

Submitter : Ms. Zena Jacobi
Organization : Apria Healthcare, Inc
Category : Other Health Care Provider

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-127-Attach-1.DOC

January 23, 2006

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

**RE: File Code CMS-0050-P
HIPAA Administrative Simplification: Standards for Electronic Health Care Claims
Attachment; Proposed Rule**

Dear Sir or Madam,

Apria Healthcare, Inc is pleased to provide the Centers for Medicare and Medicaid Services (CMS) our comments on the proposed rule for the Standards for Electronic Health Care Claims Attachments published in the Federal Register at page 55,990 Volume 70, Number 184, on September 23, 2005. , Apria Healthcare is America's leading provider of integrated home healthcare products and services, offering a comprehensive range of home respiratory therapy, diabetic supplies, medications and equipment, home infusion therapy and home medical equipment services. Apria services more than 1 million patients annually, employs more than 11,000 healthcare professionals and has over 500 branch offices across the United States.

The following are our comments on the Claims Attachment NPRM.

EFFECTIVE DATES (p. 55994)

The proposed ruling provides a 24-month implementation schedule. While this may seem adequate it's important to remember that the NPI implementation is a major project and the health care industry will be busy through the NPI effective date with enhancements required to support this HIPAA requirement. It was our experience that many payers were not ready to receive HIPAA compliant claims even at the end of the year-long HIPAA extension. Although we were ready for HIPAA on time, we were forced to extend our HIPAA implementation schedule due to payers who could not accept HIPAA-compliant claims after the final implementation date. Some industry analysts predict that the NPI could have an even greater impact than HIPAA TCS on payer adjudication practices. Therefore, we're very concerned about when we'll complete our NPI project and be ready to move on to the Claims Attachment initiative.

Also, while the NPRM presumes that the infrastructure to support the X12 transactions is now in place, the claims attachment transaction is likely to be a very new concept for most covered entities. In particular, the inclusion of image data within an X12 transaction is likely to require significant enhancements to incorporate imaging system functionality into the data flows that currently support the claims process. And the incorporation of HL7 standards within the X12 standards can provide another technical challenge and additional expense for covered entities. Therefore we think it's critical that the effective date allow at least a 2-year window following the NPI effective date of May 23, 2007.

ELECTRONIC CLAIMS ATTACHMENT TYPES (p. 55996)

We are a large DME company and while electronic attachment specifications have not been defined yet specifically for DME, it appears that some of the paper attachments we now send are incorporated under the Clinical Reports and Laboratory Reports specifications that have been defined. The NPRM suggests that new electronic attachment standards approved by the SDO but not the Department may be used voluntarily. Since the NPRM mentions that DME specs have not been created yet and also refers to voluntary use of the standards, the final rules should clearly state that any time the Laboratory and Clinical Reports attachments are sent they must adhere to the standards even when sent on DME claims. That way, any development that's done for DME services will be consistent with the health care industry as a whole. Although not relevant to our segment of the health care industry, we would advise that this would apply to periodontal care and home health care, both of which were also mentioned as being under development.

The NPRM asks 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. From a DME perspective our most common attachments are sleep studies, lab results, Explanation of benefits on secondary claims, prescriptions, CMNs (certificate of medical necessity), LMNs (letters of medical necessity), purchase price information for Medic aids and other payers (which could include copies of manufacturer invoices to pay cost plus formulas), authorization & referral forms, clinical evaluations and nursing notes and home infusion treatment plans. Sleep studies, lab results, and perhaps clinical evaluations, nursing notes and home infusion treatment plans can be sent using the lab and clinical report specifications. However the remaining attachment types have not been addressed (explanation of benefits on secondary claims, prescriptions, CMNs, LMNs, purchase price info, authorization and referral forms). The lack of specifications for many of our attachment types will prevent us from advancing our goal of submitting all claims electronically.

Another consideration is that the standards might never allow us to send EOBs via an attachment. From a theoretical sense this might make sense since the 837 itself has data elements to send EOB data. However from a practical matter we believe that there are many providers whose systems do not allow them to send secondary 837s. The ability to send a scanned EOB together with an 837 would be a great advantage over what's currently done, i.e. sending both the secondary claim and a copy of the EOB as a paper claim to the secondary payer. The same goes for payer authorization and reauthorization letters, as it appears that the electronic attachment specifications seem to be geared more to clinical data. So as long as health plans require non-clinical data to be supplied with claims, we believe that the electronic attachment specifications should incorporate an attachment type for non-clinical data. And we believe that it would be particularly beneficial if we could send the EOB image as an electronic attachment.

Another concern relating to attachments and the need to send additional information that cannot be reported on an 837 claim is that the narrative record went from 281 characters in the NSF HA0 record to 80 characters in the 837 NTE record. As a result, we have claims that could have gone electronic pre-HIPAA and now have to be submitted via paper and/or situations where payers need follow-up information from us that was previously submitted on the claim's narrative record. We think that it's preferable that the NTE be expanded to a longer record or made a repeating segment as opposed to including the information in a paper or electronic attachment.

FORMAT OPTIONS (p. 55997)

We believe that the final rule should clearly state that a provider may use any of the three variants of attachment data at provider discretion and a health plan cannot selectively choose which of the three variants they will accept. The standards were developed so that all three types of data can be converted to a format that can be used for human decision-making. Therefore, all three types of attachment data can be used by the health plans for claims payment determination.

ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT BUSINESS USE (p. 55998)

We encourage the voluntary use of the attachment standards for additional electronic transaction processes such as post-adjudication, prior authorization for e-prescribing, pre-certification, and public health reporting. However it is our experience that legislation has been the only approach which results in consistent use of the standards, so we do support future legislation that will standardize claims attachments for these business purposes.

ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT VS. HEALTH CARE CLAIMS DATA (p. 55999)

We believe the claims attachments should be an exception and not become a rule with each claim. Therefore, we believe that the Designated Standards Maintenance Organizations (DSMOs) should be an integral part of the review for the necessity of claims attachments. We recommend that the final rule name the DSMOs for this review process.

SOLICITED vs. UNSOLICITED ATTACHMENTS (p. 55999)

We believe that the use of unsolicited claims attachments provides for more efficiency in the claims adjudication process. We recommend changing the word in Sections 162.1910 and 162.1920 from “instructions” to “prior arrangement.” We also recommend that the regulatory text be modified to allow a provider, based on prior arrangement with a health plan, to be able to send unsolicited attachments.

We do support the requirement that a health plan can only submit one request for additional information per claim. We assume that the health plans know in advance what information they need to pay a claim. However we do think that there could be technical reasons that would make it difficult for a provider to always respond in a single transaction. The responses to ‘questions’ could come from multiple systems (clinical, billing, imaging, etc). If so, providers need to be able to send the attachment response as separate responses. In addition, it would be very complex for a provider’s response to verify that it has answered all payer questions before sending the response transaction. The provider needs the flexibility to respond to one question at a time. That way, the intelligence of whether a claims attachment request has been responded to can rely on a person rather than having to build it into the system. Ultimately building it into the system is a preferable way to go, but we think that’s an unnecessary burden on provider systems at this stage of claims attachment technology.

IMPACT OF PRIVACY RULE (p. 55999)

We would like to see further clarification in the final rule on “reasonable effort” when a medical record page needed for an attachment contains additional information than what is being requested. We propose that “reasonable effort” should allow for scanning the entire page(s), so long as the page includes the information that is being requested. In addition, we propose that the receiver must protect all data that is received. We’d also like to make the point that neither of these points seems to be directly related to the electronic claims attachment ruling. We assume that the privacy rule would apply to paper attachments as well as electronic attachments, i.e. there would be the same restriction regarding sending paper attachments as applies to electronic attachments. Likewise the recommendation that the receiver protects all data they receive. Therefore we’re not sure why this is part of the ruling except as a reminder that the Privacy rule needs to be considered.

PROVIDER VS PLAN PERSPECTIVE (p. 56001)

The legislation allows a provider to direct a health plan to send requests for additional documentation in the electronic form. It further allows a provider to request the health plan to accept the standard electronic response. We think that it should be clearer that these requests from the provider to the health plan are distinct. That is, a provider can direct the health plan to send requests for additional information electronically, but the provider can respond to the request using traditional paper methods. This allows a provider to first implement the request transaction and then follow-up with the response transaction at a later date.

We also note that the legislation refers to directing a health plan to send requests to the provider. But a provider requests the health plan to accept the response. We think that in both cases the provider should be able to direct the health plan regarding the request and response transaction. That would make it clearer that the health plans must have the capabilities to support both of these transactions.

CODE SET (p. 56004)

We are concerned that the LOINC question code changes made after publication of the final rule would require rulemaking. In our opinion, that process is too time-consuming to meet the health industry needs. It would be preferable if the AIS could be modified on a periodic basis similar to other code sets. We would like to see the process move more quickly to allow for more timely adoptions and modifications to better meet the needs of the industry. We propose that, for adopting new attachment types, the DSMOs be authorized to adopt them through the DSMO process after they have been developed, balloted, and published by HL7. The standards would not then go through the regulatory/NPRM steps. In addition, the DSMOs would be authorized to adopt new versions of existing attachment types after they have been modified, balloted, and published by HL7. Again, the modified standards would not go through the regulatory/NPRM steps. The proposed processes would include provisions for industry outreach and comments through the HL7 SDO procedures. To support this change in procedures, the DSMO would need to develop a notification and roll-out process.

We would also like to have language added to the final rule emphasizing the need for further education to the industry about the process for requesting changes to the adopted standards.

We suggest that HHS include an outline for streamlining the process of handling the adoption of new releases to existing standards, in the upcoming notice for proposed rulemaking on emergency and

maintenance modifications of the existing standards,. This would involve DSMO review and coordination with the appropriate SDO.

One area that would be of specific interest to the DME community is the expansion of the Rehabilitation Services AIS to include Rehab DME equipment. We believe that if the AIS could undergo periodic updates rather than going through the legislative process, we would be able to utilize the electronic attachments sooner for our DME Rehab claims.

We need a clear process on how to access the LOINC codes used for the HIPAA specific code set. We also need the final rule to indicate the LOINC code set update schedule.

ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT RESPONSE TRANSACTION (p. 56005)

We'd like to see a statement that even while standards are being developed for DME, Home Health and Periodontal charting, those services can use the AIS's that have been developed for use for any type of service, i.e. the lab, clinical reports and medications specs. The DME industry will be able to use the lab and clinical reports specifications, and we don't want to be turned away from electronic attachments by payers who think that is not possible because there isn't a specific AIS for DME. This does not negate the need to develop a DME AIS. It just allows some use of the electronic attachment before the DME AIS is developed.

We support the idea that HHS develop a survey and ongoing process to track the utilization of the named and any unnamed attachment types to determine which attachment types are most needed by the health care industry.

COSTS AND BENEFITS - GENERAL ASSUMPTIONS, LIMITATIONS, AND SCOPE (p. 56016)

We believe that it is not safe to make the assumption that attachments are usually requested after the claim has been submitted, specifically if this assumption is being used in the cost and/or savings estimates. It is our experience that we generally know in advance when our contracted health plans expect attachments. In these cases, we configure our system to drop claims to paper so we can send the attachments with the initial claim in order to expedite payment. We do have payers that do not allow us to send attachments with the initial claim. For these payers we wait for the request for additional information. However, wherever possible, we send the attachment with the initial claim if we know that an attachment is required for payment.

162.1910 (p. 56024)

We would like clarification of the language in Section 162.1910 (a) (2) that indicates that an attachment can be sent in advance of a health care claim. This does not work well with the X12 standards that expect payer and provider claim control numbers. It is very possible that claim control numbers will not exist prior to a claim being sent. And to our knowledge it does not meet a current business need.

Thank you for giving us the opportunity to provide you with our comments on the Claims Attachment NPRM. Should you have any questions concerning our comments, please contact Zena Jacobi directly at (949) 639-2477.

Sincerely,

Jeri Lose
Executive Vice President & Chief Information Officer

Cc: Kimberlie Rogers-Bowers
SVP Regulatory Affairs/Acquisition Integration

Submitter : Mr. John Scheffel
Organization : Emdeon Corporation
Category : Health Care Industry

Date: 01/23/2006

Issue Areas/Comments

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See Attachment

CMS-0050-P-128-Attach-1.PDF



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January 23, 2006

BY ELECTRONIC DELIVERY

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

Re: CMS-0050-P, Proposed Rule on Standards for Electronic Health Care Claims Attachments

Dear Secretary Leavitt:

Emdeon Corporation ("Emdeon"), formerly known as WebMD, appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule on standards for electronic health care claims attachments (CMS-0050-P).¹ We are hopeful that CMS will build on the experience of the health care industry in implementing other health care transaction standards and approach the implementation of this new transaction standard in a manner that moves the health care industry toward the goal of administrative simplification envisioned in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") -- reducing administrative costs and increasing efficiency in the health care industry.

Emdeon is a leading provider of business, technology and information solutions that transform both the financial and clinical aspects of health care delivery. At the core of Emdeon's vision is our commitment to connecting providers, payers, employers, physicians and consumers in order to simplify business processes and improve health care quality. Emdeon processes billions of transactions each year on behalf of over 300,000 physicians, hospitals, dentists, clinical laboratories, and pharmacies. Emdeon plays a vital role in assisting its health care trading partners to comply with the HIPAA Transaction and Code Set Regulations (the "Transaction Rule").

Our comments on the proposed claims attachments standards include both technical observations about the proposed standards and policy suggestions related to standards implementation.

¹ 70 Fed. Reg. 55,990 (Sep. 23, 2005).
WADC - 69927/0027 - 2221279 v7

Promote an Industry-Initiated Rational Roll-out of the Claims Attachments Standards

In the preamble to the proposed rule, CMS supports an implementation strategy for the adoption of the claim attachment standard that allows for the transition to standard adoption across industry segments, including a period of trading partner testing.² Emdeon has long argued for a rational implementation plan for the adoption of HIPAA transaction standard³ and believes that efforts to promote electronic transactions standards benefit from a systematic approach to adoption. Among other considerations, the effective adoption of the claims attachments standards requires accommodation of the great disparities in providers' readiness to convert from paper to electronic transactions. Emdeon greatly appreciates CMS's sensitivity to this issue and applauds the agency's efforts to allow the implementation of electronic claims attachments to proceed in a cost-effective, staged manner.⁴

As the agency is aware, the Workgroup on Electronic Data Interchange ("WEDI") is developing a national roll-out plan for the rational implementation of claims attachments standards. The plan will reflect the health care industry's best understanding of the readiness of the various industry segments and the education, outreach and testing required for compliance with the proposed claims attachments standards. Emdeon believes that the industry-wide adoption of a rational roll-out plan will allow trading partners to pursue standards implementation in a reasonable timeframe that is supported by a common understanding of industry readiness. We strongly recommend that CMS endorse and promote the strategy set forth in the WEDI rational roll-out plan as the means to achieve industry adoption of the claims attachments standards.

A "Clearinghouse-First" Approach is Not Appropriate for Claims Attachment Transactions

The proposed rule recommends that clearinghouses be "among the first of all entity types to come into compliance with these standards."⁵ Emdeon agrees with CMS that clearinghouses play an important role in promoting industry compliance with the Transaction Rule. However, we caution the agency that our ability to promote compliance with the claims attachments standards depends on the readiness of our trading partners. Emdeon does not initiate electronic healthcare transactions; our role as a clearinghouse is to serve as a conduit for electronic communications between health plans and providers. In the context of claims attachments transactions, Emdeon will serve as an intermediary to communicate health plans' requests to providers for health care information and to send providers' responses back to the requesting health plan. Because in this context clearinghouses function as conduits, our ability to adopt a claims attachments transaction standard is contingent on the receipt of claims attachments transactions.

² 70 Fed. Reg. at 56,001.

³ See WebMD, HIPAA Implementation: The Case for a Rational Roll-Out Plan (released July 19, 2004) available at www.afehct.org/pdfs/webmdhipaa.pdf.

⁴ 70 Fed. Reg. at 55,997.

⁵ 70 Fed. Reg. at 56,001.

Under the CMS proposal, which relies primarily on health plans soliciting claims attachments, health plans would initiate the majority of claims attachment transactions. Therefore, the initial compliance with the proposed claims attachments standard will occur not through unilateral readiness by clearinghouses, but rather through health plans readiness to initiate standard claims attachments inquiries. Only after we have successfully tested standard claims attachment inquiry transactions with our health plan trading partners will clearinghouses be able to begin testing the second step of the claim attachment inquiry transaction, the communication of the claims attachments inquiries to our provider trading partners. Furthermore, any testing of the standard claims attachment response transaction is contingent on the successful receipt of the claims attachment inquiry by our provider trading partners.

We urge CMS to support the industry consensus approach to roll-out implementation of the claims attachment standards, which begins with health plan readiness, not unilateral clearinghouse compliance. Emdeon stands ready to begin the process of adopting the claims attachments standards, upon receipt of test claims attachment inquiries from our health plan trading partners.

Incorporate Standard Acknowledgements into the Transactions for Claims Attachments Inquiry and Response

CMS proposes the adoption of the X12N 277 and X12N 275 as part of the Transaction Rule standards for claims attachments inquiry and claims attachments response, respectively.⁶ Emdeon believes that the 277 and 275 are the appropriate standards for these claims attachment transactions; however, we strongly recommend that CMS adopt a modified version of the implementation guide for each standard to address the critical issue of standard acknowledgements.

For many years, Emdeon has emphasized the essential role of standard acknowledgments to achieving HIPAA's promise of administrative simplification.⁷ Acknowledgments provide critical notification to the sender of an electronic transaction that the transmitted file has been received and that the transmission is in an acceptable format and contains the information necessary for processing. Despite industry efforts to increase the use of electronic acknowledgments, in the absence of regulatory guidance, acknowledgments are not uniformly provided and the acknowledgements that are sent reflect a wide divergence of formats and content. The lack of uniformity in the use of acknowledgments has confounded efforts to smoothly implement HIPAA transactions.

As the following example demonstrates, the absence of acknowledgement standards would be acutely felt in the implementation of the claims attachments standards. Using the 277 claims attachment inquiry transaction, a health plan would submit an electronic request for additional information from the provider that is necessary for the health plan to adjudicate the provider's claim. If the provider does not receive or is unable to read the claims attachments request, it would not respond with the requested claims attachment and may not even know that additional information had been requested. Because some time lapse is inherent in the claims attachments process, the health plan may interpret the provider's silence as evidence that the

⁶ 70 Fed. Reg. at 56,005-06.

⁷ See, e.g., WebMD, HIPAA Acknowledgements: The Need for a Standard Transaction Acknowledgement (November 2004) available at www.emdeon.com/corporate (press release dated November 1, 2004).

provider required time to gather the requested information. At the same time, ignorant of the health plan's need for additional information, the provider may assume that the delay in payment is attributable to delays in the health plan's claim adjudication process. The net result of this communication failure is unnecessary delay in claim processing. Similar problems would occur if a standard acknowledgment is not adopted in connection with the claims attachments response transaction.

CMS can and should address the particular need for acknowledgment standards as part of the claims attachments process. Specifically, the CMS should modify the implementation guides for the 277 and 275 transactions to require the use of the X12N 999 to notify the sender of syntax errors and the use of the X12N 824 TR3 to acknowledge the receipt of both the X12 and HL7 content in the claims attachments transaction. Adoption of the acknowledgment standards is critical to the successful implementation of the claims attachments standards.

Re-evaluate, Improve and Expedite Standards Modification Process

CMS expresses a commitment to encouraging innovation and promoting development of the transaction standards.⁸ Emdeon appreciates CMS's efforts to facilitate the standards development process; however, the delays inherent in the regulatory process undermine the ability of the health care industry to adopt advancements in a timely way.

Emdeon believes that the HIPAA standards modification process must be revisited with the goal of speeding the standard modification process. The deliberative processes within the standard setting organizations allow for an industry-wide, consensus-building approach to the revision of standards. Further review and approval by the designated standard maintenance organizations ("DSMOs") helps ensure that standard modifications have been appropriately vetted by all industry segments. The overlay of a regulatory review process has resulted in negligible alteration to the DSMO recommendations, yet has added years of delay to the timeline for standards revision. These regulatory delays undermine the ability of the industry to adopt developments that would improve the efficiency and reduce the costs of health care transactions. In the proposed claims attachments standards, the concurrent use of multiple standards, the need for LOINC code changes, and the likelihood adding new attachment types present conditions that are likely to pose particular difficulties unless there is a rapid standard modification process.

Emdeon strongly supports efforts within CMS to reevaluate the HIPAA standards modification process. We understand that CMS may be constrained by the current statutory framework. Therefore, Emdeon also supports the pursuit of legislative efforts as appropriate to facilitate such changes.

Allow a More Realistic Time Period for Implementation of the Claims Attachment Standard

CMS proposes that with the exception of small health plans, all covered entities must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule.⁹ As demonstrated by experience with the adoption of other transaction standards, health care industry compliance requires a longer implementation period.

⁸ 70 Fed. Reg. at 56,013.

⁹ 70 Fed. Reg. at 55,994.

Contingency Plans allowed the health care industry to informally extend the compliance period for other transactions; however, Emdeon believes that CMS should expressly recognize and accommodate this need in the claims attachments rule.

The effective date of the standards for claims attachments transactions should be 18 months after the publication of the final rule in the *Federal Register*, and the initial compliance date should remain 24 months after the rule's effective date. The net result would extend the implementation period to 48 months from the date that the industry received formal notice of the claims attachments standard. The significant development work required to implement the claims attachments standard requires this additional time. We strongly recommend that CMS push out the effective date of the claims attachment regulation to provide a realistic time frame within which the required changes can be implemented.

In addition CMS should move swiftly to determine which release of the HL7 Clinical Document Architecture ("CDA") to adopt as part of the Transaction Rule standards for claims attachment inquiry and response. The proposed rule would adopt Release 1.0 as part of the Transaction Rule standards for claims attachment inquiry and response; however, as CMS notes, HL7 has been working to revise and improve its CDA standard and there is likely to be industry support to adopt this more advanced standard.¹⁰

The selection of a CDA release version has a significant impact on industry planning. Whichever release is selected, the health care industry and vendors in particular will need time for planning, testing and deployment of technologies that comport with the standard. Timely notice of this decision is essential; to delay industry notice until the final rule is published would significantly hamper industry preparedness. We urge CMS to announce which CDA Release will be the standard as soon as this decision is made.

Clarify Requirements and Opportunities for Business Use of Claims Attachments

Emdeon appreciates CMS's efforts to articulate the appropriate business use for the proposed claims attachments standards. These comments provide valuable guidance that informs industry practices. The following clarifications would further help facilitate implementation efforts.

Affirm Use of Claims Attachments Standards for Other Transactions at the Discretion of Trading Partners

CMS states that "[h]ealth care claims attachments must not be used to convey information that is already required in every claim."¹¹ However, CMS also states that covered entities may use the standards being adopted for claims attachments for other transactions, such as post-adjudication processing, and that such transactions are not covered by the claims attachments proposal.¹² We request that CMS clarify that the proposed claims attachments standard does not limit the ability of a health plan to use the transaction standards adopted for

¹⁰ 70 Fed. Reg. at 55,995.

¹¹ 70 Fed. Reg. at 55,999.

¹² 70 Fed. Reg. at 55,998-99.

claims attachments to collect information for other purposes and that the decisions regarding the timing and content of such transactions remain in the discretion of the trading partners.

Redefine Opportunities to Send Unsolicited Claims Attachments

Emdeon agrees with the agency's proposal to structure the claims attachments process so that each claims attachments response transaction may be matched with the claims attachment inquiry in which the information was solicited.¹³ However, we request that CMS consider modifying the circumstances under which unsolicited provider claims attachments are permitted. Specifically, we suggest that CMS allow unsolicited attachments when there is a general agreement, rather than a specific advance instruction, that the health care provider should submit the claims attachments information to the health plan. In addition, we believe that CMS should consider whether to allow unsolicited claims attachments when a health plan instructs that an attachment is not required for certain services but continues to request claims attachment information for such services.

Allow Contemporaneous, Unbundled Claims and Claims Attachments Transactions

The language in the proposal refers to a health care provider submitting an unsolicited claim attachment "with a claim."¹⁴ On its face, this language does not require the health care provider to bundle the health care claim and the unsolicited health care claim attachment in the same interchange or same transmission file. We interpret this language to simply indicate that the transmission of an unsolicited attachment should be contemporaneous (*i.e.*, in the same daily cycle) with the corresponding claim transaction. We request that CMS confirm that the contemporaneous transmission of these transactions in physically separate files is permissible.

Establish Limit of One Claims Attachments Inquiry as a Goal, Not a Requirement

CMS proposes to require that a health plan send only one claims attachments request transaction for each claim.¹⁵ We appreciate health care providers' concerns about the burdens of processing multiple and potentially redundant claims attachments requests; however, in some instances a second request may prove necessary. For example, the information submitted in a claims attachments response may prompt additional questions. We request that CMS clarify that, although health plans should endeavor to limit themselves to no more than one claims attachments request per claim received, this goal is a recommendation, not a requirement.

Confirm Limits of Primary Health Plan Responsibility in Coordination of Benefit Context

In the context of coordination of benefits, CMS indicates that it does not expect the primary health plan to request an attachment on behalf of the secondary health plan and the secondary health plan would request its own attachments in a separate transaction sent directly to the health care provider.¹⁶ Since the secondary health plan knows which information it needs to process the claim and would be able to send a claims attachment inquiry to solicit the information it requires, we presume that the primary health plan is not required to transmit the

¹³ 70 Fed. Reg. at 55,999.

¹⁴ 70 Fed. Reg. at 55,999.

¹⁵ 70 Fed. Reg. at 55,999.

¹⁶ 70 Fed. Reg. at 55,999.

claims attachment response it received to the secondary health plan. Please confirm this is the case.

Ensure Data Flexibility in Claims Attachments Transactions

Throughout the standards implementation process, trading partners have expressed concern regarding the level of data accuracy required for HIPAA-compliance. Assurance that data flexibility is consistent with compliant claims attachments transaction will help assure providers that adopting electronic claims attachments will not jeopardize their HIPAA compliance or the processing of their claims.

We request that CMS encourage the recipients of claims attachment transactions to maintain flexibility when receiving imperfect transactions, particularly in Binary Data ("BIN") segment 01.¹⁷ In addition, we request that CMS clarify that the content of the BIN segment does not need to be validated for data that the recipient will not use.

Promote Consistency in Data Storage and Retention Requirements for Claims Attachments and Claims

In the claim context, federal and state regulations impose data storage and retention requirements. In contrast, the policies for the storage and retention of claims attachments are often governed by trading partner agreements. Because policies regarding the storage and retention of claims attachments vary widely, it is difficult to respond to the request for input on the impact of the proposed claims attachments standards on data storage systems.¹⁸ To promote more uniform practices in this area, we request that in the final rule CMS recommend that covered entities adopt polices for the storage of claims attachments that are consistent with federal and state requirements for storing claims.

Commit Resources to Measuring the Costs and Benefits of the Adopting the Claims Attachments Standards

The lack of perceived return on investment may discourage the health care industry, and health care providers in particular, from conducting electronic claims attachments transactions. Robust cost-benefit analyses that demonstrate the true financial impact of the claims attachments standards may help alleviate concerns about return on investment or at least allow for methodical planning regarding how to off-set anticipated costs.

Unfortunately the Cost and Benefit Analysis in the CMS proposal does not begin to capture the true costs of adopting the proposed claims attachments standards.¹⁹ The data on which the agency relies are from a 1993 WEDI report, which predicted substantial saving as a result of adopting transaction standards. While we acknowledge that there are few subsequent analyses from which CMS could draw more recent data, the evidence to date overwhelmingly indicates that the WEDI projected savings did not come to fruition. Indeed, the conventional wisdom in the health care industry is that the costs associated with the adoption of Transaction

¹⁷ See generally 70 Fed. Reg. at 55,996-97.

¹⁸ See 70 Fed. Reg. at 55, 997.

¹⁹ See 70 Fed. Reg. 56,016-22.

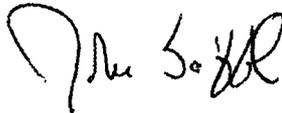
standards have been significant and that healthcare providers in particular have seen little in the way of return on their investment.

CMS should finance systematic assessment of the benefits and burdens associated adopting the proposed claims attachments standards. At a minimum, data from the claims attachments standard pilot test should be analyzed to allow at least a small window into the true costs of adopting the standards being proposed. Moreover, the agency should fund a comprehensive study of the anticipated industry impact prior to the standards' effective date.

CONCLUSION

Emdeon appreciates the opportunity to comment on the issues raised by this proposal and looks forward to working with CMS and our industry partners to promote efficient and cost-effective standards for claims attachments transactions. We sincerely hope that CMS will give thoughtful consideration to our comments and will incorporate our suggestions. Please contact me at (201) 703-3476, if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted by,



John Scheffel
Chief Privacy Officer

Submitter : Ms. Ann Berkey
Organization : McKesson Corporation
Category : Health Care Industry

Date: 01/23/2006

Issue Areas/Comments

GENERAL

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Please see McKesson Corporation's attached comments.

CMS-0050-P-129-Attach-1.DOC

January 23, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

Via Electronic Submission

RE: Standards for Electronic Health Care Claims Attachments [CMS-0050-P]

Dear Dr. McClellan:

On behalf of McKesson Corporation (hereinafter "McKesson"), we are pleased to comment on the proposed rule issued by the Center for Medicare and Medicaid Services ("CMS"), which would provide standards for electronic claims attachments.

As a Fortune 15 corporation dedicated to providing information technology, care management services, automation, medical supplies and pharmaceutical products to virtually every segment of the healthcare industry, we understand the challenges as well as the opportunity for significant quality and efficiency improvements through the use of electronic claims transactions in healthcare. McKesson touches the lives of over 100 million patients in healthcare settings that include more than 5,000 hospitals, 150,000 physician practices, 10,000 extended care facilities, 700 home care agencies, and 25,000 retail pharmacies. McKesson also provides network communication technologies and outsourcing services, as well as clinical, financial, billing and claims processing services and managed care software solutions for health care providers and payors.

McKesson has established a strong record of support and involvement in important federal and state health initiatives. We have been a pioneer in the introduction of drug savings cards to help lower the costs of pharmaceuticals through our administration of the successful Together Rx™ card and our subsequent introduction of the CMS-endorsed Rx Savings Access™ Card. We have also taken a proactive approach to providing disease management programs for commercial, Medicaid and Medicare populations where we leverage our experience with patient services, pharmacy management and healthcare quality improvement activities. Late last year,

we were awarded one of the Chronic Care Improvement Program (CCIP) demonstration projects by CMS for Medicare beneficiaries.

McKesson has been delivering core medication safety and electronic health record (EHR) components for more than a decade. These EHR solutions automate and connect the acute and ambulatory care settings to provide a patient-centric view of clinical information. Today, McKesson's systems enable health care providers to write over one million electronic prescriptions annually and review test results, diagnostic images and other information needed for effective decision-making via secure web access.

These programs and services not only provide critical savings in health care spending, but also support efforts to improve patient and health care outcomes.

McKesson enthusiastically supports the addition of claims attachments as a HIPAA standard. Establishing standards for claims attachments will enhance the communication between providers and payors and enable a workflow that will benefit both stakeholder groups. Health care providers and other entities in the U.S. health care system need a defined mechanism for expediting claims adjudication and payment.

We draw upon our extensive experience in health information technology to share our perspective and appreciate the opportunity to provide comments to CMS on this proposed rule.

PROVISIONS OF THE PROPOSED REGULATIONS

Definitions

McKesson believes the definitions in the preamble are accurate and would encourage the use of those definitions in the Final Rule.

Effective Dates

Given the allowance in the proposed rule for a phased implementation that permits use of the human decision variant (HDV) in the near term, we concur that the two year timeframe for the implementation of standardized claims attachments is sufficient. However, we respectfully ask CMS to be cognizant of the multiple initiatives underway which may require concurrent implementation, including the proposed rule for claims attachments, interoperable EHRs as well as requirements that may result from the recent introduction of House legislation that proposes the adoption of regulations for the implementation of the ICD-10-CM/PCS code set. Implementation of the ICD-10-CM/PCS code set will require significant modifications to underlying systems that contain ICD-10 codes. As a result of the considerable size of such a project and the possible convergence of these initiatives, an additional year may be necessary for software vendors to develop and implement a computer decision variant (CDV) claims attachment solution. This additional time would provide flexibility for vendors and avoid the possibility of a delay in implementation timelines.

Electronic Claims Attachment Types

McKesson believes the six attachment types noted in the claims attachments proposed rule are appropriate.

As the industry moves to the CDV, the transmittal and storage of images may require more bandwidth and processing speed than is available with the 64 megabyte BIN segment. For example, providers with large numbers of claims that currently use image-based storage systems will need to re-evaluate the size of their documents to determine if there will be a need for greater storage capacity requirements. We recommend that the originator and the recipient of the claims attachment be responsible for long term data storage as is the currently accepted business practice. Because clearinghouses are not the originators or the recipients of claims attachments, they should not be required to retain attachment data beyond business requirements.

Format Options

Many McKesson products currently support LOINC® codes; however, the automatic download and maintenance of the LOINC® code set tables for the CDV may require changes in development. It is expected that the CDV functionality will be accommodated within the implementation time frame noted in the proposed rule for claims attachments.

Combined Use of Different Standards

McKesson believes that the use of two standards accomplishes the necessary communication between administrative and clinical systems. By allowing for an ASC X12N transport containing HL7 messages and LOINC® codes, administrative system translators will be able to integrate the ASC X12N 277 Request for Additional Information and the ASC X12N 275 Claim Attachment Response with the embedded HL7 Clinical Document Architecture messages.

Solicited vs. Unsolicited Attachment

The solicitation of claims attachment information from a health care provider by a health plan should include a request for complete information pertinent to the claim in question. Realistically, additional information may be required when the initial response does not provide the necessary information for claim payment. Therefore, we recommend that the proposed rule include a provision for the request of additional claims information, if needed.

Provider vs. Plan Perspective

McKesson supports industry-wide HIPAA requirements, along with the premise that health plans may not reject any electronic transaction simply because it is being submitted as a standard transaction. We believe that a standardized claims attachment process will streamline communications and improve efficiencies in the claims adjudication process.

Proposed Standards – Code Set

McKesson supports the use of the LOINC® code set and modifiers as defined in each relevant Additional Information Specification HL7 document.

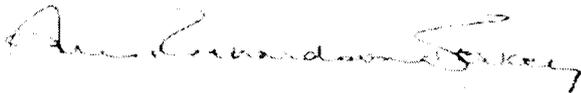
CONCLUSION

On behalf of McKesson, we appreciate this opportunity to provide comments on this proposed rule. We commend CMS for its diligence and efforts to advance appropriate standards for electronic claims attachments. Standardized electronic claims will improve efficiencies within the healthcare system and reduce healthcare costs.

Because clearinghouses are not the originators or the recipients of claims attachments, they should not be required to retain attachment data beyond their business requirements. Therefore, we reiterate our recommendation that the final rule reflect current business practices and not include any requirements for additional storage capacity for clearinghouses.

We look forward to working with CMS to implement the final rule and to address other important ways to increase efficiency and reduce costs in healthcare. Should you have any questions on these comments, please contact me at 415.983.8494 or ann.berkey@mckesson.com.

Sincerely,



Ann Richardson Berkey
Vice President, Public Affairs

Submitter : Dr. JAMES SCULLY
Organization : AMERICAN PSYCHIATRIC ASSOCIATION
Category : Health Care Professional or Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-0050-P-130-Attach-1.DOC

American Psychiatric Association

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January 23, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

RE: Proposed Rule: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; CMS-0050-P

Dear Administrator McClellan:

The American Psychiatric Association (APA), the national medical specialty society representing more than 37,000 psychiatric physicians, nationwide, appreciates the opportunity to submit these comments concerning the proposed rule for standards, under 45 C.F.R. Part 162, published in the Federal Register on September 23, 2005, with the title, "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments."¹

Provided there is rigorous protection of patient privacy, APA generally supports CMS' goal of enhancing the efficiency of electronic healthcare data transmissions for claims purposes. However, APA members are highly concerned about several aspects of this proposed rule with a particular focus on affording sufficient protection for the privacy of patient information.

A. Electronic Data Interchange (EDI) Standards: Versions, Ownership and Compliance

A HIPAA-defined "covered entity" must comply with the applicable Electronic Data Interchange (EDI) standards delineated in 45 C.F.R., Subpart S; compliance is

¹ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)].

mandated by Sections 162.1905 and 162.1930.² References to EDI standards in the proposed regulations are very specific: to Version 4050 (May 2004) for both ASC X12N 275 and ASC X12N 277 and to HL7 Release 2.1.³ Several regulations also refer to the specific company connected that use EDI standards. Examples are in Sec. 162.1915(a): “(a) The ASC X12N 277—Health Care Claim Request for Additional Information, Version 4050, May 2004, Washington Publishing Company, 004050X150 (incorporated by reference in §162.920)” and Sec. 162.1925(b): “(b) The HL7 Additional Information Specification Implementation Guide Release 2.1 . . .”⁴ Washington Publishing Company is a private enterprise that currently sells products and services related to HIPAA and EDI for the healthcare industry, including providers. The proposed regulations similarly make very specific references in Sec. 162.1002(c) to the required LOINC® identifier code and its ownership.⁵

These highly specific requirements in regulatory language can cause problems for a covered entity to remain strictly in compliance. The proposed regulations do not allow for flexibility with regard to future changes in versions, releases or ownership of EDI standards or identifier codes.

As has been historically true of computer programming, a current version of an EDI standard, such as ASC X12N 277, is likely to be modified over time to become a new version. Already, the May 2004 versions for ASC X12N standards in the proposed regulations are over one year old. When a version or release of an EDI standard changes, the name will reflect that change, as it has thus far. CMS recognizes that HL7 currently has a CDA Release 2.0, although the proposed regulations refer to HL7’s previous CDA Release 1.0.⁶ Likewise, CMS notes that ASC X12N version 4010 was upgraded to

² CMS Proposed Rule: “HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;” CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56024-25.

³ CMS Proposed Rule: “HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;” CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56022-25: Sections 162.920(a); 162.1915(a); 162.1925(a).

⁴ CMS Proposed Rule: “HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;” CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56024.

⁵ CMS Proposed Rule: “HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;” CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56023: “. . . Logical Observation Identifiers Names and Codes (LOINC®), as maintained and distributed by the Regenstrief Institute and the LOINC® Committee.”

⁶ CMS Proposed Rule: “HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;” CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55995.

version 4050, the latter version being the one that appears in the proposed regulations.⁷ However, CMS does not address the regulatory compliance complications attendant to a change in updates of versions or releases of EDI standards or LOINC® identifier codes. Unless and until the regulations' references to certain versions and releases are revised with those name changes, a provider's use of a different version or release of the EDI standard could be interpreted to fall outside acceptable parameters of legal compliance with the relevant regulations.

It is also highly possible that the choice of whether or not to use a new version or release of an EDI standard or identifier code will not be within the provider's actual control, although legal responsibility for compliance in its use may be imputed to the provider. A vendor may routinely update internal software programs or those offered for sale with new iterations that employ different versions/releases of EDI standards or identifier codes. When a provider is no longer using the version/release of the EDI standards or identifier codes required by the regulations, the question of regulatory compliance arises. In some cases, courts may have to resolve the interpretation of compliance.

Another potentially troublesome compliance issue resides in the regulatory specificity of organizations connected to EDI standards or identifier codes. For instance, the proposed regulations refer to a private entity, Washington Publishing Company, in conjunction with ASC X12N 275 and ASC X12N 277 standards, Versions 4050.⁸ This company works with Microsoft and Compuware Corporation to offer a variety of X12N and HIPAA-related products for electronic healthcare transactions.^{9, 10} It is possible that a company owning, distributing or otherwise related to an EDI standard or identifier code may change over time. It is unclear whether or not that type of description change for a standard or identifier code can trigger a question of non-compliance where there is deviation from the standard or code actually used, compared with the description of it in

⁷ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55996.

⁸ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56022-25: Sections 162.920(a); 162.1915(a); 162.1925(a).

⁹ Washington Publishing Company's website: <http://www.wpc-edi.com>

¹⁰ Compuware News Release, "Compuware Professional Services Will Use BizTalk Accelerator for HIPAA to Help Organizations Become HIPAA Compliant;" October 30, 2001:

"Compuware Corporation (Nasdaq: CPWR) announced today at the Windows on Healthcare 2001 Conference (booth # 333) that it has teamed with Microsoft and Washington Publishing Company to deliver a comprehensive HIPAA solution and will use BizTalk Accelerator for HIPAA to help healthcare providers, payers and clearinghouses become compliant under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)." Retrieved November 18, 2005: http://www.compuware.com/pressroom/news/2001/1241_ENG_HTML.htm

the regulations. A need for regulatory revision may arise, just to accommodate that change in descriptors.

The regulatory process creates a long lag time between the date when a new version or release of a standard or identifier code is issued and the date when a final, revised regulation is implemented with a revised, accurate description. For the duration of this revision process, a provider using a new version or release of a standard or identifier code could, technically, be violating the regulations.

Recommendation: APA strongly recommends that CMS revise the language of the proposed regulations to allow for flexibility with regard to future changes in versions, releases and ownership of EDI standards and identifier codes. One alternative is to simply refer in the regulations more generally, i.e., to ASC X12N and HL7 standards, which would cover both current and future versions. The same could be done for identifier codes. Presumably, industry vendors and covered entities will be using the most currently available versions of EDI standards and identifier codes at any given time for practical reasons, so that regulations would not need to prompt them to use specific versions/releases. It is imperative that covered entities be protected from inadvertent compliance violations occasioned by inevitable updates in EDI standards and identifier codes or ownership thereof. Instilling flexibility into the regulations may have the added benefit of forestalling litigation to interpret regulatory compliance.

B. Privacy and Electronic Records

HIPAA, which provides the authority for this proposed rule, embodies the concept of patient privacy. The Privacy Rule to establish standards for privacy of health information was published in 2000.¹¹ Patient privacy is particularly critical in ensuring high quality psychiatric care. Psychiatrists are also rightly concerned about how computer technologies, such as web-based portals, may compromise their patients' privacy and impair the foundation of trust that is the core of the psychiatrist-patient relationship. It is not until pilot tests sort out these and other potential issues that psychiatrists are likely to gain sufficient comfort with electronic healthcare records systems. We remain concerned about the inadequate safeguards to potential breaches in the security of identifiable patient information, through electronic data transmissions and databases. We do note, however, that CMS' definition of "Clinical Reports" does not include psychotherapy notes.¹² However, it is critically important to ensure the security

¹¹ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55991, referencing HIPAA and the Privacy Rule:

"HIPAA was discussed in greater detail in Standards for Electronic Transactions (65 FR 50312), published on August 17, 2000 (Transactions Rule), and the Standards for Privacy of Individually Identifiable Health Information (65 FR 82462), published on December 28, 2000 (Privacy Rule)."

¹² CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55994.

of and to prevent hacking into electronic systems, especially to protect the confidentiality of patients' medical records. CMS must address this privacy issue about electronic healthcare records directly.

Regrettably, confidentiality is too often overlooked as an essential element of high-quality health care. Out of fear of disclosure, some patients simply will not provide the full information necessary for successful treatment. Others refrain from seeking medical care or drop out of treatment, in order to avoid any risk that their records are not entirely private. With the use of the internet and electronic databases for accessing, processing and transmitting electronic healthcare records, this fear may be heightened for some psychiatric patients, especially those with paranoid features to their illness. A psychiatrist is hard-pressed to assure a patient about confidentiality of healthcare records when there are headlines about databank breaches. Appropriate firewalls, encryption and other data security measures should be required for any systems that handle healthcare records. While the Security Rule provides some patient protections, it would be useful to have pilot testing to see how well systems using the proposed required EDI standards and identifier codes actually work to resist hackers and other types of data security intrusions.¹³

APA believes that patients need to be certain that there will be no downstream release of information to marketers and that the security of their health records will be safeguarded. A strong CMS policy to that effect would give vendors of software and other products related to electronic healthcare records a clear message of CMS' expectations, as this applies to electronic data transmission systems and security. It is critically important that CMS respond to the privacy and data security concerns of psychiatrists, as well as all physicians, and their patients.

As mentioned above, mental health records are particularly sensitive to release and disclosure, partly due to the unfortunate, pervasive social stigma about mental disorders. Such communications could undermine mental health care, as patients avoid or delay it, to avoid stigmatization.

Recommendation: APA strongly urges CMS to adopt all reasonable means to ensure that patient privacy is protected when EDI systems are employed for healthcare claims and other purposes. APA maintains that pilot testing of EDI systems can be useful for assessing data security technologies, as well as other aspects of systems functionality.

C. Pilot Testing of Systems Incorporating EDI Standards and LOIC Identifiers

¹³ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56000.

APA is highly concerned that there have not yet been pilot tests performed on EDI systems using CMS' preferred EDI standards and LOINC® codes, yet these EDI standards and timeframes for effective dates for compliance with these standards after promulgation of a final rule are already being set forth in the proposed regulations.¹⁴ This seems premature. While HHS received funds in July 2004 for a pilot test, it will take some time to implement and complete the pilot test, then assess the results. Also, although CMS states that this pilot test will include "at least" two of the six proposed claims attachment types, it does not confirm that all six attachments will be included.¹⁵ Unless all required claims attachment types are included, as well as any other elements that would constitute a fully functional EDI system, as CMS requires, the pilot test will not be able to fully assess functionality of the system and may miss important aspects of the process.

In addition to CMS testing claims information systems separately, there should be tests on systems that interface with e-prescribing systems to determine whether there are any problems that impede full functionality. This especially makes sense, considering data overlap, in that some claims attachment information relates to the patient's prescribed and over-the-counter drugs and biologics.¹⁶ APA requested pilot testing for e-prescribing systems in our previous comments to CMS' proposed rule on e-prescribing.¹⁷

Recommendation: In order to determine the interoperability of software and hardware systems employing these proposed EDI standards and codes, APA believes that a well-integrated pilot test is necessary, within the context of the systems, as used by physicians and other providers in daily practice. Without integrated pilot testing, any systemic glitches will affect physicians and patients on a large scope. This can easily have a negative impact on patients and delay physician reimbursements substantially. The other issue is that any software or systemic problems should be identified and corrected on a small scale within a pilot test, so that the cost of correcting software and hardware will be minimized across a smaller group, instead of burdening physicians nationwide.

CONCLUSION AND RECOMMENDATIONS

¹⁴ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 56025.

¹⁵ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55996.

¹⁶ CMS Proposed Rule: "HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments;" CMS-0050-P [Federal Register: September 23, 2005 (Volume 70, No. 184)], at 55994.

¹⁷ CMS Proposed Rule: "Medicare Program; E-Prescribing and the Prescription Drug Program;" CMS-0011-P [Federal Register: February 4, 2005 (Volume 70, No. 23)].

APA commends CMS' goal of claims processing efficiency through the use of electronic records but remains adamant as to the need to maintain patient privacy at all levels of electronic data interchanges. APA also emphasizes the need for CMS to adopt regulatory language that is flexible enough to withstand future changes in versions and releases of EDI standards and identifier codes without inadvertently resulting in providers' non-compliance when the industry creates new versions or releases. Further, APA strongly urges CMS to conduct thorough, integrated pilot tests of EDI systems within real practice and claims settings, in order to fully assess functionality, including security and privacy measures.

Thank you for your consideration of these comments.

A handwritten signature in cursive script, appearing to read "James H. Scully Jr.", with a stylized flourish at the end.

James H. Scully Jr., M.D.
Medical Director and C.E.O., American Psychiatric Association

Submitter : Mr. Martin Gerry
Organization : Social Security Administration
Category : Federal Government

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT.

The Social Security Administration offers the attached comments to the subject rule. Thank you for the opportunity to comment.

CMS-0050-P-131-Attach-1.PDF



SOCIAL SECURITY

January 23, 2006

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

Dear Ms. Doo:

The Social Security Administration (SSA) is pleased to submit comments on your Proposed Rule, "HIPAA Administrative Simplification: Standards for the Electronic Health Care Claims Attachments", as published on September 23, 2005. We share the health care industry's desire to reap the efficiencies of exchanging health information electronically and seek minor clarification to the proposed rule.

Background

For the last 50 years, SSA and its affiliated State disability determination services (DDS) have processed claims for benefits resulting from disability. These benefits, administered under Titles II and XVI of the Social Security Act, represent an integral part of our nation's social welfare. SSA has an obligation to ensure we process applications as accurately and efficiently as possible. Currently, we process over 2 million new disability applications, plus hundreds of thousands more appeals and redeterminations, each year. For each case, we must request current documentation from the claimant's treating sources in order to make a medically-based determination of disability.

Historically, this has been an extraordinarily paper-intensive operation, which requires the exchange of hundreds of thousands of pages of personal medical records each day. SSA has now moved to its own electronic disability folder to eliminate the physical movement of paper internally. In conjunction with this we are making a determined effort to enable and encourage

medical providers to move their records to us in an electronic format. Records received via facsimile transmission or our secure website are routed quickly and seamlessly to each individual claimant's electronic folder. Unfortunately, far too many records are still received as paper, and must be manually scanned - at considerable cost of time and public funds. Thus, we eagerly look forward to a more ubiquitous electronic environment in the general health care community.

SSA is actively participating in the development of standards for health information, especially the Federal Health Architecture initiative and its Consolidated Health Informatics Workgroup.

General Comments

The proposed combination of transactions allows the flexibility necessary for SSA to both send out a request for records and receive a response from providers. The implementation guidance allows for both human and computer variant responses, which provides the necessary range of options for our trading partners. This also permits SSA the needed flexibility to address phases of development internally, as we move from human-readable images to machine-processable data.

When SSA and the State DDSs request medical records, we see ourselves acting much like a health plan that requests additional information from a provider to support a claim for reimbursement for services. As such, we strongly support the movement toward standardization of such transactions, especially the ANSI X12N 277 and 275 transactions as described in the proposed rule. **SSA requests clarification that use of the proposed transactions is not limited to transactions within the health care industry, but can be applied more generically to comparable transactions with authorized third-parties as well.** Such outside partners include not only SSA and the DDSs, but also others that routinely require individual health information to perform their roles, such as private disability insurers and carriers for workers' compensation. In the preamble to the final rule, we encourage CMS to highlight for providers and software vendors the added benefits of including such outside partners in their evaluation of the costs and benefits of building and utilizing standards-based transactions.

SSA has worked with the ANSI X12N subcommittee to develop an implementation guide that provides for initiation of a X12N 277 without a pre-existing claim, and also supports inclusion of an

authorization to disclose information. SSA hopes that developers factor these minor but important modifications into their software requirements.

SSA believes the LOINC code set can effectively serve to capture SSA's requests for information and the providers' responses, especially given the breadth of the clinical attachment type. In the short-term, SSA may seek definition of a panel within LOINC that could constitute a locally pre-defined set of items necessary to routinely respond to SSA and DDS requests. In time, as the computer-variant becomes more common, SSA could return to a more code-intensive array of LOINC codes.

In light of SSA's efforts to adapt these standards for mutual benefit, we look for guidance about two specific items:

- That the proposed transactions and related guides **permit the inclusion of an authorization to disclose information.**
- That **non-healthcare partners, like SSA, will need to be identified in a standard way** in these transaction. At this point it is unclear how SSA would identify itself to healthcare providers comparable to the National Provider Identifier or National Health Plan Identifier.

Specific Comment

Background, section II-D-7, page 56000, "Connection to Consolidated Health Informatics": The sentence, "We include a reference to CHI here to clarify that while the federal government is reviewing and adopting standards for **intra**-agency communications..." should read "**inter**-agency." SSA agrees that it is imperative that FHA/CHI activities be closely coordinated with HIPAA standards and the private healthcare sector.

Rule, section 162.1900, page 560024, definitions:

- *Medications* includes, "...that are ordered for an individual after treatment has been furnished." Medication itself is treatment, so we suggest revision.
- *Rehabilitation Services* includes cardiac rehabilitation but not pulmonary rehabilitation. While similar, the latter focuses on rehabilitating those patients who have chronic lung disease (and may not have concomitant heart disease).

We appreciate the overall direction provided by the HIPAA standards, and look forward to working with the health care industry to achieve secure yet efficient exchange of health information. We promise our continued cooperation as we serve our mutual interests.

Sincerely,

Patricia Jonas for M. Gerry

Martin H. Gerry
Deputy Commissioner
for Disability and
Income Security Programs

Submitter : Mr. Daniel Sisto
Organization : Healthcare Association of New York State
Category : Health Care Provider/Association

Date: 01/23/2006

Issue Areas/Comments

GENERAL

GENERAL

See attached comments from HANYS

CMS-0050-P-132-Attach-1.DOC



Healthcare Association
of New York State

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, MD 21244-8014

Dear Dr. McClellan:

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

On behalf of its more than 550 non-profit and public hospitals, nursing homes, home care agencies, and other health care organizations, the Healthcare Association of New York State (HANYs) appreciates this opportunity to comment on the proposed rule on standards for electronic health care claims attachments as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

HANYs welcomes many of the recommendations in the proposed rule but, in reiterating the attached opinions of the American Hospital Association (AHA), wishes to emphasize the importance of having an attachment standard that also imposes specific limitations on its use. Without clear guidelines on how and when to use attachments, we anticipate that the attachment standard is subject to inappropriate use. All too often, health plans ask providers for data not within existing standards, resulting in routine attachment requests. We believe, as was the intent of the HIPAA Administrative Simplification rules, that the practice of requesting an attachment should be rare and never become a routine item that would accompany all claims for a specific type of service. Health plans and others that require routine reporting of a particular piece of data have opportunities to present their requests to the appropriate data content committees, and we urge that these rules emphasize that process. Misuse of the attachment standard will increase not only the administrative burden and costs for providers, but more importantly, has the potential for privacy violations.

The proposed standards introduce several elements that are not widely used in today's billing process. These elements will require new methods for capturing and handling clinical information at significant cost for providers. Indeed, as an unfunded mandate, AHA estimates that the attachment standards will yield a zero net return on investment for hospitals. Moreover,

the attachment standards will be far costlier to implement than the previous HIPAA claims standards, since it requires building from the ground up.

Hospitals will also need time to meet these requirements largely due to budgetary and educational considerations. HANYS recommends a contingency period of at least three years after the final rule is issued to allow hospitals adequate time to prepare budgets, train staff, and conduct testing with their trading partners.

HANYS offers detailed comments to specific sections of the proposed rule in the attachment prepared by AHA. However, one area not directly mentioned in the proposed rule, but of significant concern to providers, involves the establishment of a formal communication process between providers and health plans.

Today, many claims are delayed, pending additional information from the provider. However, hospitals are often unaware that the health plan has submitted a request for additional information and are left wondering about the status of their claims. The health plan's request is often lost as it moves from the health plan to the clearinghouse and sometimes even to an unspecified location within the provider's operations. The communication flow is unpredictable.

Clearinghouses usually do not know how to handle such requests and, consequently, they are unable to direct the request to the responsible person at the provider's operation. We would welcome a set of comprehensive business rules that would improve how covered entities would formally communicate with one another to handle such requests on a timely basis. While the "request" transaction standard (American National Standards Institute 277) includes specific information about the contact at the health plan, there is no comparable segment for the provider organization to indicate the contact person within its operations. It is unfortunate that the claim standard (American National Standards Institute 837) does not have a similar segment that would allow providers to designate contact persons within their organizations to handle specific types of attachment requests. HANYS recommends the Centers for Medicare and Medicaid Services (CMS) establish a technical group to explore options for creating better communications between providers and health plans.

HANYS appreciates this opportunity to comment on the proposed rule for adopting standards for electronic claims attachments. If you have any questions or concerns about the comments presented here or in our attachment, please contact Edward McGill, Senior Principal Analyst at (518) 431-7698 or emcgill@hanys.org.

Sincerely,



Daniel Sisto
President

DS:lw
Attachment

**American Hospital Association
Detailed Comments on the Proposed Rule for HIPAA Claims
Attachments**

Definitions (pg 55993-4)

Generally, we agree with the definitions as stated in the proposed rule.

Effective Dates (pg 55994)

The proposed rule calls for implementation to begin two years after the final rule for all covered entities except small health plans, which have an additional year.

We recommend a three-year implementation period to allow providers sufficient time to budget, train, and test these standards. We further suggest CMS consider a staggered implementation schedule with specific sequencing of the attachment standards mentioned in the proposed rule. Hospitals have indicated that an orderly progression for each of the attachment standards would also be best for all parties.

Overview of Clinical Document Architecture (CDA) (pg. 55995)

Proposed language includes a discussion and overview of the merits of using XML-based standards to simplify data exchange and database connectivity. CDA of HL7's "stylesheet" is available (it could be CDA release 1 or CDA release 2); or, organizations may choose to create their own style-sheet.

We recommend CMS adopt CDA release 2, but only if it has undergone satisfactory pilot testing prior to the issuance of the final rule. There are benefits associated with release 2 that warrant serious consideration for adoption as the CDA style-sheet standard. We urge immediate pilot testing of CDA release 2 so evaluations are available prior to the final rule. If results are satisfactory, release 2 should be adopted.

Transactions for Transmitting Electronic Attachments (pg 55996)

This section calls for the adoption of Version 4050 of the X12N 277 Attachment Request and the X12N 275 Attachment Response, and solicits comments on implementing this version of the attachment standard.

The AHA recommends adopting Version 5010 for these standards. By the time the final rule is issued, it is likely that 5010 will have replaced the existing named standards. Using the same version across standards would be best, especially since the intent is to supplement the information contained in the claim standard.

Electronic Claims Attachment Types (pg 55996-7)

This section seeks comments on whether the six attachment types mentioned are still the most frequently requested by health plans. It also asks if there are other attachments for adoption and, if so, should these be allowed on a voluntary basis.

Of the six attachment types mentioned in the proposed rule, the one pertaining to emergency services appears troublesome. According to several large hospitals and health systems, a request by health plans for emergency room notes rarely occurs. This may be due to data elements introduced to the claim standard in recent years. For instance, the Balanced Budget Act of 1997 introduced language pertaining to emergency room services and the prudent layperson. The

National Uniform Billing Committee (NUBC), which has responsibility for the data content to the institutional claim, added the “patient’s reason for visit” to the claim in 1999. This code uses the ICD-9-CM codes to describe the basis for the patient’s visit to the emergency room. Many health plans indicated this information would alleviate the need for asking for emergency room notes. We suggest CMS conduct a national survey of providers and health plans to gauge the frequency of use of the different attachment types.

The ambulance and rehabilitation therapies attachment types also include many data elements that are on the institutional claim. For instance, institutional-based ambulances report miles traveled as a revenue code within the UB-92 data set and in the SV2 segment of the 837 (institutional) claim transaction. Similar reporting occurs for plan of treatment dates and visits. Typically, these items are occurrence codes or value codes contained in the HI segment in the 837. We recommend reporting these data items within the institutional claim standard rather than in an attachment transaction.

The claim attachment should be used only as a supplement to the claim. If information is part of the institutional claim, a health plan should not request the same information in a claim attachment. Health plans must be prepared to handle the entire range of data elements that comprise the claim standard. Failure to do so would be a compliance violation on two fronts: they are unprepared to use the information reported in the claim standard; and they are misusing the attachment standard by asking for information contained in the claim.

Hospitals recommend several other types of attachments for future adoption. These include DME – Medical Necessity; Secondary Payer Questionnaire; Sterilization Consent Forms; and Medicaid Spend-down forms. These supplemental documents would alleviate delays in claims processing. We encourage the adoption of a formal process that involves the data content committees and the standard developing organizations. The data content committees, the NUBC, National Uniform Claim Committee and Dental Content Committee, already have a special consultative role as mentioned in the HIPAA legislation. Since their focus is on reviewing the data needs for a claim, they should be the first to review any new proposals to supplement the claim. Once these national committees approve a new type of attachment, they could work with the X12 and HL7 groups to ensure that the 275 and 277 standards and the corresponding implementation guides handle these new types of attachments.

Format Options -- Human vs. Computer Variants (pg 55997)

The proposed rule would allow sending claim attachments in one of three formats:

1. Human variant – scanned image of document;
2. Human variant – narrative text along with original LOINC request code; or
3. Computer variant – narrative text along with LOINC response code.

The AHA recommends that the final rule clearly states that a hospital may use any one of the three variants and that a health plan cannot force a hospital to use one variant over another. A health plan that is not ready to use the computer decision variant can still convert this format to a human decision variant.

Electronic Health Care Claims Attachment Business Use (pg 55998-9)

The proposed rule indicates that the attachment standards should not convey information that is already in the claim, but instead provide supplemental information to the claim. Supplemental information gives the medical justification for health care services provided to the individual when this is necessary for a health plan to adjudicate the claim.

We support the proposed rule's view that the electronic claim attachment process is not appropriate for post-adjudication reviews. Additionally, requests for attachments should not interfere with any state's prompt payment laws. Further, only the services in question should be subject to a delay in payment. Services not in question should be adjudicated expeditiously.

As mentioned earlier, the AHA opposes expanding the attachment standard to include post-adjudication reviews without an analysis of the merits. In 1993, a voluntary collaboration of health care organizations came together to develop a set of post-adjudication guidelines. This came at the request of Sen. William Roth of Delaware who was interested in establishing a post-adjudication review process that was fair to providers and health plans. The organizations that participated included the Health Insurance Association of America, Blue Cross Blue Shield Association, AHA, Healthcare Financial Management Association, and the Association of Internal Auditors. The group published The National Billing Audit Guidelines. We recommend reconvening this group, expanded to include a few more organizations such as government health plans (e.g. Medicare and Medicaid and others), to examine whether post-adjudication procedures could benefit from the use of attachment standards. There are numerous issues to explore before deciding to utilize the claim attachment standards in post-adjudication reviews.

Electronic Health Care Claims Attachment vs. Health Care Claims (pg 55999)

This section indicates that attachments not convey information that is already required on every claim; the purpose of the attachment is to convey supplemental information.

We agree that the attachment standards should be limited to providing supplemental information only. When the claim standard includes specific codes to describe a particular event or situation then providers should use the claim standard to report this information; health plans must be able to process this information. Health plans must stay current with billing codes and build the necessary logic in their processing systems to recognize this information.

Many health plans appear weak in handling the diagnosis and procedure codes reported in claims. The claim standard allows the provider to report up to 25 diagnoses and 25 procedure codes; however, many health plans, including Medicare, recognize and process only a small number of these codes. Some health plans have indicated that their claim adjudication systems only handle the first three codes. This is extremely problematic since a patient with multiple comorbidities or complications could easily require more than nine diagnosis or nine procedure codes to explain services provided for an episode of care. Health plans must have the ability to process and evaluate the entire number of clinical codes allowed on the claim standard. Otherwise, providers will receive requests for attachments that seek justification for the services that could have been derived if the health plans had the ability to process all of the clinical codes reported.

Coordination of Benefits (pg 55999)

The proposed rule indicates that each health plan (primary, secondary or tertiary) should file a separate request for attachments if they need information to help them adjudicate their portion of the claim. The health plans should not forward their attachment information to subsequent payers.

We concur with the proposed language supporting the minimum necessary concept. We support the proposal to require health plans to submit their own requests for attachments only if they need this information to adjudicate their portion of the claim.

Impact of Privacy Rule (pg 55999)

Covered entities must make reasonable efforts to limit requests for, or disclosures of, protected health information to the minimum necessary to accomplish the intended purpose of the request for disclosure. The proposed rule seeks comments as to whether the proposed attachment standards will facilitate the application of the minimum necessary.

We would appreciate further clarification around the term “reasonable efforts,” especially when a provider receives a request for information and the relevant document contains unrelated information. It would be burdensome for a provider that adopts the human decision variant of a scanned image to edit the document to remove sections not requested. It would be “reasonable” for the provider to scan and send the entire page of the document as long as it contains the information requested by the health plan.

Connection to Signatures (hard copy and electronic) (pg 56000)

The proposed rule suggests that electronic signatures not be part of the standard. However, some health plans and/or regulations require a signature for services such as sterilization or for the issuance of specialized equipment.

We agree that electronic signatures should not be part of the electronic attachment standard. If in the future, a document, such as sterilization consent form, becomes a standard, the field should evaluate the merits of a digital signature. In this case, it might be best to scan the entire document that includes the patient’s signature.

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Organization : HIMSS EHRVA
Category : Health Care Industry

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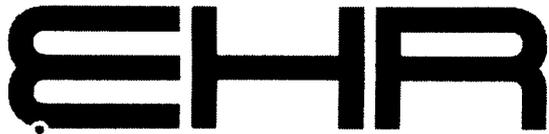
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-133-Attach-1.DOC



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Physician Micro Systems, Inc.
PowerMed
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SOAPware
WebMD
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December 6, 2005

Centers for Medicare & Medicaid Services
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Re: Comments on Proposed Rule – 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 – HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments

The member firms of the HIMSS Electronic Health Record Vendors Association (EHRVA) are pleased to provide the following commentary regarding the proposed rule on standards for electronic health care claims attachments. The following summarizes the consensus opinion of our member firms on key points of the proposed rule.

- 1. General Support for Proposed Standards.** In general, EHRVA supports the standards outlined in the proposed rule – both the X12 and Health Level 7 (HL7) standards, including both the Human Decision Variant (HDV) and the Computer Decision Variant (CDV), both solicited and unsolicited attachment transaction protocols, and the use of Logical Observation Identifiers, Names, and Codes (the LOINC code set).
- 2. Attachment Types.** EHRVA supports all six (6) proposed attachment types. They are all significant and important to the industry, and there is no reason to prioritize among the attachment types as they are all important. EHRVA believes that all of the proposed attachments should be implemented before shifting attention to other, new attachment standards, but it is reasonable to allow organizations to implement other attachment types voluntarily.
- 3. Clinical Document Architecture (CDA) Release 1 vs. Release 2.** The proposed rule explicitly suggests the adoption of CDA Release 1.0 rather than Release 2.0. EHRVA strongly supports the adoption of CDA Release 2.0. The groundwork necessary for the transition from Release 1.0 to 2.0 is already well underway, with the HL7 ASIG working group mapping the first release to the second. The industry at large is familiar with CDA Release 2.0, and generally prefers on the use of Release 2.0 for communicating specific, complex clinical

information. Release 2.0 is also consistent with proposed health information exchange (HIE) standards. Should adoption of CDA Release 2 follow the implementation of the attachment standard at a later date, there will be significant resources required by payors, providers, and vendors alike to migrate from 1.0 to 2.0. Because of this, and the widespread acceptance of 2.0, EHRVA recommends and supports the use of Release 2.0 exclusively, rather than either allowing only Release 1.0 or allowing both.

4. Human Decision Variant (HDV) vs. Computer Decision Variant (CDV). EHRVA supports both the HDV and CDV proposals. EHRVA believes, however, that organizations will require dedication of significant resources to sufficiently implement CDV. Furthermore, CDA Release 2 supports both HDV and CDV.

5. Solicited, Unsolicited and Coupled Attachments. It is necessary to support both solicited and unsolicited claims attachments. CMS may consider extending the protocol to allow unsolicited clinical attachments to be submitted to payors uncoupled from the related claim. Sending an uncoupled, unsolicited attachment is similar to sending an uncoupled, solicited response to a request for attachment. Furthermore, embedding clinical attachments into a stream of electronic claims might be burdensome to small providers and those who do not have electronic medical records and billing systems that are not fully integrated together.

6. Use of LOINC codes. EHRVA generally supports the proposed use of LOINC codes. Clarification is needed regarding the LOINC version control process. How will the relevant subset of LOINC codes be explicitly identified, updated and distributed for support of claims attachments?

7. Phased Implementation. If implementation of the proposed rule is to be phased in according to the organization type, EHRVA recommends implementation by payors and clearinghouses first, to be followed by provider organizations.

8. Electronic Signature. As stated in the proposal, there is no standard for electronic signatures. Furthermore, when a signature is required, it needs to be clear exactly what signature is needed – the enterprise signature versus an individual person's signature, the latter being far more complex to implement. EHRVA recommends that CMS analyze the use-cases that would require a signature.

Because of the lack of interoperable electronic signature standards, EHRVA suggests that the rule should be either silent on this topic, or be specific enough to specify an interoperable standard.

9. Privacy Considerations. There is a balance to strike between sending sufficient data to support a claim, and sending too much data, infringing on a patient's privacy. The rule should be more specific in this area, with a minimum set of requirements, to minimize the risk to payors, providers, and information systems vendors. EHRVA is concerned that this issue may be difficult to address technically.

10. 64 MB BIN Segment limit. EHRVA recommends leaving segment size limit as a recommendation only. Any limit in the standard can become outdated quickly. Two trading partners should be allowed to negotiate an agreement on the BIN segment size limit that they agree to support.

11. Effective Dates. In the opinion of EHRVA, 24 months from the effective date of the rule (36 months for small health plans) is not enough time for covered entities to come into compliance. This timeline is likely to cause undue burden on many payors, providers, clearinghouses, and vendors. Sufficient allowances should be made for typical schedules for the software development and release cycle, with subsequent analysis and implementation by individual entities. Furthermore, EHRVA suggests that allowing time for a broader range of pilots before the effective date would allow participants to see the impact of implementing and testing transactions under the standard, thus facilitating earlier successful adoption overall.

Furthermore, the timeline between the adoption and mandatory compliance with this rule should allow for other healthcare information technology mandates and initiatives that may be underway at the time; e.g., e-prescribing, ICD-10, UB-04 implementation, etc. Coordination with AHIC and HITSP is highly recommended.

12. Testing. EHRVA also stresses the importance of testing, on the part of both vendors and covered entities, as a part of implementing systems to comply with the final rule. While EHRVA does not believe that an official certification process is necessary for smooth adoption of this standard, the EHRVA supports making a low-cost, reliable testing mechanism available to organizations implementing claims attachment transaction standards. Perhaps this could be a new part of the 'Integrating the Healthcare Enterprise' (IHE) financial transactions domain, or a similar platform that could be established. This would allow payors, providers, clearinghouses, and vendors to test their implementations of the standard, and serve as a platform to help resolve rule interpretation discrepancies between trading partners in a collaborative, cost-effective and transparent manner.

13. The Long-Term View. EHRVA believes that, in the future, claims attachments will not be separate transactions at all, but rather, will evolve into

mere pointers to clinical information residing elsewhere; e.g., a URL to information in a HIE. Ultimately, rather than sending out electronic copies of patient data as claims attachments, providers will host and secure the data, and invite recipients to look at the relevant attachment data by sending out a link. This is analogous to the current practice of providers with electronic health records to share data with other providers via web portals to their EHR systems. It is our view that the proposal supports sending links as claims attachments, and this would be a positive outcome in many ways.