to review are present.
18716-1	Allergy Test		
18717-9	Blood Bank Tests		
18767-4	Blood Gas Tests		
18718-7	Cell Marker Tests		
18719-5	Chemistry Test		
26437-4	Chemistry Challenge Studies		
18720-3	Coagulation Tests		
26438-2	Cytology Studies		
18722-9	Fertility Tests		
18723-7	Hematology Tests + Cell Counts		
18724-5	HLA Tests		
18725-2	Microbiology Tests		
26435-8	Molecular Pathology Studies		
18727-8	Serology Tests		
26439-0	Pathology Reports Sections + Stains		
18721-1	Toxicology + Therapeutic Drug Monitoring Test		
18729-4	Urinalysis Studies		

CLINICAL NOTES – Pages 12 – 21

Clinical Notes

Cardiac Echo Study - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
11522-0	Cardiac Echo Study	0,1	0,1	MO Medicaid Med Policy reviews suspect dupe exception. Staff validate who performed the test.
18106-5	Cardiac Echo Study, Procedure	0,1	0,1	
18836-7	Cardiac Stress Study, Procedure (narrative)	0,1	0,1	
18146-1	Cardiovascular Central, Study Observation Overall (narrative)	0,1	0,1	

EKG Study - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
11524-6	EKG Study	0,1	0,n	opposite card (multiple in a day) MO Medicaid Med Policy reviews Suspect Dupe exception. Depending on diagnosis, information may not be needed.
18843-3	Heart, Comparison Study (narrative) (EKG)	0,1	0,n	
8598-5	Heart, Comparison Study Date and Time (EKG)	0,1	0,n	
18844-1	Heart, EKG Impression (narrative) (EKG)	0,1	0,n	

Obstetrical Study - Information Med. Policy Reviews

Code	Study	Card	Med. Policy Card	Notes
11525-3	Obstetrical Ultrasound Study	0,1	0,n	opposite card (complications may need two in a day, twins may need one for each baby). MO Medicaid Med Policy reviews Abortion claims and suspect dupe claims
11778-8	Delivery Date (clinical estimate)	0,1	0,1	
11779-6	Delivery Date (estimated from last menstrual period)	0,1	0,1	
11780-4	Delivery Date (estimated from ovulation date)	0,1	0,1	
11781-2	Delivery Date (ultrasound composite estimated)	0,1	0,1	
11627-7	Fetus Amniotic Fluid, Index Sum Length (ultrasound derived)	0,1	0,n	
12167-3	Fetus Amniotic Fluid, Volume Amniotic Fluid (ultrasound)	0,1	0,n	
11768-9	Fetus, Body Weight Percentile Range Percentile (categorization by comparison with standards)	0,1	0,n	
11883-6	Fetus, Gender Finding (narrative) (ultrasound)	0,1	0,n	
11884-4	Fetus, Gestation Age (clinical estimate)	0,1	0,n	
11885-1	Fetus, Gestational Age (estimated from last menstrual period)	0,1	0,n	
11886-9	Fetus, Gestational Age (estimated from ovulation date)	0,1	0,n	
11887-7	Fetus, Gestational Age (estimated from selected delivery date)	0,1	0,n	
11948-7	Fetus, Heart Rate (ultrasound measured)	0,1	0,n	
11957-8	Fetus, Length Crown Rump (ultrasound measured)	0,1	0,n	
12130-1	Fetus, Study Observation General (narrative) (ultrasound)	0,1	0,n	

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

11878-6	Fetuses (ultrasound)	0,1	0,n
11955-2	Last Menstrual Period Date and Time (reported)	0,1	0,1
12128-5	Ultrasound Fetus Yolk Sac, Study Observation (narrative)	0,1	0,n

Clinical Notes/Reports - Information Med. Policy Reviews

Code	Summary	Card	Med Policy Card	Notes
11490-0	Physician Hospital Discharge Summary	0,1	0,1	MO Medicaid Med. Policy reviews exception 902, 704, and suspect dupe exceptions
8656-1	Hospital Admission Date	0,1	0,1	
18841-7	Hospital Consultations (narrative)	0,1	0,1	
8649-6	Hospital Discharge Date	0,1	0,1	
8650-4	Hospital Discharge Disposition (narrative)	0,1	0,1	
18771-6	Provider Signing - name	0,1	0,1	

Operative Note - Information Med. Policy Reviews

Code	Note	Card	Med Policy Card	Note
11504-8	Operative Note	0,1	0,N	Opposite Card (may need to have more than one surgery if sick). MO Medicaid Med Policy reviews exception 800, 433, 436 and suspect dupe. Does this include Anesthesia?
8723-9	Date Surgery	0,1	0,1	
10219-4	Operative Note -preoperative DX (narrative)	0,1	0,n	
10218-6	Operative Note - Postoperative DX (narrative)	0,1	0,n	

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

10223-6	Operative Note -Surgical Procedure (narrative)	0,1	0,n
10213-7	Operative Note _Anesthesia (narrative)		
8722-1	Operative Note _Anesthesia	0,1	0,n
8717-1	Operative Note - estimated Blood Loss Vol		
11537-8	Operative Note - Surgical Drains (narrative)	0,1	0,n
10221-0	Operative Note - Specimens Taken (narrative)		
10830-8	Operative Note-Complications	0,1	0,n
10215-2	Operative Note -Findings	0,1	0,n
8724-7	Operative Note - Surgery Description	0,1	0,n
10214-5	Operative Note - Anesthesia Duration	0,1	0,n
18772-4	Surgeon Resident - name	0,1	0,1
18773-2	Surgeon Staff - Name	0,1	0,n

Provider Unspecified History and Physical Note - Information Med. Policy Reviews

Code	Note	Card	Med Policy Care	Note
11492-6	History and Physical Note	0,1	0,1	MO Medicaid Med Policy reviews exception 154, 155, 707, 902 and suspect dupe exceptions. May need to talk with medical consultant about exception 528 and 529.
10154-3	Chief Complaint	0,1	0,1	
10164-2	History of Present Illness	0,1	0,1	
11348-0	History of Past Illness	0,1	0,n	card is opposite (if narrative, list illnesses)
10162-6	History of Pregnancies	0,1	0,n	

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

11449-6	Pregnancy Status	0,1	0,1	
8665-2	Date Last Menstrual Period	0,1	0,1	
10167-5	History of Surgical Procedures	0,1	0,n	opposite card (if narrative, more than one surgery in a life time)
10187-3	Review of System	0,1	0,1	

Cervical Spine X-Ray - Information Med. Policy Reviews

Code	X-Ray Study	Card	Med Policy Card	Notes
24946-6	X-Ray Cervical Spine Study	0,1	0,n	opposite card (2 different doctors in one day or same doctor multiple x-rays) MO Medicaid Med Policy reviews suspect dupe exceptions.
18785-6	Radiology Reason For Study	0,1	0,n	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,n	
19005-8	Radiology - Impression	0,1	0,n	If this represents results, MO Medicaid Med Policy needs. MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?
11489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	same as above
18771-6	Provider Signing - Name	0,1	0,1	same as above
11513-9	Provider Signing - Identifier	0,1	0,1	same as above

CT Study Head - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
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Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

11539-4	CT Head Study	0,1	0,n	
18785-6	Radiology Reason For Study	0,1	0,n	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,n	
19005-8	Radiology -Impression	0,1	0,n	
11489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	Opposite card (2 different doctors in one day or same doctor multiple x-rays) MO Medicaid Med. Policy reviews exception 436 and suspect dupe.
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	If this represents results, MO Medicaid Med Policy needs.
18771-6	Provider Signing - Name	0,1	0,1	MO Medicaid Med. Policy needs to know who performed the study.
11513-9	Provider Signing - Identifier	0,1	0,1	Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?

CT Study Extremity - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
24690-0	CT Extremity Study	0,1	0,n	
18785-6	Radiology Reason For Study	0,1	0,n	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,n	
19005-8	Radiology -Impression	0,1	0,n	
				Opposite card (different areas of the body - arms and legs, left and right) MO Medicaid Med Policy reviews exception 436 and suspect dupe.
				If this represents results, MO Medicaid Med Policy needs.

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

14489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	" "
18771-6	Provider Signing - Name	0,1	0,1	" "
11513-9	Provider Signing - Identifier	0,1	0,1	" "

MRI Study Head - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
11541-0	MRI Head Study	0,1	0,1	Card - 0,1 for head but if MRI is for other parts of the body 0,n MO Medicaid Med Policy reviews exception 436 and suspect dupe.
18785-6	Radiology Reason For Study			
18779-9	Radiology Comparison Study - Date and Time	0,1		
18834-2	Radiology Comparison Study - Observation	0,1		
19005-8	Radiology -Impression	0,1		If this represents results, MO Medicaid Med Policy needs.
14489-2	Provider, Dictating Practitioner - Identifier	0,1		MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?
18770-8	Provider, Dictating Practitioner - Name	0,1		same as above
18771-6	Provider Signing - Name	0,1		same as above
11513-9	Provider Signing - Identifier	0,1		same as above

Mammogram Screening Study - information Med. Policy reviews

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Code	Study	Card	Med Policy Card	Notes
24606-6	Mammogram Screening Study	0,1	0,1	MO Medicaid Med. Policy reviews suspect dupe exceptions.
18785-6	Radiology Reason For Study	0,1	0,1	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,1	
19005-8	Radiology -Impression	0,1	0,1	If this represents results, MO Medicaid Med Policy needs.
14489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	same as above
18771-6	Provider Signing - Name	0,1	0,1	same as above
11513-9	Provider Signing - Identifier	0,1	0,1	same as above

Nuclear Medicine Bone Scan Study - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
25031-6	Nuclear Medicine Bone Scan Study	0,1	0,1	MO Medicaid Med Policy reviews suspect dupe exception.
18785-6	Radiology Reason For Study	0,1	0,1	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,1	
19005-8	Radiology -Impression	0,1	0,1	If this represents results, MO Medicaid Med Policy needs.
14489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Page 20
who?

18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	same as above
18771-6	Provider Signing - Name	0,1	0,1	same as above
11513-9	Provider Signing - Identifier	0,1	0,1	same as above

CT Guidance for Aspiration Study, Unspecified Site - Information Med. Policy Reviews

Code	Study	Card	Med Policy Card	Notes
25043-1	CT Guidance for Aspiration of Unspecified Site Study	0,1	0,n	Opposite card (several areas of the body) MO Medicaid Med Policy reviews suspect dupe exception.
18785-6	Radiology Reason For Study	0,1	0,n	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,n	
19005-8	Radiology -Impression	0,1	0,n	If this represents results, MO Medicaid Med Policy needs. MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate
14489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	who?
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	same as above
18771-6	Provider Signing - Name	0,1	0,1	same as above
11513-9	Provider Signing - Identifier	0,1	0,1	same as above

Ultrasound Study of Neck - Information Med Policy Reviews

Missouri (MO) Medicaid Review of Electronic Health Care Claim Attachments

Code	Study	Card	Med Policy Card	Notes
24842-7	Ultrasound Neck Study	0,1	0,1	Opposite Card (Card - 0,1 for neck but if Ultrasound is for other parts of the body 0,n) MO Medicaid Med Policy reviews suspect dupe exception.
18785-6	Radiology Reason For Study	0,1	0,1	
18779-9	Radiology Comparison Study - Date and Time	0,1	0,1	
18834-2	Radiology Comparison Study - Observation	0,1	0,1	
19005-8	Radiology -Impression	0,1	0,1	If this represents results, MO Medicaid Med Policy needs. MO Medicaid Med. Policy needs to know who performed the study. Does the information in 11489-2,18770-8, 18771-6, 11513-9 indicate who?
14489-2	Provider, Dictating Practitioner - Identifier	0,1	0,1	
18770-8	Provider, Dictating Practitioner - Name	0,1	0,1	same as above
18771-6	Provider Signing - Name	0,1	0,1	same as above
11513-9	Provider Signing - Identifier	0,1	0,1	same as above

Submitter : Ms. MaryAnne Zingaro
Organization : BlueCross BlueShield of FL
Category : Health Plan or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

There are many attachment types that have not yet been developed into HL7 attachment booklets. Because the standards organizations rely upon industry volunteers to support work efforts, development of the booklets may take many years. The X12 transactions will support sending of scanned document attachments when the HL7 booklet work is not yet complete, as long as a LOINC code has been established to identify document content. We recommend LOINC codes be established for each document type with industry value.

Examples of a few attachment types that could be identified by a LOINC code are:

Home Health Treatment Plans

Durable Medical Equipment (for example, one LOINC for each of the major categories of DME, such as Manual Wheelchairs, Motorized Wheelchairs, Oxygen, Infusion Pumps, etc.)

Other Certificates of Medical Necessity

Skilled Nursing documents

Assignment of identified attachment type LOINC codes would permit the industry to use the attachment transactions for virtually any required document prior to creation of the HL7 HVA and CVA structures, and provide an a smooth migration to the HL7 Human or Computer Variant when new booklets are approved.

Submitter : Ms. Esther Scherb
Organization : Latham & Watkins, LLP
Category : Attorney/Law Firm

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. This is related to the early submission from Esther Scherb (the attachment was neglected in the first submission).

CMS-0050-P-120-Attach-1.PDF

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LATHAM & WATKINS LLP

January 23, 2006

VIA ELECTRONIC MAIL

Michael O. Leavitt
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G 200
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Washington, D.C. 20201

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File No. 025149-0000

Re: CMS—0050—P: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments (Comments on DEFINITIONS; ELECTRONIC CLAIMS ATTACHMENT TYPES; FORMAT OPTIONS; and SOLICITED vs. UNSOLICITED ATTACHMENTS)

Dear Secretary Leavitt:

On behalf of Kinetic Concepts, Inc. (“KCI” or the “Company”), a global medical technology company that designs, manufactures and provides advanced wound care products, we submit these comments to the above-referenced proposed rule. On September 23, 2005, the Department of Health and Human Services (“HHS”) published in the Federal Register proposed Electronic Data Interchange (“EDI”) standards that would be used to transfer health information between health care providers and health care plans.¹ As a Medicare Part B supplier and a health care provider, KCI appreciates the opportunity to offer its comments and provide suggestions to HHS’s proposed EDI standards.

Background

This proposed rule plays a significant role in the trend towards electronic medical records. HHS has proposed adoption of standards to facilitate electronic interchange of clinical and administrative data to improve claims adjudication when additional information beyond the health care claim itself is required. This is part of HHS’s efforts to implement the Administrative Simplification aspects of HIPAA, in particular those requiring adoption of standards for electronic submission of claims attachments.

¹ 70 Fed. Reg. 55990 (Sept. 23, 2005).

LATHAM & WATKINS LLP

HHS proposes two transaction types: (1) the health care claims attachment *request* transaction, in which the health care plan requests additional information be provided along with a specific claim or type of claim, and (2) the health care claims attachment *response* transaction, in which the health care provider furnishes the requested information to the health plan. HHS also proposes two sets of standards to transmit health information between provider and plan: one for the transfer of administrative data (here, ASC X12 has been proposed), and one for the transfer of clinical data (HL7 has been proposed). Each transaction would involve use of both sets of standards. In addition, each would involve use of Logical Observation Identifiers Names and Codes ("LOINC") codes and modifiers, as well as narrative text.² LOINC would be the code set that provides standardized names and codes for requesting clinical information and identifying clinical results. In particular, LOINC codes would be used to identify the attachment information being requested and the information being furnished.³

KCI supports HHS's efforts to adopt reasonable, practical EDI standards that will permit exchange of clinical data and render more efficient health care claims processing. KCI supports HHS's approach to development of EDI standards in three main areas:

- (1) The proposed definition of attachment information to which the proposed rule would be applied;
- (2) The proposal to permit providers to submit electronic health care claims attachments for clinical reports, laboratory results or medications, and the anticipated inclusion in the future of specifications for durable medical equipment documentation; and
- (3) The flexibility afforded as to how electronic health care claims attachment information is submitted to health care plans, including the use of scanned or imaged documents containing clinical information.

The Company is concerned that the proposed prohibition on submission of unsolicited

² As to the request transaction, HHS proposes to adopt the ASC X12N 277 (Health Care Request for Additional Information, Version 4050, May 2004, Washington Publishing Company, 004050X150). To convey the LOINC codes identifying which clinical reports are being requested, the CDAR1AIS0004R021 AIS 0004: Clinical Reports Attachment (Release 2.1, based on HL7 CDA Release 1.0) would be used. For the response transaction, HHS proposes to adopt the ASC X12N 275 (Additional Information to Support a Health Care Claim or Encounter, Version 4050, May 2004, Washington Publishing Company, 004050X151). The HL7 AIS Implementation Guide (Release 2.1) would be used to implement HL7 AIS to convey attachment information within the binary data segment of the ASC X12N 275 form. To convey the LOINC codes that identify the clinical records attachment and specific attachment information being sent, the CDAR1AIS0004R021 AIS 0004: Clinical Reports Attachment, (Release 2.1, based on HL7 CDA Release 1.0) would be used.

³ If the provider furnishes scanned images and text documents in its submission to the plan, *i.e.*, using a human decision variant-type method, discussed below, the proposed rule specifies that LOINC codes would not need to be entered to provide clinical information. The provider would only enter the LOINC codes used in the request from the plan to indicate which request the attachments were responsive to and with which they should be associated. 70 Fed. Reg. at 56024 (proposed 45 C.F.R. § 162.190(d)).

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attachments and the proposed limitation on responses that a provider can furnish to a plan's request are unduly restrictive. KCI requests that a more flexible requirement be adopted. Specifically, there should be an opportunity for providers in certain circumstances to submit additional information for initial adjudication of claims, even if not requested by the plan. KCI also believes that providers should be permitted to submit a second response to a request for attachment information where information that was not available at the time of the provider's first response becomes available. Finally, KCI believes that there should be safeguards in place so that providers have an ability to track any pending request transaction. We discuss each comment in turn below.

Types of Electronic Claims Attachments

[(Comments on "DEFINITIONS" and "ELECTRONIC CLAIMS ATTACHMENT TYPES")]

The proposed standards would apply to "attachment information," defined as the "supplemental health information needed to support a specific health care claim."⁴ HHS underscores that attachments are not required for every claim; rather, attachments covered by the proposed rule are those submitted prior to and required for the initial payment for the claim:

Attachments may be requested or submitted [1] when the supplemental medical information is directly related to the determination of benefits under the subscriber's contract, or [2] when directly related to providing medical justification for health care services provided to the individual when that medical justification can affect the adjudication of payment for services billed by the provider of health care services.⁵

Based on industry feedback, HHS's proposed rule requires that attachment information be used only for health care claims for the following three services: ambulance services, emergency department services or rehabilitation services. Alternatively, the additional information may be for one of the following three types of information: clinical reports, laboratory results, or medication.⁶ HHS proposes to define "clinical reports" to mean "reports, studies, or notes, including tests, procedures and other clinical results, used to analyze and/or document an individual's medical condition."⁷ KCI believes that the attachment information described captures the relevant additional clinical information that health care providers generally would need to submit to substantiate medical necessity of an item or service. KCI believes that there is also a need for specifications for attachment information to support durable medical equipment claims. The proposed rule indicates that an HL7 workgroup has been developing standards for this type of attachment. KCI welcomes the opportunity to provide input on any such standards prior to their implementation.

⁴ 70 Fed. Reg. 55990, 56023 (proposed 45 C.F.R. § 162.1900) (Sept. 23, 2005).

⁵ *Id.* at 55998.

⁶ *Id.* at 56024 (proposed 45 C.F.R. § 162.1905).

⁷ *Id.* at 56023 (proposed 45 C.F.R. § 162.1900).

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Methods for Submitting Electronic Claims Attachments
[(Comments on "FORMAT OPTIONS")]

HHS expects that providers would be given options for supplying additional information to health care plans. In the preamble to the proposed rule, HHS states that "[h]ealth care providers would also be given considerable latitude on how to submit the information—with either narrative text, scanned documents or with fully coded data."⁸ The EDI standards proposal would permit providers to use one of three different methods to transmit information to health plans. These methods of transmittal in turn are categorized according to whether a human or a computer would review the attachment and make a decision as to whether payment would be made or denied—termed Human Decision Variants and Computer Decision Variants, respectively. The two Human Decision Variants are (1) scanned or imaged documents that would need to be reviewed physically by the recipient; and (2) narrative text typed into an electronic document that would be reviewed by the recipient. The Computer Decision Variant is coded data that would be read and interpreted by the computer. This variant allows for auto-adjudication, so that, for instance, payment decisions could be made using automated processing rules.

KCI supports the adoption of EDI standards that permit health care providers to furnish the additional information needed to adjudicate claims in a number of different ways. Flexibility is needed because of the vastly differing technological capabilities of providers and the variety of kinds of additional documentation that is needed to support claims. KCI requests that HHS ensure that the standards adopted permit providers to use a scanning mechanism to transmit medical records, as this is a common and simple way to transmit information. As stated above, the standards proposed permit this type of transmission and KCI agrees that this option should be adopted. HHS should also ensure that any future update to adopted standards includes the ability to submit scanned documents.

Submission of Certain Unsolicited Attachments and Limitation on Responses Provided
[(Comments on "SOLICITED vs. UNSOLICITED ATTACHMENTS")]

HHS proposed that only "solicited attachments" would be permitted to be submitted. A health care claims attachment response transaction is defined as "the transmission of attachment information, from a health care provider to a health plan, *in response to a request from the health plan for the information.*"⁹ The proposed regulation states that a health plan would be permitted to make an electronic health care claims attachment request in three circumstances: (1) upon receipt of a health care claim; (2) in advance of submission of a claim; and (3) through instructions for a specific type of claim that permit a supplier to submit an attachment on an unsolicited basis each time that type of claim is submitted.¹⁰ Providers would only be able to transmit attachments in response to a request made in one of those circumstances. HHS further

⁸ *Id.* at 55998.

⁹ *Id.* at 56024 (proposed 45 C.F.R. § 162.1920(a)) (emphasis added).

¹⁰ *Id.* at 56024 (proposed 45 C.F.R. § 162.1910(a)).

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clarified that providers could only transmit unsolicited electronic attachments along with an initial claim if the provider had been given "specific advance instructions pertaining to that type of claim or service" or with respect to the particular claim at issue.¹¹ Indeed, the proposed regulation specifies that "[a] health care provider may submit an unsolicited response transaction only upon advance instructions by a health plan."¹²

KCI believes that this proposed requirement should be amended. "Advance instructions" should include policy statements by the health plan that constructively advise providers as to additional documentation that is needed to adjudicate a claim. For instance, a policy may state that a claim for an item or service is evaluated based upon individual consideration in certain specified circumstances. The provider should be permitted to submit attachment information for items or services in such situations. In addition, it is not uncommon for plans to request additional documentation prior to adjudicating a claim even though there are no advance instructions. If a particular issue is being reviewed, often plans will require additional information for all similarly-situated claims. In other words, in certain circumstances, providers can fairly anticipate that additional information will be requested for future claims involving the same or similar issue. The standard adopted should explicitly permit providers to transmit additional information in this situation. KCI suggests that HHS revise the exception for unsolicited response transactions in proposed 45 C.F.R. § 162.1920(e) to state:

A health care provider may submit an unsolicited response transaction only upon advance instructions (including policies) by a health plan *or where the health care provider has received a request on similarly-situated previous claims and reasonably anticipates a request for the subsequent claim or claims.* (Revisions requested in italics.)

A second parameter that KCI believes should be revised is HHS's proposal to limit health plans to one electronic transaction request for additional information and providers to one response to such request.¹³ HHS indicated that this restriction is intended to simplify and make more efficient claims processing by decreasing the number of submissions for each claim. While in many instances it may be advisable and feasible for a provider to submit all additional attachment information requested in a single response, this is not always the case. Additional clinical information not infrequently becomes available after an initial submission has been made (for instance, because a physician's office or facility that had been slow to provide requested information does so). A provider should be able to put such information before the plan for its consideration in order to ensure appropriate adjudication of the claim involved. KCI suggests that proposed 45 C.F.R. § 162.1920(c) be revised to state:

A health care provider that conducts health care claims attachment response transaction using electronic media must submit a complete

¹¹ *Id.* at 55999, 56024.

¹² *Id.* at 56024 (proposed 45 C.F.R. § 162.1920(e)).

¹³ *Id.* at 55999, 56024 (proposed 45 C.F.R. § 162.1920(c)).

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response by providing, to the extent available, all of the requested attachment information or other appropriate response in the transaction. *If additional attachment information later becomes available, the health care provider may transmit such attachment information through a second or subsequent response transaction.* (Revisions requested in italics.)

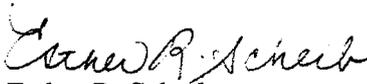
Claims Status Inquiry Capability

KCI believes that plans should be required to have claims status inquiry capability so that providers can check whether a request for attachment information has been submitted. There is a concern that a plan could send a request that the provider does not receive. To avoid a provider being penalized in such situation (for instance, for missing a response deadline), the Company requests that HHS add a requirement that health plans using the electronic health care claims status attachment request transaction set up and ensure proper functioning of a claims status inquiry system that providers could access to determine the status of its claims and, in particular, whether the plan has asked for additional information. This could be accomplished by adding a new subsection (e) to 45 C.F.R. § 162.1910 addressing the need to establish such an inquiry capability.

At this juncture, we note that KCI would welcome an opportunity to partner with HHS in a pilot program to further explore administrative simplification of EDI. For instance, KCI would consider using an electronic system that would permit Medicare contractors, such as the Durable Medical Equipment Medicare Administrative Contractors—the contractors responsible for administration of Medicare Part B durable medical equipment claims—to access KCI's electronic files through an encrypted server.

Thank you in advance for your consideration of these comments. Should you wish to obtain additional information, please do not hesitate to contact me at (202) 637-2266.

Very truly yours,


Esther R. Scherb
Of LATHAM & WATKINS LLP

cc: Kinetic Concepts, Inc.
Stuart S. Kurlander, Latham & Watkins LLP

Submitter : Ms. Patricia Merryweather
Organization : Illinois Hospital Association
Category : Health Care Professional or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-121-Attach-1.DOC



January 23, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-0050-P
P.O. Box 8014
Baltimore, Maryland 21244-8014

RE: CMS-0050-P HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule (70 Federal Register 55990) September 23, 2005.

Dear Dr. McClellan,

On behalf of our 200 member hospitals and health care systems, the Illinois Hospital Association (IHA) appreciates the opportunity to comment on the proposed rules for standards on electronic health care claims attachments as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

While we support several of the recommendations of the proposed rules, we also are once again concerned that there is a lack of business rules governing the HIPAA rules. That is, the usage of an attachment should be a rare occurrence and not routine. If it is a routine practice and will be required on all claims of a particular condition, then the reporting requirements should fall under the actual HIPAA claim, the 837, than under an attachment.

Current Limitations of Health Plans Effecting Provider ROI

IHA members continue to be concerned about the overall lack of usage of the features of the 837 claim and find that many health plans can readily have their issues resolved if they would only read in and process the data currently required to be reported to them. For example, while providers are required to submit up to and including 25 diagnostic and 25 procedure codes, most health plans only process 9 diagnostic codes and 6 procedure codes thereby reducing the understanding of the complexity of the patient's condition and often times reducing payments to providers. One of the largest health plans that requires all 25 codes to be reported but only processes the first 9 diagnostic codes and first 6 procedure codes is Medicare.

Business Rules Required

We remain extremely concerned that the amount of resources required to implement the attachments is significant and that providers remain concerned about receiving a return on investment for both the 837 and the attachments. While HIPAA has not in the past addressed business rules or processes, the fact that attachments are subject to be required

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David Schertz
Rockford
Connie Schneider
Peoria
Kathleen Yosko
Moline

when a health plan decides they need them, could serve to delay payments and not allow a hospital to operate efficiently. There needs to be business rules and guidance around the usage of attachments and under what circumstances they will be required. Providers are extremely concerned that there are large amounts of dollars involved in building the systems and programs for the attachments and there appears to be no return on investment.

Formal Process Needed for Coordination with 837 and Future Modifications

Additionally, there is no formal process for coordination of attachments with the 837 and therefore there are redundancy of information requirements and inefficient solutions being proposed. IHA strongly recommends that the process using the Data Standards Maintenance Organizations (DSMOs) established under federal rule, be utilized for this purpose. The DSMOs have a well established process for under-taking and reviewing requests and for coordinating activities to allow for the most efficient approach to be utilized by a requestor.

Effective Date (page 55994)

Given the amount of programming involved and the need for testing and training, a minimum of a three year time frame is needed from the time the final rules are issued.

Tied to the date issue, is the concern over reference to a Version 4050 which at the point of implementation will be **Version 5010**. IHA strongly recommends that the versions be in sync with practice at time of implementation.

Electronic Claim Attachment Types (Pages 55996 – 55997)

It is unclear why emergency services are being requested to have emergency room notes reported. According to hospitals, this is a very rare occurrence as the 'patient's reason for visit' was added to the 837/UB format in 1999 and it is a rare occurrence for health plans now to need emergency notes.

Rather than focus on the rare occurrences which have no return on investment, it would be best to focus on the attachments that have delayed payments and are increasingly being required by health plans. These occurrences include: Secondary Payer Questionnaire, Sterilization Consent Forms, Medicaid Spend Down Forms, and DME – Medical Necessity.

Thank you for the opportunity to comment on the proposed rule for electronic claims attachments. If you have questions or require further explanation of our membership issues, please contact me by telephone at 630-276-5590 or by e-mail at pmerryweather@ihastaff.org.

Sincerely,

Patricia Merryweather
Senior Vice President

Submitter : Dr. Mureen Allen
Organization : American College of Physicians
Category : Health Care Professional or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Mureen Allen
Organization : American College of Physicians
Category : Health Care Professional or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-123-Attach-1.PDF

ACP

AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

January 10, 2006

Office of the Secretary
Department of Health and Human Services
Attention: CMS-0050-P
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule, 45 CFR Part 162, CMS-0050-P, (September 23, 2005)

To Whom It May Concern:

The American College of Physicians (ACP), representing over 119,000 doctors of internal medicine and medical students, appreciates the opportunity to submit comments on the proposed rule: *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule*, published in the Federal Register dated September 23, 2005. This proposed rule would establish new standards for electronically requesting and sending additional health care information to support submitted health care claims data. In addition, we recognize the importance of this rule as it helps to simplify and expedite the health care claims adjudication process when additional documentation is requested to support the original claim.

We appreciate this opportunity to provide comments about the adoption of this rule as it will allow our members to reap the rewards from the standardization of the claims adjudication process. In this proposal we recognize the Centers for Medicare & Medicaid Services' (CMS) attempt to increase the adoption of information technology, however those who use the technology the least but stand to benefit the most, will face significant obstacles in attempting to comply with this proposal without some modification and additional consideration. Further, the College recognizes the potential to facilitate the auto-adjudication of claims for those who possess Electronic Medical Records (EMRs) will significantly reduce their administrative costs but the process of electronic claims attachments may present an onerous burden on providers with small offices (a significant number of our members) and therefore defeat the intention of accelerating the adoption of health care information technology and the development of the national electronic health information system.

SUMMARY OF RECOMMENDATIONS

- We propose a pilot or the publication of the results of any previous pilots to fully evaluate the implications to health care providers, health plans, and clearinghouses as they attempt to comply at the *practical* level.
- We further recommend that when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.
- We propose as part of the rule that CMS consider establishing an expedited procedure for the adoption of other claims types for industry use.
- We also recommend that large imaged or scanned documents be imbedded in the X12 transaction as compressed or zipped file format. This will ultimately reduce the size of the file that will be stored on servers and computers, and in addition, facilitate the reduction of upload, transmission, and download times of the files
- In addition, we request the exemption of computerized faxes used in response to a request for additional information, as a form of electronic transmission.
- We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.
- We propose that health plans be specific about documentation needed for prior authorization of visits, procedures, and medications and if physicians requested and received prior authorization they should send the pre-specified documentation in the original claim. Prior authorization should be sufficient to adjudicate a claim and physicians should not be required to send additional information to adjudicate the claim further.
- We request (as a practical consideration) that physicians who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision.
- We recommend that there should be a standard field/code that will allow the physician to indicate that he does not have the documentation and/appeal the request.

GENERAL COMMENTS

We believe the standardization of the electronic claims attachment process will speed up the adjudication of claims. This will be beneficial to health plans, clearinghouses, and healthcare providers. We are concerned however, that certain aspects of this proposal will be burdensome for many providers and will act as a deterrent to its use and ultimately the adoption of EMRs.

It is our contention that those who will reap the greatest benefit from this rule are those who have invested or plan to invest in EMRs and benefit from auto-adjudication. For these physicians the implementation of this rule will result in significant administrative savings and expedited reimbursement. However, for a significant number of our members, who do not have EMRs and choose to comply, there are aspects of this proposal that will pose significant challenges.

The ACP offers the following comments on the proposed rule:

SPECIFIC COMMENTS & RECOMMENDATIONS

EFFECTIVE DATES (p. 55994)

Though we recognize the need to standardize the claims attachment process and although this rule proposes to take effect in two years for large health plans and three years for smaller ones, we think that prior to full implementation there should be some attempt to pilot the application of this proposal to ensure that all aspects of this process effectively interact and to clarify the necessary processes for providers --- both those in large and small practices, and those using and not using EMRs --- to implement realistically these claim attachment procedures. It would also be helpful if CMS would include in the final rule the results of any pilots that have been previously conducted. Further, when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.

Recommendations:

- We propose a pilot or the publication of the results of any previous pilots to fully evaluate the implications to health care providers, health plans, and clearinghouses as they attempt to comply at the *practical* level.
- We further recommend that when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.

ELECTRONIC CLAIMS ATTACHMENT TYPES (p. 55996)

We agree that covered entities need to gain experience with implementing and using an initial proposed set of claims attachment types for the initial rollout of this rule. In addition, we agree that there is a subset of information that will be common to most claims attachments. We propose that CMS should identify a standardized methodology to facilitate the adoption of other claims attachment types at a later date. We think that leaving the adoption of other types to ad hoc voluntary agreements between covered entities will negate the benefits of adopting standardized claims types and the standardization of the electronic claims attachment process. We think that there should be an expedited methodology to facilitate the development and adoption of new claims types; for example HL7 or an

appointed group of industry and provider representatives who would vet, approve, and disseminate new claims types for universal adoption.

Recommendation:

- We propose as part of the rule that CMS consider establishing an expedited procedure for the adoption of other claims types for industry use.

FORMAT OPTIONS (p 55997)

The *human decision variant* allows the health care provider to send electronic claims attachments to the payer as imaged or scanned documents or as narrative text for human review. You propose that this will be a benefit to small practices that do not have EMRs. We think that for many of our members this method will predominate and while this will encourage some to use the standard there are still significant hurdles to overcome: the size of files, the bandwidth for transmission, and the size/storage capacity servers etc.

For example, if large sections of the medical record need to be scanned or imaged, there will be a substantial burden on the provider to have available additional server and computer storage capacity. In addition, the upload and transmission of these large data files can be slow and inefficient if the practice does not have sufficient bandwidth. One solution to these problems is to reduce the size of the files by compressing them. The benefits of compressed or zipped files include faster upload and transmission, less storage space on servers and desktops. For this reason, the X12 transaction should facilitate the use of compressed files.

We also request that to the extent that providers transmit claims attachments using computerized faxes that these faxes should be exempted from the electronic claims attachment rule. This will be consistent and in keeping with other rules (e.g. e-prescribing rule) that have exempted computerized faxes as electronics formats.

Recommendations:

- We also recommend that large imaged or scanned documents be imbedded in the X12 transaction as compressed or zipped file format. This will ultimately reduce the size of the file that will be stored on servers and computers, and in addition, facilitate the reduction of upload, transmission, and download times of the files
- In addition, we request the exemption of computerized faxes used in response to a request for additional information, as a form of electronic transmission.

SOLICITED vs. UNSOLICITED ATTACHMENTS (p. 55999)

The College is in agreement with the proposal to require health plans to submit only one electronic request for additional claims information. We also agree that this requisition should contain all the questions that are minimally necessary or the health plan to adjudicate the claim. In addition, we agree that there should be an attempt to limit “unsolicited” claims attachments. However, there are certain, specific, service claims for

which health plans routinely request additional information. Nonetheless, the plans will not accept “unsolicited” claims attachments submitted with the original claims. This causes an unnecessary delay in the billing process. We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.

As a special circumstance we request that those instances where the provider requested and obtained prior authorization for a procedure, visit, or medication from a health plan that on submission of that claim, the health plan should not be permitted to ask for additional information to adjudicate the claim. In this instance, the physician will be required to attach all the necessary documentation used for the approval with the original claim.

We also agree that it is important for providers to comply with the minimum necessary standard, however it maybe impossible or impractical for medical practices to comply as shown in the following practical example:

A physician refers a patient to an orthopedist for a back problem. In theory, the physician should send the patient with a referral (if required) and the minimum necessary information for effective continuity of care. Then the patient follows up with his physician for review of his hypertension, diabetes mellitus, obstructive lung disease, and back pain. All information pertinent to the visit is recorded in the note for that day. The medical note represents a summary of all the issues related to the visit in this instance all four diagnoses. For this visit and all others the medical note represents a single integrated note, which touches on multiple issues. The managed care company sends an electronic claims attachment request, which specifies, "...please send all notes pertaining to back pain."

What is considered the minimum necessary information to comply with this request - the entire note, or just the parts of the note that are relevant to back pain? We seek further clarification considering the practical considerations and implications. For the average physician it is not often possible or practical to separate from the medical note that information only specific for back pain. If the physician complies using *Provider Scenario 1* (see page 56007 of proposed rule) all the notes, results etc that contain back pain would have to be copied, and checked for compliance with the minimum necessary provision and all information not pertinent to the request would then have to be blacked out. The final document(s) would then have to be scanned, and finally uploaded into the system as an image or Portable Document File (PDF) to be sent electronically to the health plan. In this scenario compliance with the “minimum necessary” provision would require that physicians hire additional medical records staff to function as chart redactors. If the ultimate aim is to encourage physicians to adopt electronic transmission of claims and claims attachment, we think this will represent a significant obstacle to adoption. As a possible solution, we request that physicians who respond electronically to the request for additional information with scanned or imaged documents be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision

In *Provider Scenario 4* (page 56008), the provider uses an EMR to respond electronically to the request for additional information. To an extent EMRs may make it relatively easy for physicians to separate visit notes by diagnosis, but they may not be able redact notes according to the minimum necessary standard. In other words, it may not be possible to take that note and only extract information pertinent to back pain. Again, we request that

physicians with EMRs who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision

Recommendations:

- We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.
- We propose that health plans be specific about documentation needed for prior authorization of visits, procedures, and medications and if physicians requested and received prior authorization they should send the pre-specified documentation in the original claim. Prior authorization should be sufficient to adjudicate a claim and physicians should not be required to send additional information to adjudicate the claim further.
- We request (as a practical consideration) that physicians who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision.

PROVIDER vs. PLAN PERSPECTIVE (p. 56001)

There are instances where the health plan will request additional documentation to adjudicate a claim; however, there is no provision in the proposed rule to allow the physician to indicate that he does not have the required documentation and to appeal the request.

Recommendation:

- We recommend that there should be a standard field/code that will allow the physician to indicate that he does not have the documentation and/appeal the request.

ATTACHMENT CONTENT AND STRUCTURE (p. 56001)

To reduce the size of files facilitate the incorporation of compressed data files (see *FORMAT OPTIONS* above)

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS (p. 56013)

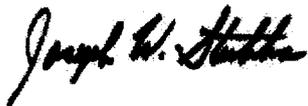
There should be an expedited process to facilitate modifications and new attachments especially if they conform to previous standards. There should be a clear roadmap to guide the modification of existing types and the introduction of new claims attachment types. If they go through a SDO such as HL7 and are consistent with previous standards then their adoption as standards should be expedited. Also see *ELECTRONIC CLAIMS ATTACHMENT TYPES* above.

CONCLUSION

The College applauds any attempt to encourage healthcare providers, clearinghouses, and health plans to adopt health technology and ultimately build the healthcare information technology infrastructure. The electronic claims attachment proposal is one element that will help our members to implement technology in their clinical practice. However as outlined about there are many considerations that we think CMS should take into account.

Again, the ACP greatly appreciates this opportunity to comment on the proposed standards. Please do not hesitate to contact Dr. Mureen Allen., Senior Associate, at (202) 261-4539 or mallen@acponline.org if you have any questions regarding these submitted comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph W. Stubbs". The signature is written in a cursive style with a large initial 'J'.

Joseph W. Stubbs, MD, FACP
Chair, Medical Service Committee

Submitter : Mr. Keith Boone
Organization : Dictaphone
Category : Health Care Industry

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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Dictaphone Corporation
Healthcare Solutions Group

Claims Attachments NPRM Comments

CMS-0050-P

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1.0	September 23, 2005	Keith W. Boone	Initial Draft
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Claims Attachments NPRM Comments

CMS-0050-P

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Overview

20 This document contains comments from Dictaphone Corporation on the Claims Attachments NPRM.

Document Conventions

Editorial corrections are shown with deletions ~~struck out~~, and insertions underlined.

Related Documents

- 25 [1] HIPAA Administrative Simplification: Standards for Electronic Healthcare Claims Attachments; Proposed Rule, 09/23/2005, Federal Register
- [2] Clinical Document Architecture Release 1.0, 11/2000, HL7
- [3] Clinical Document Architecture Release 2.0, 4/21/2005, HL7
- [4] CDA L1 R1 Schema, 03/02/2003, HL7
- [5] LOINC® Users Guide, 07/2005, The Regenstrief Institute
- 30 [6] LOINC® Version 2.15 Report, 07/06/2005, The Regenstrief Institute
- [7] Extensible Markup Language (XML) 1.0, 2/10/1998, W3C
- [8] Namespaces in XML, 1/14/1999, W3C

Glossary

Several acronyms and specialized technical terms used in this document are defined below.

- 35 CDA Clinical Document Architecture. A standard created by HL7 and approved by ANSI. There are two releases of this standard that have been approved. Release 1.0 was approved in November of 2000, and Release 2.0 was approved in April of 2005.
- CDV The Computer Decision Variant of a claims attachment. Encoded in CDA, and containing specific coded values suitable for automatic adjudication of claims.
- 40 CHI The Consolidated Health Informatics Initiative. A Federal initiative to adopt a portfolio of existing health information interoperability standards enabling all agencies in the federal health enterprise to "speak the same language" based on common enterprise-wide business and information technology architectures.
- 45 HDV The Human Decision Variant of a claims attachment. Encoded with a CDA Header, but whose body may contain a document image, or un-coded text. Not suitable for automatic adjudication of claims.

NPRM Comments

Comments in this section are on the Notice of Proposed Rulemaking published in the September 23rd edition of the Federal Register.

50 II. Provisions of the Proposed Regulations

C. Overview of Key Information for Electronic Health Care Claims Attachments

2. Overview of Clinical Document Architecture

We are aware ... one release version over the other.

55 HL7 CDA Release 2.0 was approved by ANSI on 4/21/2005, 5 months in advance of the publication of the NPRM. Compatibility between the CDA Release 1.0 and CDA Release 2.0 specification is well documented in Section 7.2.4 Changes from CDA Release 1 of the final text. More specific comments on the different versions of the standard are contained in the section discussing CDA Release 1.0/2.0 Comments below.

3. How XML Is Applied Within the Clinical Document Architecture

60 *Table: Demonstration of How XML Is Used Within a CDA Document*

<Ddocument_type_ecd>

<Ppatient>

<Bbody>

<Ssection>

65 <Ccaption>

The capitalization of the element names is significant. Indention (shown above) is not reflected in the table. If CDA Release 2.0 is named, then this table would need to be changed.

5. Electronic Claims Attachment Types

Any new electronic ... should work in collaboration with HL7.

70 Existing HL7 Attachment Implementation Specifications should use HL7 CDA Release 2.0, not HL7 CDA Release 1.0.

In fact, as these and other ... and the regulators.

75 The codes found in LOINC® 2.15 are insufficient to support easy migration from the Human Decision Variant to the Computer Decision Variant. LOINC® codes are assigned to unique combinations of up to ten different pieces of information describing an observation. This is entirely appropriate when the observations are lab results, because knowledge of this information is vital in order to determine whether, and how two different results might be comparable. It is also relevant when using the LOINC® code as a query value, since each given LOINC® code represents up to 10 different parts of a single query.

80 However, when classifying narrative information in a clinical document, the pre-coordination
of these multiple values is not appropriate. Some of the information used to determine the
most specific code can be determined from within the context of the clinical document. For
example, the type of document will indicate whether a specific treatment plan was for
85 physical therapy, or drug/alcohol treatment, thus only a single LOINC code would be needed
for classification purposed to identify a section containing a treatment plan.

*We also solicit industry input on the impact to servers and other data storage systems for
processing and storing electronic files of clinical information, both coded and text or image
based.*

90 Our own small survey shows that the typical size of a CDA release 1.0 document containing
narrative and structured text, after compression, is approximately 4Kb. Allowing for
variations in size due to more coding or text, indexing of the data, and other overhead, a
typical storage device of 128Gb capacity could still easily support storage of 10 million or
more documents. Backup requirements might triple the storage requirements¹, but this is still
well within the capacity of current data storage technology.

95 Some very simple experiments with image storage lead to a different story. We used a sample
CDA document, which when styled generated four pages of documentation. This was then
printed to PDF format. The first page was then copied into a picture editor as a monochrome
bitmap and saved in a variety of formats. Storage requirements were estimated based on these
100 results and appear in Table 1 below. The raw column shows the results on disk, without any
subsequent compression. The compressed column shows the results after applying typical
compression software to the resulting output.

File Format	Stored Requirements (Kb)	
	Raw	Compressed
Original ASCII Text	6	2
CDA XML	24	4
PDF	50	46
TIFF	76	68
GIF	220	220
PNG	240	196
JPG	1800	1300

Table 1 Approximate Storage Requirements for different formats.

As you can see, using GIF, PNG or JPG to store scanned image data yields storage requirements at least two orders of magnitude greater than storage in the CDA XML format.

105 Please note that these storage requirements account only for the storage and access of the
CDA documents in some form of repository, and do not account for the storage requirements
of EHR data, which might accompany such a repository of clinical documents.

¹ Assuming a scenario where the last two full system backups are maintained in on-line storage.

6. Format Options (Human vs. Computer Variants) for Electronic Claims Attachments

110 *Entire Section.*

115 A significant quantity of Emergency Department reports, Radiology reports, Pathology reports, History and Physical Examination reports, Discharge Summaries, Operative reports, and Rehabilitation reports are dictated at many institutions. The current AIS guides do not provide a practical migration strategy from scanned images on through to natural language text and structured information for these attachments. The main issue is that the Computer Decision Variant imposes requirements upon the narrative text that do not fit well with existing workflows used for generating clinical documentation. The requirement that the natural text translation contain a human readable representation of the codes creates an unnecessary obstacle to use of the computer decision variant for a large number of the documents that make up the patient chart.

120

The practical matter is that healthcare providers do not dictate the codes, and so they are not present in the narrative text that is eventually signed and entered into the health chart of the patient. In order to get these into the narrative text, one of two things needs to occur:

1. The provider needs to dictate the codes, OR
- 125 2. The transcriber needs to generate and insert the codes.

130

Neither of these is very practical using many software applications presently in use today. The former requires retraining providers, increasing their workloads (decreasing the time that they have for patient care), and imposing upon them a discipline that is designed to generate data used for billing instead of patient care. The latter requires either duplicating a skill-set currently employed by many facilities in their coding departments, or combining the coding and transcription tasks. In either case, combining the transcription and coding task is not desirable, as it delays the turnaround time for completed and signed clinical reports, and makes the coding task less efficient. Finally, even if the latter case were feasible, it would then impose a penalty on providers who generate their own clinical documentation (e.g., via manual entry or through speech recognition technology), as their documents would still need to undergo the coding step before it could be signed.

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This means that a significant number of claims attachments will need to be processed using the human decision variant. However, a practical solution does exist. First, the process used to encode for billing can be adapted to support the association of codes with narrative text in a clinical document (via CDA entries) without changing the narrative content. This is extremely relevant, as codes used for claims are not normally part of the signed patient chart. By adapting the coding process, the coded information is still obtained, but without delays in generated completed and signed clinical documents, as the coding can be done separately from the generation, transcription, signature and entry into the patient chart. Second, the stylesheet used to display a claims attachment can be written in a way that makes the computer processable entries visible to those processing claims manually. Therefore, the request can be understandable in either the human or computer decision variant without requiring that the narrative text duplicate the coded entry.

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D. Electronic Health Care Claims Attachment Business Use

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6. Connection to Signatures (Hard Copy and Electronic)

We solicit input from the industry on how signatures should be handled when an attachment is requested and submitted electronically.

155 To accommodate signatures, we recommend using the CDA mechanism to record the signature on file. The recorded signature should only be used to indicate legal authentication of the narrative content of the clinical document, not the computer processable entries. Requiring a signature on the computer processable entries (which use codes that are intended to facilitate billing) would impose restrictions on the use of the computer decision variant that would delay production of signed clinical documents, which is a highly undesirable outcome.

7. Connection to Consolidated Health Informatics Initiative

160 *Entire Section.*

165 The use of CDA Release 1.0 as the named standard in this NPRM, and specifically the off-label use of paragraph caption codes, and local markup specified in the AIS guides, present serious challenges to the healthcare industry in supporting interoperability with applications utilizing HL7 Version 3 standards. The CHI initiative, while adopting HL7 Version 2.3+ for messaging, strongly recommends supporting HL7 Version 3 messaging capabilities when these standards become available. More specific comments on this topic are discussed below in the section on CDA Release Compatibility with HL7 Version 3 Messages.

E. Electronic Health Care Claims Attachment Content and Structure

170 *The size of the file in the response transaction will be impacted by the option the health care provider chooses for the transaction – either text and imaged documents or coded data. ... Industry comment on file size is also welcome.*

See Table 1 above and related comments on section II.C.5 above.

F. Alternatives Considered: Candidate Standards for Transaction Types and Code Sets

2. Code Sets

175 *More discussion on LOINC.*

CDA L1 R1 Schema Comments

180 Comments in this section are on the CDA L1 R1 Schema, available via download from the Washington Publishing Company, or from HL7. This informative document reports that the class of documents validated by the schema it contains are equal to the class of documents that would be validated by the DTD published in the normative specification. Unfortunately, this is not correct.

185 The CDA Release 1.0 standard defines the content of a CDA Document using an XML DTD. The syntax of an XML DTD was defined in [7] Extensible Markup Language (XML) 1.0. Namespaces were introduced into XML almost a year later in [8] Namespaces in XML, but no mechanism was specified to define how namespaces would be declared in a DTD. As a consequence, any XML format (such as CDA Release 1.0) that is defined via a DTD does not have a namespace.

190 Thus, a CDA Release 1.0 format document cannot use namespaces. The CDA L1 R1 schema provided in the download declares the elements to be in the namespace "urn:hl7-org/cda". As a consequence, the format defined by this Schema is not the same as that defined in the CDA Release 1.0 specification, and so XML documents created using this schema are not CDA Release 1.0 documents, even though, for all intents and purposes, they are nearly identical.

195 A simple technical correction to these schemas (changing about three lines), resolves the issue, and the two definitions then become equivalent. Such a technical correction is about to be issued by HL7.

200 Some have argued that use of a namespace in the schema is desirable, as it would support use of CDA Release 1.0 in future X12 transactions that are defined using XML. This would allow the CDA attachment to reside in a different namespace than that of the markup for the X12 transaction. If the X12 transaction uses namespaces, then the CDA Release 1.0 markup is already effectively in a different namespace (technically, it does not reside in any namespace).

205 Finally, as the NPRM names the current X12 transactions, not some XML based form, the need for namespaces is arguably limited. If such changes were to occur, I would also expect that CDA Release 2.0 would be named as the standard for attachments, which would resolve the issue of namespaces, as it is defined using XML Schema, which does allow for the declaration of namespaces.

CDA Release 1.0/2.0 Comments

210 Comments in this section are related to CDA Release 1.0 and CDA Release 2.0. These comments are intended to be informative about the advantages of using CDA Release 2.0 in the NPRM.

CDA Release Compatibility with HL7 Version 3 Messages

215 The CHI initiative has adopted a portfolio of standards for communication, including HL7 Version 2.3+ messages, and strongly advises moving to Version 3 when these standards become approved. The CDA Release 2.0 schema uses much more recent schemas for vocabulary and data types, making it compatible with many Version 3 standards that are either in development, published as a DSTU, or published as a standard.

 The CDA Release 1.0 specification uses a much older version of the HL7 data types that is no longer interoperable with the current V3 standards.

220 CDA Release 2.0 vs. CDA Release 1.0

 The principal reason to support CDA Release 2.0 over CDA Release 1.0 in an implementation stems primarily from the advances in the machine readable portions of the CDA Document that have been updated in the newer standard, and the potential workflow improvements in providing clinical documentation that can also support billing transactions (e.g., attachments).
225 This latter reason is perhaps the most important reason to go to CDA Release 2.0.

230 The Claims Attachment Implementation Guide specifies two variants, the human decision variant, and the computer decision variant. The former can make use of existing clinical documentation, but the latter supports automatic adjudication of claims, thus improving turnaround and reducing adjudication costs.

235 Some have estimated that over 60% of the electronically available patient medical record comes from dictated or transcribed text. However, the existing Claims Attachment Specifications require a number of non-narrative document sections, recording information such as diagnostic codes, identifiers, numeric observations, dates, and other data types. The fact is that clinicians in these settings do not typically dictate this information into the narrative. This information, when present, is captured through other mechanisms, and is stored as meta-data associated with the clinical document.

240 The design of Claims Attachments with CDA Release 1.0 requires reorganization and restructuring of the clinical document to include this information, or dramatic changes in the way the providers dictate the clinical document to produce the computer decision variant of a claims attachment. The former process creates discontinuity between the signed, legal medical record, and the resulting document that is submitted as an attachment. The document
245 submitted as an attachment in this case is not the same one that the provider reviewed, and authorized for entry into the patient's chart. In the latter case, it imposes additional work on the provider, whose time can be better spent caring for patients. Neither of these is a desirable outcome, thus, the opportunity to generate computer decision variants for a significant quantity of electronically available medical records is lost.

250 CDA Release 2.0 obviates the need for either of these solutions by moving the codes, identifiers, values, et cetera into machine-readable portions of the document, and out of the narrative content. Using CDA Release 2.0, it is possible to maintain the integrity of the narrative content of the document, while supporting the need for some additional structure to
255 support automatic adjudication when the document is submitted as an attachment. Some analysis and restructuring of the existing dictation process may be needed, to ensure that

required information is dictated, and that this information can be readily identified by automated systems to provide the necessary encoding of sections within a clinical document. However, this is not nearly as burdensome as requiring providers to dictate codes, identifiers, observation values, et cetera. It does involve some changes, but that often is a matter of providing training and new dictation cards (or cheat sheets).

To support the computer decision variant of a claims attachment requires machine-readable content. This content appears primarily in three places in a CDA Document, in the header (level 1), the narrative text or body (level 2), and in entries (level 3).

In the header (so called Level 1) is a wide variety of metadata, including information about the document itself, the participants involved in creation of the document or the service it documents, the clinical encounter in which that service was performed, and the type of service that was performed. CDA Release 2.0 supports a richer information set than that supported by CDA Release 1.0.

In the narrative text, or body (Level 2) of the document, codes may be utilized to identify specific portions of the document. For example, section titles and captions used for tables, lists or paragraphs can be encoded to classify the content. Little has changed between CDA Release 1.0 and CDA Release 2.0 here. Some CDA Release 1.0 implementations (e.g., Claims Attachments) made extensive use of caption codes for paragraphs in order to identify discrete clinical data elements. In CDA Release 2.0, much of this information is now supported by structured entries.

In each section of the narrative, entries (Level 3) can be used to identify the:

- Problems observed,
- Allergies reported,
- Procedures performed, and
- Medications used.

While CDA Release 1.0 could only apply coded vocabularies to each of these, more discrete information can be recorded in CDA Release 2.0. CDA Release 2.0 added structure to these entries, allowing for information such as the effective time, value of the observation, method of observation, author, subject, specimen, et cetera, to be recorded.

Specific enhancements at each level are described in more detail in the sections below. Please note, CDA Release 2.0 provides so much more than CDA Release 1.0 that the detail described in the sections below only provides the highlights. It does not cover all of the enhancements that are supported by CDA Release 2.0 standard.

CDA Header (Level 1)

The CDA Release 2.0 header has richer capabilities over the CDA Release 1.0 header, while retaining backwards compatibility. Section 0 provides more details on the compatibility between CDA Release 1.0 headers to CDA Release 2.0. Sections below describe some of the specific capabilities added by CDA Release 2.0.

Patient Demographics

In addition to providing information about the patient name, ID, birth-date and gender, as supported by CDA Release 1.0, CDA Release 2.0 can also supply birth-place, race, and ethnicity.

Family Relations

CDA Release 2.0 also supports recording the names, addresses and contact information of relevant family relations.

Financial Information

CDA Release 2.0 supports recording the names, addresses and contact information for policy holders, guarantors, and payers. In addition, it supports the recording of the identifiers for the

310 payer (payer group number), and policy holder (policy holder id), and the effective time of the policy coverage. This is not supported in CDA Release 1.0.

Encounter Information

315 CDA Release 1.0 and 2.0 both support recording information about the encounter, including the date/times relevant to the encounter, and the treatment facility. CDA Release 2.0 further supports recording of the type of encounter and the discharge disposition.

Providers

320 In CDA Release 1.0, multiple providers can be present, but only one originating organization can be reported. In CDA Release 2.0, the organizations that each provider is affiliated with can be recorded. It is not unusual, for example, that an outpatient surgery might involve providers from two or more different organizations (e.g., the surgeon and anesthesiologist). CDA Release 2.0 also allows for the specialty of each provider to be recorded, and provides a richer vocabulary for provider roles (e.g., attending, rounding, primary surgeon, midwife, et cetera).

325 **CDA Release 1.0 compatibility with CDA Release 2.0**

The mapping from the CDA Release 1.0 header to CDA Release 2.0 is included as part of the CDA Release 2.0 specification, and can be found at:

http://www.hl7.org/v3ballot/html/infrastructure/cda/cda.htm#CDA_Header_Changes

330 Almost every field in the CDA Release 1.0 header can be transformed through software into an appropriate field in the CDA Release 2.0 header. The three main differences are:

- 335 1. The `is_known_by` and `is_known_to` elements in CDA Release 1.0 used to record various patient identifiers allowed for multiple patient identifiers and their related organizations to be recorded. In CDA Release 2.0, there is a place for only one related organization.
- 340 2. In CDA Release 1.0, many of the participant elements (author, data enterer, et cetera) allowed a time range to be specified for the participation of that person. CDA Release 2.0 only supports the starting time of participation.
- 345 3. Confidentiality is modeled differently in CDA Release 2.0 than in CDA Release 1.0. In CDA Release 1.0, a set of confidentiality codes can be provided for the document. One or more of these can then be referenced by each section of the document. In CDA Release 2.0, the document and each section can individually assign one (and only one) confidentiality code.

345 The first two cases can be overcome technically using very simple extensions to the CDA if full fidelity is deemed necessary. However, I would note that the current Claims Attachment implementation guides do not require these fields. The last case could also be overcome technically, assuming foreknowledge of the code set used for confidentiality. Again, this field is not required for claims attachments, and furthermore, the use of confidentiality indicators in CDA Documents is an area that many organizations have yet to implement in their use of CDA, so it is highly likely that this would not require any attention.

350 Work on developing a transformation tool from CDA Release 1.0 to CDA Release 2.0 was reported by at least one software vendor on the Structured Documents Technical Committee mailing list, and in fact that vendor contributed to the development of the mapping table referenced above.

355 Given the mapping information available in the CDA Release 2.0 specification, building a transform from the CDA Release 1.0 header to CDA Release 2.0 is a fairly trivial project (1-2 weeks) for someone well versed in development of XSLT transformations and the related CDA specifications. The implication of this is that it is relatively easy to convert a Human Decision Variant of a Claims Attachment in CDA Release 1.0 into the equivalent CDA Release 2.0 document. Having done so, the transformation is also easily reversible in about the same amount of time from CDA Release 2.0 back to CDA Release 1.0. This can be done

365 with extremely low risk and low cost, covering most if not all cases. Slightly more work would be needed to ensure perfect round-trip transformation (to address the three main issues identified above), but even this is readily managed using a very small set of extensions to the CDA Release 2.0 standard.

370 While I know of no commercially available tools to do this at this time, you might query members of the Structured Documents Technical Committee, via the HL7 list server, for possible sources.

CDA Body (Level 2)

375 Little has changed between CDA Release 1.0 and CDA Release 2.0 in the structured body with respect to machine-readable information, as this section of the document contains narrative content.

Structured Entries (Level 3)

380 As in CDA Release 1.0, CDA Release 2.0 supports the encoding of problems, procedures, allergies, and medications using any of various coding systems (e.g., ICD-9-CM, or SNOMED CT® for problems and/or allergies, CPT-4 for procedures, NDC or RxNorm for Medications, or others as necessary).

CDA Release 2.0 structured entries further allow for the detailed recording of relevant information to be included for each entry, whereas CDA Release 1.0 does not. Each entry can also record the subject, specimen, performer(s), author(s), and other participant(s), when these are different from those already specified in the CDA Header.

385 **Problems**

Not only can problems be coded, but also within the same structured entry the dates of first and last observation, current status and severity of the problem can be recorded.

Allergies

390 As allergies are simple a specialized form of problem, this same information can be recorded for allergies. In addition, specific allergic reactions and their severity can also be recorded.

Procedures

Procedures can record not only the actual procedure performed, but also other information such as the duration over which it was performed.

Medications

395 Structured entries for medications can record the dose, frequency, dose rate, route of administration, and site of administration. Special cases, such as split dosing, tapered dosing, or conditional dosing can be addressed within the structured entries. Compounded medications (e.g., a GI Cocktail), can be recorded in such a way as to show the makeup of the individual constituents. The medication prescriber can be recorded in the structured entry
400 when that person is not the author of the document. Finally, medications can be linked to the problems for which they have been prescribed.

405 The current mechanism used by the Medications Attachment Implementation Guide (Claims Attachments Additional Information Specification 0006) to record this sort of information for medications makes use of paragraph captions to indicate these "fields" of an administered or ordered medication. This may be supported by CDA Release 1.0 specification, but it is admittedly a workaround to a deficiency in the CDA Release 1.0 standard, which has since been corrected by CDA Release 2.0 by the introduction of richer structured entries.

410 **LOINC® Comments**

Comments in this section are related to Logical Observations and Identifier Names and Codes (LOINC®) release 2.15. This release is publicly available from The Regenstrief Institute.

In the Claims Attachment Transactions, LOINC codes are used to:

1. Classify Documents along several axes,
- 415 2. Specify a query for documents,
3. Classify Document Sections along several axes,
4. Specify a query for sections.

420 This introduces some issues in classification of both documents and sections, due to the fact that several equally valid codes now exist to classify the same document or section within a document. Many of these issues are similar to those already being discussed by various designated standards maintenance organizations (DSMOs), regarding the application of pre-coordinated codes.

425 From a query perspective, pre-coordinated codes are good, because they allow values from several axes to be specified at one time. However, from a classification perspective, the pre-coordinated codes makes it difficult to perform comparisons between document sections, due in part to the lack of codes for concepts that specify fewer axes.

430 Most of the issues with the LOINC database of document and section codes can be resolved by changing the process for assigning LOINC codes. At present, LOINC codes are assigned by request (e.g., from other DSMOs) for codes to identify a particular concept. However, it appears that more work is needed to assign codes that identify the meta-concepts that each new concept might introduce into the ontology of document sections.

Submitter : Dr. William Jesse
Organization : MGMA
Category : Health Care Professional or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-125-Attach-1.DOC



January 23, 2006

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Administrator
Centers for Medicare & Medicaid Services,
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Attention: CMS-0050-P
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Re: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments

Dear Dr. McClellan:

The Medical Group Management Association (MGMA) appreciates the opportunity to comment on the proposed rule for electronic claims attachments. MGMA is the nation's principal voice for medical group practice. MGMA's almost 20,000 members manage and lead more than 12,000 organizations in which more than 242,000 physicians practice. Our individual members, who include practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so physician time and resources can be focused on patient care.

We are a strong proponent of administrative simplification and believe that, once properly implemented, e-claims attachments can streamline an important billing transaction for medical group practices. We encourage CMS to move forward expeditiously in the development of the final rule and continue to solicit provider feedback during this process.

General Comments

As the federal government and the health care industry move toward adoption of standards for electronic claims attachments, the following issues should be considered:

- **Standards Should be Flexible and Scalable** – From the physician perspective, standards for electronic claims attachments must take into account the wide variety of clinical settings and specialties. The final standard must be both flexible and scalable to encourage adoption by both small and large health care organizations and physician specialties processing both low and high volumes of claims attachments. The standards should also provide for the needs of larger, more complex group practices and health systems. This flexibility will allow physicians to consider critical factors such as clinical quality, safety, efficiency and integration with existing practice management software and electronic health record systems when making an investment.
- **No Undue Burdens on Providers** – In these challenging economic times, with decreasing reimbursement and increasing practice expenses, it is critical that CMS craft a final rule that does not impose undue financial burdens on physician practices. Furthermore, e-claims

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attachments systems should be designed in such a way that clinicians are able to utilize this technology in a time-efficient manner.

- Promote the Security and Privacy of Patient Data – Patients are more concerned than ever about maintaining the security and privacy of their health information. At the same time, providers are embracing the new standards in these areas as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Electronic claims attachments must maintain these HIPAA standards as part of its core operating features. CMS should provide guidance on the critical issues surrounding the minimum necessary provision of the Privacy regulation and its impact on e-claims attachments.
- Incentives for Providers – While medical practices typically absorb the cost of purchasing the health information technology necessary for e-health technologies, many of the benefits accrue to others in the system. MGMA believes there should be a “realigning” of these incentives by promoting appropriate public and commercial reimbursement programs. MGMA has supported the concept of a federal program of tax credits for physician investments in health technology that could serve as a significant incentive. Additionally, a federally guaranteed loan fund for physician health technology investments, coupled with loan forgiveness for service to medically underserved populations, could also serve as a stimulus to e-health adoption.
- Technology Savings Accounts – The federal government should also explore innovative methods to assist medical practices in the acquisition of health information technology. Technology Savings Accounts (TSAs) would provide a reduced level of taxation for funds designated for practice health information technology (HIT). A TSA would be a special account owned by a group practice where contributions to the account pay for current and future qualified health information technology expenses including e-claims attachments software and hardware. A TSA is a savings product that would offer a different way for group practices to pay for their health information technology expenses. TSAs could enable group practices to pay for current expenses and save for future qualified health information technology expenses on a tax-free basis. Unspent account balances would accumulate and accrue interest.
- Stark Regulation Safe Harbor – There are clear legal barriers to the adoption of health technology solutions in medical groups. Anti-kickback and self-referral concerns prevent some health care organizations from offering free or discounted technology to medical practices. MGMA has advocated for government approval of legal protections, such as safe harbors and regulatory exceptions, to facilitate health technology implementation. We congratulate CMS for their important step in this direction through its creation of a health technology safe harbor in the physician self-referral phase II interim final rule (CMS-1810-IFC; 59 Fed Reg 16054).
- Development of Clinical and Administrative Crosswalks—To assist the industry in fully realizing the administrative savings potential of e-claims attachments, CMS should develop and freely make available crosswalks between ICD, CPT, and LOINC code sets. It is expected that the 277RFI transaction will encompass ICD and CPT codes (in addition to other requests) and a robust and publicly available crosswalk would assist software developers, standardize products, and potentially lower costs for purchasers.
- Staggered Compliance Dates – The protracted nature of the HIPAA implementation process suggests that the federal government’s e-health regulatory process must be modified. MGMA calls on the government to stagger implementation dates, thus providing clearinghouses and health plans time to upgrade and test systems before

provider implementation takes effect. While piloting is not needed to establish the applicability of the core function standards, piloting of the e-claims attachments standard should be completed prior to full national implementation in order to identify and correct problems. The proposed rule (p. 56001) states that “It would be helpful if health care clearinghouses were among the first of all entity types to come into compliance with these standards so that testing between trading partners - health care providers and health plans - could be executed in a timely fashion.” We agree with this assertion but believe this testing phase should be mandated as part of the implementation process.

- Development of a National Rollout Plan - HIPAA regulations typically call for implementation 26 months after the final rule. This timeline may not be feasible for e-claims attachments. CMS should initiate a national rollout plan that would take into account the requirements of each impacted sector of the industry. MGMA recommends that providers be given an additional 12 months to come into compliance. CMS should institute piloting to ensure that implementation of the final rule will be as efficient and costs-effective as possible. In addition, Medicare and state Medicaid programs should develop the capability to send and receive e-claims attachments as quickly as possible after the final rule is released. This will facilitate a more rapid adoption of these transactions.
- Continued Consultation with the Physician Practice Community – Physician practices must play an integral role in the development and deployment of any standardized e-claims attachments system. Since the vast majority of all health care is delivered in these practices, the success or failure of these initiatives will depend heavily upon physician acceptance of this new technology. MGMA encourages CMS to continue its outreach to this community to ensure that the requirements and concerns of physicians are addressed.
- Industry Outreach – The successful adoption of e-claims attachments will depend, in part, on the ability of the federal government and the industry to encourage all covered entities understand and support the system. Providers in particular will be most challenged by this new regulation. Physician practices typically are not well versed in HL7 and LOINC and will require substantial education before they are fully aware and comfortable with this transaction. CMS should also communicate with the software vendor community, through town hall meetings and open door forums, etc., Vendors must be encouraged to move forward with the development of products as quickly as possible. In addition, MGMA recommends that CMS work with the appropriate industry associations to deliver a consistent message on this important change in the health care system.

Specific Comments on the Notice of Proposed Rule Making

Summary

Citation (P. 55991) “And finally, this rule proposes the adoption of the Logical Observation Identifiers Names and Codes, or LOINC for specific identification of the additional information being requested, and the coded answers which respond to the requests.”

Issue: The implementation guides for the claim attachment standards references a subset of LOINC. How will health care providers acquire the educational materials pertaining to LOINC? Additionally, as changes to LOINC are made will the standards reflect these changes and will the industry be prepared to adjust to these changes?

Comment: Providers will be significantly challenged by LOINC. The HL7 “languages” are not commonly used by physician practices, especially smaller ones. CMS needs to identify a process to educate providers on how to access and utilize LOINC codes. In addition, providers will need to be appraised of how the maintenance and updating to LOINC will occur. We understand that educating the provider community on claims attachments will be a significant undertaking for CMS. Accordingly, we recommend that CMS partner with provider associations and industry coalitions to develop consistent outreach materials and programs to ensure that the transition to these new transactions is as rapid and effective as possible.

Effective Dates

Citation: (P, 55994) “Covered entities must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule unless they are small health plans. Small health plans will have 36 months from the effective date of the final rule.”

Issue: Is the proposed time implementation time frame sufficient for the industry to come into full compliance?

Comment: MGMA believes that the timeframe outlined is not adequate for the implementation of the claims attachment standard. In order to transition to this new standard, like the other HIPAA transaction and code set standards, providers will be forced to rely on their software vendor partners, the majority of which are not covered entities. The extraordinary delay in the promulgation of this rule may have delayed development of software products. It is our understanding that few software vendors are currently offering “compliant” e-claims attachments products. These will have to be designed and marketed and we expect that many of the vendors will wait until after the final rule is released before initiating the development process. This will greatly shorten the time available for providers and others to come into compliance within the 24-month period allocated. Providers, and other covered entities, will require time for budgeting, adoption, training, and testing. In addition, there are numerous other e-health activities that will be competing for scarce resources, including electronic health records, electronic prescribing, and other HIPAA regulations including updates to the transactions and code sets standards and implementation of national identifier standards. We recommend that providers be given 36 months to come into compliance. This affords a designated 12-month testing period between clearinghouses/health plans and their provider partners.

In addition, MGMA recommends that Medicare and state Medicaid programs develop the capability to send and receive e-claims attachments as quickly as possible after the final rule is released. By exhibiting this leadership and adopting these standards, Medicare and Medicaid programs can immediately begin experiencing administrative savings while jumpstarting the industry and facilitating the widespread implementation of these transactions.

Overview of Clinical Document Architecture

Citation (P. 55995) “We invite comment on the pros and cons of each CDA release.”

Issue: The NPRM is seeking comment on whether to name HL7’s CDA Release 1 versus Release 2 as part of the clinical document architecture.

Comment: CMS should consider moving to CDA Release 2. Release 2 adds the improvement of technical consistency among all new HL7 standards including some of the following: Genomic Reporting; Adverse Event Reporting; and the Care Record Summary used for Continuity of Care Record. Release 2 facilitates the use of off the shelf software to a greater degree than Release 1. It increases the compatibility of electronic health records for standards and other applications based on CDA. In addition, Release 2 offers improved technology for validating computer-decision variant instances of attachments (when this is required) and complies with the recommendations offered by the U.S. Federal Consolidated Healthcare Informatics initiative. At the same time though, MGMA recommends that CMS initiate and complete a pilot prior to the identification of Release 2 as the national standard.

Electronic Claims Attachment Types

Citation (P. 55997) “In this proposed rule, we propose six specific attachment types, each with data content requirements related to treatment or services provided. Comments are invited as to whether the six proposed attachment types are still the most frequently requested by health plans, and if there are others that are equally or more pressing for the industry”

Issue: The NPRM is seeking to identify whether the six attachment types are the right ones or whether there are other types of attachments that should be considered for adoption.

Comment : While we agree that the six attachment types named in the proposed rule are still relevant and important for claims adjudication, we contend that there are numerous other types that should be incorporated into the final rule. These may include such types as durable medical equipment, medical necessity, sterilization consent forms, Medicaid spend-down, secondary payer questionnaire, and home health. We encourage CMS to partner with the industry to establishment a process to explore which additional types should be prioritized and proposed to HL7 for implementation guide development.

Electronic Claims Attachment Types

Citation (P. 55996) “Based on industry feedback following implementation of the Transactions Rule, it became clear that pilot programs and early testing of new standards and processes were vital to the standards adoption process.”

Issue: The use of pilot programs to facilitate adoption of e-claims attachments.

Comment: For many group practices, the economics of investing in e-claims attachments and other health information technology is simply not evident. In an environment of scheduled Medicare reimbursement cuts, sharply rising malpractice premiums and ever-increasing administrative expenses, many practices are concerned that moving to an electronic information systems will not be financially beneficial. MGMA recommends that CMS develop educational programs that utilize the lessons learned from the claims attachment pilot completed in New York State. Establishing and widely disseminating the fact that provider and health plans both observed a replicable quantifiable return on investment (ROI) is an excellent method of encouraging the industry to more quickly adopt this electronic transaction. We also encourage CMS to initiate additional pilots to

help identify the ROI for this transaction.

Solicited vs Unsolicited Attachments

Citation: (p. 55999) “We are proposing that health care providers may submit an unsolicited electronic attachment with a claim only when a health plan has given them specific advance instructions pertaining to that type of claim or service.”

Issue: The proposed rule indicates that unsolicited attachments could continue if “instructions” between health plan and provider exist.

Comment: MGMA asserts that providers should be permitted to send unsolicited attachments if, based on prior arrangement and/or experience with a health plan, they have been asked to send them previously. If the health plan does not wish to receive these unsolicited attachments, they should inform the provider and make other arrangements to collect the necessary data. In addition, should the plan instruct the provider that an attachment is not required but resumes requesting the attachment, CMS should permit the provider to resume sending unsolicited attachments. CMS should also take a leadership role in coordinating industry efforts to adopt “operating rules” pertaining to these “specific advance instructions.” It would be extremely beneficial for providers to receive these instructions in a common format. In addition, CMS should prohibit health plans from refusing to offer specific advance instructions to providers when requested.

MGMA recommends that the term “instructions” (in Sec. 162.1910 and 162.1920) be changed to “prior arrangement.” This would allow the sending of unsolicited attachments between providers and health plans where a trading partner agreement already exists. If possible, CMS should design the final rule so that current trading partner agreements permitting unsolicited attachments would not have to be rewritten.

MGMA also has concerns that health plans may send unnecessary attachment requests, which would have the effect of delaying the payment cycle. In order to avoid this, MGMA recommends that CMS not permit the requesting of information in a claims attachment that is already contained in a compliant 837 transaction.

Issue: Should the attachment transactions allow a separately submitted unsolicited attachment (separately submitted from the claim)?

Comment: MGMA believes that CMS should allow an unsolicited attachment to move separately from the 837. We do not believe CMS should place a time limit on when a provider is permitted to send an attachment in support of an 837. Trading partner agreements between providers and health plans will determine the appropriate time limits.

Citation: (p. 55999) “We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired “questions” and/or documentation needs relevant to that specific claim.”

Issue: Should health plans be permitted to request an attachment to the same claim more than once?

Comment: MGMA believes that the CMS objective here is laudable—namely, to further the goal of administrative simplification by not permitting health plans to request an attachment on more than one occasion for the same claim. On one hand, providers would

like to avoid the situation where they respond to an attachment request with the appropriate response only to find later that the plan has additional attachment requests. It is clear that multiple requests slow the adjudication process. On the other hand, we recognize that there may be situations where the health plan legitimately requires more information than they anticipated in the initial attachment request. We have concerns that health plans, having not received the information they feel is necessary to adjudicate, would simply deny the claim. We recognize that the appeals process adds administrative burden to both providers and health plans and would like to avoid any potential situation that could cause an increase in this occurrence. Should CMS decide to include the “one attachment only” provision in the final rule, we recommend a provision that would prohibit the health plan from denying the claim solely for the reason that they failed to ask the appropriate questions in the initial attachment request.

Issue: Are health plans that utilize the unsolicited attachment business model required to send the 277 transaction when asked by providers?

Comment: If a health plan does not have a business model that sends a 277 transaction for additional information, but rather relies on an unsolicited attachment business model, MGMA contends that they still must support the 277 transaction when requested to by providers. In a practical sense, specific advance instructions and trading partner agreements should eliminate the need for a 277, but MGMA believes providers must have the opportunity to utilize this transaction if they request it.

Electronic Health Care Claims Attachment Business Use

Citation: (P. 55998) “Although additional clinical or administrative information may be required following adjudication of claims, such as for post-adjudication review to support quality control, fraud and abuse, or other post-adjudication reviews and reporting requirements, we do not consider these post-adjudication requests for claims-related data to be part of the claims payment process. Therefore, post-adjudication processes are not covered by this proposal.”

Issue: Should e-claims attachments be utilized in non-claim payment situations?

Comment: MGMA agrees with the CMS proposal not to specifically permit e-claims attachments to be used in, for example, post-adjudication processes. However, it is important to recognize the potential for the e-claims attachment to transmit clinical and administrative data from the provider (or other entity) to an authorized recipient. These other uses (i.e., public health data reporting, pay-for-performance) should not be prohibited, but rather should be permitted so long as the appropriate trading partner agreements are adopted. MGMA recommends that CMS work with the industry to examine the issue of additional (non-claims) usage of e-claims attachments and develop industry consensus on how best to leverage this transaction.

Coordination of Benefits

Citation: (P.55999) “However, with respect to electronic attachment requests and responses in a COB scenario, we assume that the primary health plan will request only the attachments it needs to adjudicate its portion of the claim. The secondary health plan would request its own attachments in a separate (X12N 277) transaction sent directly to the health care provider. In health plan-to-health plan (also known as payer-to-payer) COB transactions, the primary health plan may not know the

secondary health plan's business rules, and therefore would not be expected or required to request an attachment on behalf of the secondary health plan."

Issue: The NPRM indicates that when multiple health plans are involved in the adjudication of a patient's claim (coordination of benefits process) that each health plan would submit their own claim attachment request for information. Should the primary health plan should forward the responses they receive to the secondary or tertiary health plan?

Comment: MGMA agrees with the CMS assertion that the primary payer cannot be responsible for forwarding additional claim information onto secondary payers. Marketplace practices make it unlikely that the primary payer will know the business rules and claims requirements for other payers. In addition, the primary payer may be disinclined to forward information that was not specifically asked for by the secondary payer due to concerns regarding the minimum necessary provision of the HIPAA Privacy regulation. It should be left up to secondary and other payers to request additional information via an e-claims attachment from the provider.

Requirements: Health Plans, Covered Health Care Providers and Health Care Clearinghouses

Citation: (P. 56012) "The use of the standard electronic health care claims attachments would not preclude the health plan from using other processes or procedures to verify the information reported in the attachment documentation."

Issue: Once the rule is implemented, will a health plan be permitted to deny a claim due to insufficient clinical information?

Comment: It is our understanding that some health plans use a business process that will deny a claim for a reason of "needing additional clinical information." Once the rule is implemented, this "clinical information" would be available in an e-claims attachment. If this process can continue, how would the provider know what additional information to submit? We recommend that CMS not permit health plans to deny a claim when they have the ability to request that information through a 277 transaction.

MGMA appreciates your consideration of these comments. If you have any questions, please contact Robert Tennant in the MGMA Government Affairs Department at 202.293.3450.

Sincerely,



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