

Submitter : Dr. Frank Kyle
Organization : American Dental Association
Category : Other Practitioner

Date: 01/12/2006

Issue Areas/Comments

GENERAL

GENERAL

January 12, 2006

Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Boulevard
Washington, DC 20201

RE: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments ? 45 CFR Part 162 ? (File Code CMS-0050-P)

The American Dental Association (ADA) is a named Designated Standards Maintenance Organization and is a consultant to the Secretary of Health and Human Services on HIPAA Administrative Simplification standards [Public Law 104-191? Health Insurance Portability and Accountability Act of 1996, Title II, Subtitle F, Part C, Section 1172 (c) (3) (B) (iv)]. The ADA is also an ANSI Accredited Standards Organization that has developed standards for dentistry since 1928. As the world's oldest and largest dental professional organization representing over 152,000 member dentists or approximately 72 percent of the dentists in practice across the United States, the ADA believes this proposed rule may have significant implications for the dental profession and appreciates the opportunity to comment on this NPRM for Standards for Electronic Health Care Claims Attachments. Our comments are attached as a separate Word document

If there are questions about our submission, please feel free to contact Mr. Frank Pokorny, Senior Manager, Dental Code Standards and Administration, telephone 1-312-440-2752, e-mail pokornyf@ada.org or Dr. Frank Kyle, Manager, Legislative and Regulatory Policy, telephone 1-202-789-5175, e-mail kylcf@ada.org.

Sincerely,

Robert M. Brandjord, D.D.S.

President

James B. Bramson, D.D.S

Executive Director

CMS-0050-P-68-Attach-1.DOC

CMS-0050-P-68-Attach-2.DOC



American Dental Association
www.ada.org

January 6, 2006

Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Boulevard
Washington, DC 20201

RE: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments – 45 CFR Part 162 – (File Code CMS-0050-P)

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CMS-0050-P: Standards for Health Care Claims Attachments NPRM / Comments from the American Dental Association (ADA)

Comment Number	Page Number	Section	Comment
1.	55993	A. DEFINITIONS	The ADA is in agreement with the definitions of the terms listed in the preamble of the proposed rule. These same definitions should be repeated in Section 162.1900 of the regulation text.
2.	55993	2. Implementation Guides in the HIPAA Regulations	<p>In implementation of previous standards, one of the ongoing issues has been lack of synchronization between request and response transactions. An example in the current set is the missing Procedure Code Qualifier in the 275 2000A REF segment where the code qualifier of 'AD' for the dental codes is not present (P. 74). It is, however, present in the 277 transaction 222E SVC segment (page 98). Further, there is inconsistency in the code qualifier identification between the 275 and 277 for the same segments.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1) The Qualifier HC should be used consistently between the 275 and 277, instead Code Qualifier HC is used in the 277 and CPT is used in the 275. 2) The implementation guide be subject to exhaustive review and revision to ensure that all references to professional, institutional and dental claims are correct (e.g., by their presence or absence) before the Guide is adopted as a standard under Section 162.1920 of the proposed final rule (page 56024 of the NPRM).
3.	55993	2. Implementation Guides in the HIPAA Regulations	<p>The 277 Implementation Guide implies that the transaction is relevant to all HIPAA standard claim transactions (837P, 837I and 837D) and includes dental procedure codes as valid for use in the 277 (e.g. Page 98). However, there are several instances where a specific reference to dental is missing. For example; 1) Note on Page 22 should also include reference to a dental claim, not just professional claim; 2) Note 1 on Page 77 should state that the segment is not needed for dental, in addition to the existing exclusion of professional claims.</p> <p>Recommendation: The implementation guide be subject to exhaustive review and revision to ensure that all references to professional, institutional and dental claims (e.g., applicable/not applicable) are correct before the Guide is adopted as a standard under Section 162.1915 of the proposed final rule (page 56024 of the NPRM).</p>

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Comment Number	Page Number	Section	Comment
4.	55994	B. EFFECTIVE DATES	<p>The ADA finds the timeframe outlined to be insufficient for the implementation of the claims attachment transaction. Although the NPRM states that covered entities have already implemented other X12 transactions and set up the business agreements for translator services, submission and receipt protocols, and testing, such mass implementation of the core HIPAA standard transactions has not taken place in the small or solo practice sector. Members of this sector include dentists and physicians.</p> <p>The proposed standard is set forward as a “second-round” HIPAA transaction standard, which presumes that most of the technical infrastructure and supporting processes should already be in place to accommodate a new standard transaction. However, we note that the proposed rule incorporates data content (e.g., LOINC) that is likely unfamiliar to significant portions of the health care community. It is uncertain whether the implementation period is sufficient to allow for the necessary education on such matters.</p> <p>The ADA recognizes that the Electronic Claims Attachment Project through Empire Medicare Services was able to implement and conduct claims attachment transactions within a six-month period of time. As this project was much more limited in scope, we question whether it is an accurate bellwether of the health care community’s ability to implement the proposed transactions within the timeframe specified in the rule.</p> <p>Please note that the ADA supports the WEDI SNIP Claims Attachment Workgroup efforts in developing an implementation plan for the industry related to this standard.</p>

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5.	55995	1 Overview of Extensible Markup Language (XML)	<p>This section acknowledges that "...XML, is a relatively new technology" and further states that "...XML has been adopted by most major companies in information technology as the basis for obtaining interoperability..." These two comments cast further doubt on the ability of significant portions of the health care community to adopt the proposed standard within the proposed 24 month implementation period before compliance is mandatory.</p> <p>The ADA supports the adoption of XML for health insurance transactions because tools to create, exchange and read the transactions are readily available and will simplify the development of required software. However, the dental industry has very limited experience with the use of XML in practice management, clearinghouse and plan systems. Health care companies, and the individual practitioners who make up most of our market, will be treading new ground with such a new architecture. Small entities will face additional costs to implement the proposed transactions.</p> <p>We encourage HHS to develop an overall implementation strategy to enable all covered entities to implement the claims attachments standards without disrupting business operations. This strategy must include pilot tests to expand the knowledge base for and industry experience with the use of XML in claims attachment standards prior to requiring all covered entities to adopt it.</p>
6.	55995	2. Overview of Clinical Document Architecture	<p>The ADA concurs with moving to CDA Release 2.0, in stead of the current Release 1.0, assuming that there is an adequate pilot of Release 2.0 that demonstrates acceptable functionality. It is our understanding that the following are benefits of CDA Release 2.0:</p> <ul style="list-style-type: none"> • More technical consistency with all new standards coming from HL7 including, but not limited to genomic reporting, adverse event reporting, and the care record summary used for continuity of care. • More consistency with code being developed by EHR developers (vendors and users) for standard and other applications based on the CDA. • More ability to use off-shelf software being developed by health care vendors. • Improved technology for validating computer-decision variant instances of attachments (when this is required). • Compliance with the U.S. Federal Consolidated Healthcare Informatics initiative.

Comment Number	Page Number	Section	Comment
7.	55996	4. Transactions for Transmitting Electronic Attachments	<p>The ADA strongly supports the use of structured, as opposed to unstructured, content in electronic data interchange and we believe that the HL7 standards provided such structure. We note that the language regarding Binary Data (BIN) segments does not specify that it conveys the HL7 CDA standard as discussed in "3. How XML Is Applied Within the Clinical Document Architecture." It should be made clear that the HL7 standards are to be used in the BIN segment.</p> <p>What is not clear is whether imaged data and text, for example, could be in the BIN segment without the CDA structure. These clarifications are necessary with each reference to BIN segments throughout the proposed rule.</p>
8.	55996	5. ELECTRONIC CLAIMS ATTACHMENTS TYPES	<p>The ADA agrees that the six proposed attachment types: Ambulance Services, Emergency Department, Rehabilitation Services, Clinical Reports, Laboratory Results and Medications are the most frequently requested by health plans and there are currently no others that are equally or more pressing for the health care community.</p> <p>Further, the ADA strongly recommends that prior to consideration of additional attachment types a large scale survey be done in the health care industry to determine the perceived need for additional types of claims attachments, the anticipated frequency with which additional standard attachments would be used, and the anticipated costs and savings related to implementation of electronic claims attachment transactions.</p>
9.	55996	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	<p>The ADA desires to express its interest in the adoption of attachment standards to support the claim adjudication process. As the vast majority of attachments for dental claims are radiographs, which are not included in the proposed standard, we encourage the Secretary HHS to develop an interim final rule for comment and investigation prior to the promulgation of final standards. This would help ensure that the resulting attachment transaction can adequately address the needs of the dental benefits industry without undue confusion, or operational or financial burden, on practitioners, payers and clearinghouses</p>

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10.	55997	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	The NPRM states that any new attachment standards will be developed in accordance with the HL7 CDA and that "...industry representatives interested in participating in the development process should work in collaboration with HL7." We concur with this position and note that the ADA and HL7 have signed an MOU to coordinate all claim attachments that effect dentistry. We encourage the Secretary HHS to support this MOU in any regulations for claim attachments.
11.	55997	6. FORMAT OPTIONS (Human vs. Computer Variants) for Electronic Claims Attachments	The ADA strongly supports the flexibility being allowed in the proposed rule for using either the human or computer decision variant options of the HL7 CDA. We agree with the human variant option's provisions for transmission of scanned or imaged documents as well as transmission of narrative text. What is not clear is any provision for transmission of radiographs (DICOM standard) or photographic images (digital or otherwise). If these items are not within the scope of the proposed six types of attachments, that must be noted.
12.	55998	7. COMBINED USE OF DIFFERENT STANDARDS Through Standard Development Organization (SDO) Collaboration	<p>The ADA strongly supports the use of standards for electronic data interchange, versus non-standard approaches. We support the collaborative efforts of HL7 and X12 in developing the format and content of the transactions in this proposed rule.</p> <p>In addition, the ADA Standards Committee on Dental Informatics (SCDI), an ANSI accredited SDO, has an MOU with HL7 that addresses development and approval of content and functional requirements for dental health care transactions. The collaborative effort between SCDI and HL7 has begun with development of a Periodontal Attachment standard, an attachment type that the NPRM envisions as a future HIPAA standard.</p> <p>Further, we encourage the Secretary HHS to include the ANSI/ADA Specification No. 1000 for the Standard Clinical Data Architecture for the Structure and Content of an Electronic Health Record to provide the next level of granularity required for implementation of an EHR architecture.</p>
13.	55998	D. Electronic Health Care Claims Attachment Business Use	The ADA agrees that the purpose of the proposed standard does not include required use for post-adjudication purposes (e.g., quality control; fraud and abuse). Should there be future consideration of extending the purpose to address post-adjudication activities, the ADA strongly recommends that a balanced provider/payer group be established to consider the merits and mutual benefits of such action, and that National Billing Audit Guidelines be considered in that process.

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Comment Number	Page Number	Section	Comment
14.	55999	1. Electronic Health Care Claims Attachment vs. Health Care Claims Data	<p>The ADA agrees with the statement “Electronic health care claims attachments must not be used to convey information that is already required on the every claim.” Duplicate transmission of data brings no additional value to the proposed transaction and places an additional administrative burden on both the originator and recipient of the transaction. Further, claims attachments must remain as an exception and not become a rule with each claim. We see the Data Content Committees (NUCC, NUBC, and ADA) having responsibility for examining and recommending claim data requirements as well as data best included in an attachment.</p> <p>The ADA Standards Committee on Dental Informatics (ADA SCDI) is the Standard Development Organization (SDO) responsible for managing and coordinating these recommendations for incorporation into the appropriate standard for implementation. In addition, MOU’s such as the one between ADA SCDI and HL7 provide for joint SDO development.</p>
15.	55999	2. SOLICITED VS. UNSOLICITED ATTACHMENTS	<p>The ADA disagrees with the proposal that would permit providers to submit unsolicited claim attachments only after receiving specific advance instructions from the health plan. We believe that use of unsolicited claims attachments enables a more efficient claims adjudication process. Further, the ADA also believes that unsolicited attachments should be sent only when there is a standard that is consistent between all providers and all payers.</p>

Comment Number	Page Number	Section	Comment
16.	55999	2. SOLICITED VS. UNSOLICITED ATTACHMENTS	<p>The ADA agrees with the intent of the regulatory preamble statements concerning a health plan's ability to solicit only a single electronic attachment request.</p> <p>Members of the provider sector of the health care community have experienced multiple requests for additional information concerning a claim submission, which results in additional time and resource expenditures before the claim is adjudicated. Such multiple requests are contrary to the goal of administrative simplification.</p> <p>We find an inconsistency between the regulatory preamble and the regulatory text on this matter. The language in the preamble does not provide for the health plan to make a subsequent request, but in Section 162.1910 of the regulatory text is not as clear. Section 162.1910 (c) needs to be clarified as that text does not specifically state that the health plan can only make one request, the text states that the health plan's request must be "complete".</p> <p>However, there is a conundrum. Although we have concerns about a potential for endless requests by the health plan resulting in the need for the provider to respond, we also recognize that there may be a genuine need for a subsequent request by a health plan. Therefore the final rule should allow for a subsequent request by the health plan to avoid a potential denial if the need for additional information could not have reasonably been foreseen. In situations where additional requests appear to present a pattern, there should be a burden of proof on the requestor to demonstrate that the need for such additional requests.</p>
17.	55999	3. Coordination of Benefits	<p>The ADA recognizes the potential of the standard claims attachment to facilitate the COB process, and we support the preamble's language that states that any secondary health plan would send an attachment request separate from a request made by the primary health plan. This statement needs to be reiterated in the regulatory text.</p>

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18.	55999	4. Impact of Privacy Rule	<p>The ADA believes that the Department of Health and Human Services (HHS) should provide more formal guidance on the relationship between a claims attachment's data content and the HIPAA Privacy regulation's concept of "minimum necessary" information. As written this portion of the regulatory preamble makes some 'good-faith' assumptions, e.g., "...health plans or health care providers may exercise discretion as to whether the information should be provided or requested in the transaction..." and "A health care provider may rely, if such reliance is reasonable under the circumstances, on a health plan's request for information, or specific instructions for unsolicited attachments, as the minimum necessary for the intended disclosure."</p> <p>We believe there needs to be a balance between the patient's right to privacy and the ability for the provider to respond to a request for additional information, specifically as it relates to the use of scanned documents within the attachment. In addition, the NPRM does not address the recipients' maintenance of the data and use of the data under which the rule applies. We recommend that all data on a single scanned page that contains required attachment information should be deemed to fall within the minimum necessary requirements of the Privacy rule.</p>
19.	56000	6. Connection to Signatures (Hard Copy and Electronic)	<p>The ADA believes that signature information should be conveyed in the same manner as on the claim (837) transaction, the signature on file indicator or by applicable HL7 CDA standards. If necessary, an image of the signature could be included within the attachment transaction envelope.</p>

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20.	560000	6. Connection to Signatures (Hard Copy and Electronic) [HL7 suggested response]	<p>The ADA concurs that there is no interoperable standard for electronic signatures. The term electronic signature is broadly understood to include a variety of technical approaches that vary in technological complexity and forensic accountability. Some representative technological approaches include:</p> <ul style="list-style-type: none"> (a) simply transmitting a data field that indicates that the sender has a "wet" signature on file (b) simply transmitting a data field that indicates that an authenticated user of an electronic has performed an overt act that would serve as a "signing ceremony" (c) transmitting an image of a document, or a portion thereof, that includes a wet signature (d) strongly authenticating a computer user and using digital signature technologies to record the electronic act of signing a document and associate it with the electronic document itself in a manner that allows subsequent verification that only the authorized signer could have performed the act of signing and the electronic document has not been subsequently altered. <p>The choice of approach depends on the specific business use, applicable legislation and governmental regulations and the policies of the parties exchanging electronically signed documents.</p> <p>We further concur that there is an important business requirement to share signatures electronically as information in support of a healthcare claim. The signature that must be shared is often not the signature of the author of the electronic attachment document. For example, a consent signature is generally that of the patient or the patient's agent and a rehabilitation plan may include the signatures of multiple providers not all of whom are the authors of the plan.</p> <p>The <signature_cd> element of CDA Release 1 is only defined for case (b), above, and only describes the signature of the author of the CDA document.</p> <p>It is important that the standard for additional information in support of a claim support multiple approaches to signature so that the correct approach may be chosen that is practical, cost-effective and consistent with the federal, state and local legislation, regulations and policy. For example, there are regulatory and practical concerns that rule out approaches (a), (b) and (d) for consent forms, since policy makers have indicated that a "wet signature on file" is not adequate and it is unlikely that the person providing the signature will usually be an authenticated user of a healthcare provider's electronic system, much less a strongly authenticated user.</p> <p>We propose, therefore, that the final rule and commentary either be silent on electronic signature or indicate that individual attachments should specify the approach to electronic signature appropriate to the business needs for that attachment.</p>

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Comment Number	Page Number	Section	Comment
21.	56001 - 2	E. ATTACHMENT CONTENT AND STRUCTURE	The ADA finds the 64 megabyte file size to be acceptable, but the final rule should not prohibit trading partners to agree on a higher limit when necessary to adjudicate a claim. In addition, the ADA recommends that there be a process in place to periodically review the rule's file size limit to accommodate technology change.
22.	56004	G. Proposed Standards	The ADA supports adoption of the HL7 and X12 standards, as named in the preamble and Section 162.1915 of the regulatory text, to fulfill the business need addressed by the proposed claims attachment transaction standard. The X12 standards request and response transactions coupled with the HL7 messaging structures appear to represent the best electronic solution for exchanging additional information for the purposes of claims adjudication.
23.	56004	1. Code Set	<p>The ADA supports LOINC as the code set for representing the specific elements of attachment information. We, in part, are basing our support on the understanding that the "Proof of Concept" study in 1996 demonstrated that another code set, Health Care Claim Status Reason, did not adequately support the electronic claims attachment needs.</p> <p>Further, we believe that many sectors of the health care community are not familiar with the frequency or process by which the LOINC code set is changed. Therefore, the ADA recommends that a process and timetable be established and published for updates to the LOINC code set as it applies to the proposed claims attachment standard. The data content committees (ADA, NUBC and NUCC) named by the Secretary of HHS should review the business case for proposed changes to the LOINC code set for the claims attachment standards.</p> <p>In addition, the final regulation should allow for additional code sets that work in concert with LOINC.</p>
24.	56005	3. Electronic Health Care Claims Attachment Response Transaction	The ADA recommends 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.

Comment Number	Page Number	Section	Comment
25.	56006	4. a. Use of the Proposed Transaction, Specifications, and Codes for Electronic Health Care Claims Attachments	The ADA interprets this section as meaning one transaction may contain multiple attachments and attachment types to satisfy the need of the payer to adjudicate a claim.
26.	56012	H. Requirements (Health Plans, Covered Health Care Providers and Health Care Clearinghouses)	<p>The preamble of the NPRM states that “No other electronic transaction format or content would be permitted for the identified transactions.” In addition, the regulatory text in Section 162.1905 states that when using “electronic media” a covered entity must comply with the applicable standards. The ADA would like further clarification of what constitutes “other electronic transactions” and “electronic media.”</p> <p>Currently, some health plans and health care providers have systems in place in which the health plan can access patient information from the provider through a web portal. In this situation, there is no exchange of information between the health plan and provider. The health plan is able to obtain the information they need through the viewing capability. In addition, some providers respond to requests for additional information by emailing the scanned document to the health plan.</p> <p>The ADA recommends that the final rule recognize that these types of exchanges are allowed via web portals. In addition, the rule should state that a payer may not force a provider to use a web portal in lieu of the standard transaction (i.e., the payer must still be able to accept the standard transaction).</p>

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27.	56012	H. Requirements (Health Plans, Covered Health Care Providers and Health Care Clearinghouses)	<p>The ADA requests clarification of the second paragraph in this section, which states that "...use of the standard electronic health care claims attachment would not preclude the health plan from using other processes or procedures to verify the information reported in the attachment documentation."</p> <p>Clarification is needed when considering possible scenarios, including the following two examples:</p> <ol style="list-style-type: none"> 1) If the intent of this language is to address a post-payment review, then this should be more clearly stated. 2) If the intent is to allow for non-electronic verification of claims attachment information without any specific limitations as to when the verification can be requested, then there would be an undue burden to the health care provider to respond to the claims attachment request and later verify the attachment information either via the phone or paper submission.
28.	56012	[H.] Covered Health Care Providers	<p>The ADA supports the provisions which enable providers to convey information via paper or in other non-standard electronic formats when such matter is not part of the claims attachment transaction standard. This flexibility enables uninterrupted continuation of existing business processes, and may well facilitate transition to the proposed standard for its enumerated attachment types.</p>
29.	56013	3. Maximum Data Set	<p>The ADA agrees that each AIS should be considered to contain the "...maximum data set for each of the named electronic attachment types." The ability to predict the maximum facilitates implementation planning and execution.</p>
30.	56013	III. MODIFICATIONS TO STANDARDS AND NEW ELECTRONIC ATTACHMENTS	<p>The ADA agrees that the 1993 WEDI estimate of attachments should be reviewed for currency and accuracy. We believe, and have submitted comments on earlier portions of this NPRM, that the nature and number of attachment types should be determined by the named Data Content Committees, with information provided through surveys/information collection supported by HHS.</p> <p>Further, the ADA agrees that modifications to the claims attachment standard, once adopted by the Secretary, HHS, should be submitted, evaluated and acted upon through the DSMO process and the standards process as outlined in the ADA SCDI/HL7 MOU. Such modifications include transaction content and format, and attachment types, including new attachments. Modifications to external code sets would be not be subject to the DSMO process as such maintenance would be according to the protocols established by the entities responsible for such code sets.</p>

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31.	56016	COSTS AND BENEFITS 1. General Assumptions, Limitations, and Scope	<p>The ADA objects to what it proposed for 45 CFR 162.1920(e). We find that the assumption that attachments are "...usually...sent in response to a specific request after a claim has been submitted...." to be problematic, especially if it is being used in the cost and/or savings estimates. The ADA finds that what is actually occurring is provider submission of attachments without waiting for a specific payer request.</p> <p>Providers regularly comment, and health plans confirm, that currently attachments are frequently submitted in conjunction with the original claim submission whether or not they are necessary for a specific health plan's adjudication process. Myriad attachments are routinely sent by providers due to the lack of accepted standards concerning when an attachment is necessary for a particular type of claim.</p>
32.	56017	COSTS AND BENEFITS 1. General Assumptions, Limitations, and Scope	<p>The ADA strongly disagrees with one of the "...assumptions ...based on anecdotal comments by industry professionals...." The assumption "The volume of unsolicited attachments accompanying original health care claims today is relatively small" is not applicable to the dental community. As noted in the ADA comment for page 56016, myriad attachments are routinely sent by providers due to the lack of accepted standards concerning when an attachment is necessary for a particular type of claim.</p> <p>The perception that the overall volume is small may be correct for the entire health care community, but it is important to recognize that difference sectors work in different business environments.</p>
33.	56018	COSTS AND BENEFITS 3. Cost and Benefit Analysis for Covered Health Care Providers	<p>The ADA takes exception to the presumption that "...many of these items should not represent unusual expenditures..." or the cost "... to implement this proposal...are not to be considered to be significant..." Within dentistry and other medical arts the predominant organizational size results in annual revenue far under the \$8.5 million for physicians or \$6.0 million for other practitioners cited in the preamble's discussion of Small Business Association table of size standards (page 56015).</p> <p>Solo or two-person professional practices with annual revenues are more prevalent than the preamble suggests. The American Dental Association's "2003 Survey of Dental Practice" determined that 64.3% of all dentists were in solo practice and the annual gross billings per owner dentist were \$550,920 for general practitioners and \$778, 630 for specialists. The combined weighted annual billings were \$592,310, with 95.3% of billings collected (\$564,471) and considered annual revenue.</p>

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34.	56024	162.1910 Electronic health care claims attachment request transaction	The ADA would like clarification of the language in Section 162.1910 (a) (2) that indicates an attachment can be sent in advance of the health care claim submission. The process being allowed by this language would begin to make sense if the attachment was in support of a request for predetermination.
35.	56024	162.1920 Electronic health care claims attachment response transaction	The ADA objects to the language in Section 162.1920 (e). As drafted the regulation requires the existence of prior advance directives (“...advance instructions by a health plan.”) before a provider may send an unsolicited attachment. Other ADA comment on the NPRM notes our positions that use of unsolicited claims attachments enables a more efficient claims adjudication process, and that unsolicited attachments should be accommodated when there is a clear and unambiguous standard that is applied consistently between all providers and all payers.

Submitter : Mr. Robert Richardson
Organization : Dept of Veterans Affairs, General Counsel
Category : Federal Government

Date: 01/12/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-0050-P-69-Attach-1.DOC

Comments Submitted by the Department of Veterans Affairs
Office of the General Counsel

On

HIPAA Administrative Simplification: Standards for Electronic Health Care Claims
Attachments; Proposed Rule

Published September 23, 2005

GENERAL COMMENTS:

1. The business processes recommended in the NPRM lack specific guidelines in the use of the Claims Attachment. This leaves the potential for covered entities to use the transaction inappropriately. Please include instructions, such as a claim attachment can only be requested if the information is not readily available on the standard electronic claim, is directly related to the services reported on the claim and is required to process the claim.
2. VHA is concerned that this rule only addresses standardizing the process for submitting electronic claims attachment information, but does not address the information content for the human readable format. If the content scanned and submitted does not adequately address what the payer requires, claims processing will not improve.
3. The proposed standards introduce electronic business processes that are not commonly used in the reporting of claim information. Although the pilot performed by WEDI demonstrates the use of the transaction, the controlled environment did not account for the potential variations in Health Information Management processes or associated technology. Therefore, the VHA recommends an implementation period of 36 months for all covered entities.
4. The business processes described within the NPRM do not provide for or define a formal process for communication between a provider and health plan. The proposed process for requesting additional information is unpredictable and lacks guidelines. This often results in providers not knowing that a claim is held-up during processing because the health plan needs additional information. It is recommended that standards for acknowledgements and associated timing be incorporated into the final rule.
5. VHA strongly recommends that there be an efficient process for adding new HL7 Additional Information Specifications (AIS), adding new

standards, modifying existing standards, and managing versions that do not involve the lengthy rule-making process.

6. VHA requests clarification of which provider treatment setting this proposed rule applies. Is the rule meant for all provider organizations or just hospitals and physicians as implied? Although the claims attachment types specified could apply to a variety of provider settings, the discussion of additional HL7 Additional Information Specifications (AIS) for durable medical equipment (DME) and home care called the question of whether these settings are to be using the proposed attachments or wait for specific attachments unique to their setting.
7. VHA strongly urges testing of the different methods for submitting electronic claims attachments (computer and human variant) and the different types of attachments prior to implementation of the final rule.
8. Adequate training and implementation support are needed for most organizations to understand the new concepts of using LOINC and CDA within the X12 275 transaction. These costs need to be included in the cost benefit analysis and the Department of Health and Human Services needs to develop plans for providing implementation support as part of the final rule.
9. VHA has experienced difficulties due to health plans not fully supporting the current HIPAA claim standard (837), especially related to the coordination of benefits (COB) functions. In order to facilitate the adoption of these new standards, it is recommended that "contingency plans" be eliminated as soon as possible, but certainly prior to the release of the final claims attachment rule.
10. Please address how these proposed rules support the vision for a national health information infrastructure (NHIN). It appears that this process could be efficiently included in health information exchange efforts. Could claims attachment information be more appropriately incorporated as a component of the NHIN and Regional Health Information Organizations (RHIO)? This alternative needs to be addressed in the final rule.
11. VHA supports the recommendation in the proposed rule to include both Human Decision Variant (HDV) and Computer Decision Variant (CDV).

DEFINITIONS:

1. DEFINITIONS – LOINC® Codes are currently not used by all segments of the health care industry. This is an additional code set that will need to be understood and maintained by payers and providers alike, at additional costs. Currently these codes are available for free from the Regenstrief

Institute, however as additional versions are released, this may not be the case. The final rule needs to address how the LOINC Codes will remain available at no cost to covered entities.

2. DEFINITIONS – Provide clarification of the definition of Rehabilitation Services and related claims attachments. There is a concern with the lumping of skilled nursing under rehabilitation services. Although some skilled nursing services are rehabilitation, others are not. Is the intent to only allow skilled nursing service claims attachments that relate to rehabilitation or may any skilled nursing service (rehab or not) be submitted through this claims attachment?

EFFECTIVE DATES:

1. EFFECTIVE DATES – Due to the technical complexity of these transactions, it is requested that the implementation period be 36 months from the publication of the final rule, with no distinction between large and small payers.
2. EFFECTIVE DATES – It is recommended that the implementation of the attachment types be staggered, with two attachment types being required to be implemented by all covered entities within 24 months, with the remaining four attachment types within the following 12 months.

OVERVIEW OF KEY INFORMATION FOR ELECTRONIC HEALTH CARE CLAIMS ATTACHMENTS

1. It is recommended that CDA Release 2.0 be adopted at this time. Delay of adopting CDA 2.0 will increase the cost of implementation of this transaction. The current CDA Release 2.0 is being utilized for the development of the Electronic Patient Record. The Electronic Patient Record is a key to the ability of automating responses to the 277 electronically in the future. Increased cost would be associated with the initial implementation using CDA 1.0 and then implementing CDA 2.0.
2. It is recommended that CDA Release 2.0 be named in the final rule, but allow the Standards Development Organizations (SDO) (X12N and HL7) to specify the adoption of future versions/releases. This strategy works effectively with code sets, such as DRGs, and allows SDOs to specify the appropriate version/release and effective dates.

TRANSACTIONS FOR TRANSMITTING ELECTRONIC ATTACHMENTS

1. There is a concern that supporting standard transactions using different versions of the X12 standards adds unnecessary complexity. VHA recommends the adoption of X12 version 5010 (or later) for the claims attachment transactions. Further it is recommended that the claims

attachment transactions be "harmonized" with the other standard transactions X12 version. The claims attachment final rule should be incorporated within a rule for the next version of all of the HIPAA transactions.

2. VHA recommends that the X12 275 transaction and the X12 277 transactions named in the proposed rule be adopted in the 5010 version of the X12 standards instead of the 4050 versions.
3. The X12 275 Implementation Guide currently recommends using the 102 transaction to acknowledge the 275/HL7 CDA. VHA recommends using the 824 transaction to acknowledge the 275, as well as all components of the HL7 CDA. The 824 has the ability to support the acknowledgment information used by in both X12 and HL7 parts of the transaction.

ELECTRONIC CLAIMS ATTACHMENT TYPES

1. ELECTRONIC CLAIM ATTACHMENT TYPES - The six attachment types named in this proposed rule are a good start toward moving the industry from paper to electronic health care claim attachments and should be moved forward for standards. However, it is already known that additional attachment types are needed and under development by HL7 for DME, periodontal care, home health, EAP, CPHS and Consent Forms. The proposed rule did not mention all those under development. The extended period of time that it would take for the Department to move any additional attachment types forward after the compliance date creates an undue burden for payers and providers. Provisions for sun setting older versions of the standard or attachment types after a transition period must be included in the final rule.
2. ELECTRONIC CLAIM ATTACHMENT TYPES - New electronic attachment types should be developed in the CDA Release 2.0 given the period of time it will take to move to compliance at a future date. The six proposed electronic attachment types that are currently in CDA Release 1.0 should also be under development by HL7 in CDA Release 2.0 so that they can also be name in a future NPRM at the same time that any additional types are named.
3. ELECTRONIC CLAIM ATTACHMENT TYPES - Text and image based attachments will require payers to acquire additional storage space for electronic attachment files in their systems resulting in increased costs to process a claim. It would be helpful if a plan to reduce the human variant text and image based documents be a part of the final rule. Auto adjudication using the computer decision variant is the most cost effective for all covered entities.

FORMAT OPTIONS (HUMAN VS. COMPUTER VARIANTS) FOR ELECTRONIC CLAIMS ATTACHMENTS

1. **FORMAT OPTIONS** – There are two human variance options for submission of claims attachments – 1) image/scan a document or 2) manually enter data into conversion utility. VHA is concerned with the additional work and the increased potential for error with manually entering data. This should not be an option under consideration for electronic submission of claims data.

CONNECTION TO SIGNATURES (HARD COPY AND ELECTRONIC)

1. VHA is concerned with the language in the proposed rule related to electronic signatures, in particular the payers ability to request a paper copy of the signature without limitation. We are concerned that payers will use this practice for routine audit of claims – a practice that would be to the detriment of providers. We are particularly concerned that a payer could use the request for an original signature to routinely delay the claims adjudication process by requiring a paper document to be copied and submitted. We recommend that the final rule limit this practice for specific purposes, such as routine audits of claims or compliance checks for specific concerns. We recognize the payers need to determine that required signatures were obtained and recommend payers accept a response code indicating that a signature is on file. In absence of a national standard, we also recommend that payers accept the provider's policy for use of electronic signature to authenticate electronic documents and not impose their own standard or policy for what is or what is not an electronic signature.

SOLICITED VS. UNSOLICITED ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT

1. SOLICITED vs. UNSOLICITED ATTACHMENTS – VHA requests clarification of the process of unsolicited attachments described as “health plan has given them specific advance instructions pertaining to the type of claim or service” (Page 55999).
2. SOLICITED vs. UNSOLICITED ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT – Will health plans be required to store attachments that are sent to them in the unsolicited model (beyond the health plans published policy)?
3. SOLICITED vs. UNSOLICITED ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT - Health Plans may request that additional documentation (the attachment) accompany a claim, however in the Payer to Payer Coordination of Benefits Model will the primary payer be required to store documents that they did not request or utilize for claim adjudication and is being sent to meet a requirement of a secondary or later payer?

IMPACT OF PRIVACY RULE

1. VHA agrees that only the minimum necessary information should be provided. We are concerned that electronic attachments (either scanned or computer variant) will contain information that exceeds the minimum necessary standard. It is impractical and extremely labor intensive and error prone to redact scanned documents so that they only contain

minimum necessary information. The requirements for minimum necessary standard needs to be clarified for scanned and text documents.

HEALTH CARE PROVIDER VS. HEALTH PLAN PERSPECTIVE

1. PROVIDER VS PLAN PERSPECTIVE - It is of concern that the proposed rule indicates that a provider can require a health plan to send the 277 requests for attachments to an entity not identified in the 837 claim. The 837 transaction identifies the contact point for the 835 transaction return, but does not in the current 4010A1 version provide a contact point specific to attachments. If the provider would like a different entity contacted, then the 837 claim should have an additional loop specific to attachment requests. The current 837 transaction is lacking this functionality. This will create undue burden on the payer to contact a provider by phone or in writing to find out who the request should go. Not all payers have contracts or trading partner agreements in place with all providers submitting claims to them electronically. This should be addressed in the final rule.

ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT CONTENT AND STRUCTURE

1. ATTACHMENT CONTENT AND STRUCTURE – The design of the claim attachment is to answer all questions related to a claim within a single response. The 64 megabyte limitation may not be adequate if considerable content is required, especially if the provider responds with human readable digital images. It is recommended that this limit be increased or the ability to “split” responses be developed.
2. ATTACHMENT CONTENT AND STRUCTURE - This section states the X12 275 response transaction permits up to 64 megabytes of the data in a single transaction. The X12 275 transaction recommends that the size of the BIN segment does not exceed 64 MB. A single transaction (275) can support multiple BIN segments; therefore the recommended size limitation is not on the transaction but rather the BIN segment within the transaction.

G. PROPOSED STANDARDS

1. VHA is concerned that only LOINC is called out in the standard without reference to supporting or related terminologies and code sets and their relationship. Clinical content contained within a claims attachment must be based on a robust clinical vocabulary – which LOINC is not. How will LOINC relate to SNOMED and map to other pertinent code sets such as ICD-9-CM or ICD-10?

H. REQUIREMENTS (HEALTH PLANS, COVERED HEALTH CARE PROVIDERS AND HEALTH CARE CLEARINGHOUSES)

1. VHA requests clarification if a provider is required to respond only with an electronic claim attachment if they receive an electronic request for an attachment. In other words, can a provider submit a paper response to an electronic request, on a request by request basis? How will the payer know that the document is being sent on paper?
2. The proposed rule requires covered entities to comply with the rule, but is not clear whether the traditional paper process is still an option for some payers or some providers (if they choose). What is the scope of enforcement? Can a payer or a provider opt out? Can documents continue to be faxed to the payer? Some providers use secure website for records requested by high volume payers – will this type of communication be allowed for payers to request claims attachments and for providers to respond once the final rules are implemented?

III. MODIFICATIONS TO STANDARDS AND NEW ELECTRONIC ATTACHMENTS

1. MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS - The goal of HHS should be to move the regulatory process forward more quickly for new transactions, attachment types and versions of current HIPAA transactions. More time is needed to create and implement new attachment (AIS) types than to make changes to current ones.
2. MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS - Recommend that the six named attachments (AIS) be adopted as standards.

Submitter :

Date: 01/16/2006

Organization : Accu-Med Services LLC

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Please see attached MSWord document.

CMS-0050-P-70-Attach-1.DOC

**Comments from Accu-Med Services LLC
To
Department of Health and Human Services
Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62
For
HIPAA Administrative Simplification:
Standards for Electronic Health Care Claims Attachments**

Subject:

The following comments are offered concerning the September 23, 2005 Federal Register notice for proposed rule from the Office of the Secretary, HHS. The rule notice covered proposed standards for “electronically requesting and supplying particular types of additional health care information in the form of an electronic attachment to support submitted health care claims data.” The file code under which these comments are tendered is CMS-0050-P.

Who We Are:

Accu-Med Services (Accu-Med), a division of Omnicare Inc., is the largest clinical and financial software provider in the Long Term Care industry with approximately 5,000 facilities nationwide. Ten of the most prominent national Long Term Care chains use the software and services of Accu-Med, a driving force in the Long Term Care, Subacute and Assisted Living marketplace since 1984. Our parent company, Omnicare (NYSE: OCR), is the nation's leading provider of pharmaceutical care for seniors and is the largest provider of institutional pharmacy services to the Long Term Care industry.

General Comments:

Accu-Med applauds HHS's efforts with the Transaction Rule standards stipulated within The Health Insurance Portability and Accountability Act (HIPAA) of 1996 to bring an electronic exchange of information standardization to the health care industry. We agree standardization of health care information exchange, including full automation of health care claims, attachments and payments processing, is important and vital. And, it will have a positive financial benefit to the health care industry though monetary benefits may not be realized for several years.

With the goal of full automation in mind and directed from Accu-Med's expertise in the Long Term Care industry, the specific comments on the following pages are offered.

**Comments from Accu-Med Services LLC to Department of Health and Human Services
Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for
HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments**

DEFINITIONS:

Page 55994, Column 2, Text –

“LOINC stands for Logical Observation Identifiers Names and Codes (LOINC®). It is a code set that provides a standard set of universal names and codes for identifying individual laboratory and clinical results as well as other clinical information.”

Comment:

The adoption of the LOINC® code set as a HIPAA code set appears to be a good choice. However, with approximately 41,000 terms - 31,000 of them related to laboratory testing - further review of the code set for clinical applicability is needed. Clinical content contained within claims attachments must be based on a robust clinically derived vocabulary. In addition, how will the LOINC® code set relate to SNOMED and map to other pertinent HIPAA code sets?

EFFECTIVE DATES:

Page 55994, Column 2, Text –

“Covered entities must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule unless they are small health plans. Small health plans will have 36 months from the effective date of the final rule to come into compliance”

Comment:

Given Accu-Med's past 50-State experience with the development of the 837 Institutional Health Care Claim Transaction Set (837I), we do not feel 24/36-month compliance “from the effective date of the final rule” will be enough time given the specifications of the proposed 277 and 275. To illustrate:

There was only one implementation guide for the 837I transaction. For the proposed 277/275 transaction sets, there are two Implementation Guides, six AIS booklets, and two different methods (CDV & HDV) of implementation; three if you further subdivide the HDV between scanned documents and free-typed text. Further, the 837I transaction did not involve the introduction of a code set that will be entirely new to the Long Term Care industry, (i.e. LOINC®). Nursing Homes have not used LOINC® in the past. Consequently, not only will they need to develop, test, train and implement the new transaction sets; they will also need to train and learn an entirely new code set. This process simply cannot be accomplished in the time frame provided.

Comments from Accu-Med Services LLC to Department of Health and Human Services Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments

Therefore Accu-Med encourages HHS to address legislative and regulatory barriers that impede creative implementation models that enhance the likelihood of successful implementation of the standard. Furthermore, we promote for consideration a phased implementation plan of the proposed 277 and 275 Health Care Claims Attachments standards. This plan would be implemented by region with the first region to be online no less than 36 months after effective date of the final rule. An alternate (reduction in initial AIS booklets) version of the plan could be implemented within a 24-month period. The implementation plan would be similar to the adoption process of Minimum Data Set (MDS) 2.0 where MDS+ was piloted in several states in effect testing the 2.0 release of the MDS. In this manner the implementation process itself could flush out any issues not currently understood or seen from the limited CMS sponsored 277/275 pilot.

Page 55995, Column 3, Text –

“We are aware that HL7 continues to improve its standards, including the CDA. In fact, CDA Release 2.0 was first balloted in August 2003 and re-balloted in 2004. While Release 2.0 may be approved between the time of this proposed rule and the final rule, this proposed regulatory text does not suggest its adoption at this time. However, if Release 2.0 is approved by HL7 between the time of this proposed rule and the final rule, we may propose its adoption for future AIS, based on the impact of CDA Release 2.0 on the existing AIS.”

Comment:

Since HL7 CDA 2.0 was approved in May 2005, Accu-Med recommends a delay of this rule until modification of the six proposed AIS booklets to use CDA 2.0 has been completed. Why set up the potential need to support the possibility of two CDA standards within a relatively short period of time?

ELECTRONIC CLAIM ATTACHMENTS TYPES:

Proposed:

- Ambulance Service Attachment
- Emergency Department Attachment
- Rehabilitation Services Attachment
- Clinical Reports Attachment
- Laboratory Results Attachment
- Medications Attachment

Comment:

Are the above electronic claim attachment types enough for the Long Term Care industry? For example, consider the Rehabilitation Services Attachment. Though some Long Term Care providers are rehabilitation oriented, many are not. This would mean the

**Comments from Accu-Med Services LLC to Department of Health and Human Services
Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for
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implementation of a difficult and cumbersome process in the Long Term Care industry for a limited number of claims. The bulk of the claims in a typical nursing home are not rehabilitation claims. Implementing the rehab transaction only will be extremely costly and provide very little benefit. Also, few nursing homes have the basic equipment necessary to enable scanning of response documents and embedding them in the BIN segment for submission to the payer. Once again implementing only one transaction in the Long Term Care industry would cause these facilities to incur increased costs with little benefit.

Page 55997, Column 1, Text –

“New electronic attachment standards approved by the SDO but not adopted by the Department may be used on a voluntary basis between trading partners, but there is no regulatory authority over their use.”

Comment:

It is not certain to which SDO this text is referring, X12N or HL7 or both. Based on the previous sentence it appears to be referring to the HL7 SDO; however, for clarity HL7 should be added to uniquely identify which SDO. In addition the use of “attachment standards” further complicates which SDO standard, (i.e. X12N or HL7) is referenced.

In general, Accu-Med agrees with the principle described. Allowing trading partners to utilize SDO approved attachment types will give the industry the ability to adapt to changes without the restriction of the regulatory process. However, the use of the word “voluntary” without limitation may give cart-blanc to a health plan to mandate use of a newly approved but not adopted HL7 attachment type.

Suggested replacement wording to be:

New electronic HL7 attachment types approved by this SDO but not adopted by the Department may be used on a voluntary basis between trading partners. There is no regulatory authority over their use; however, if a trading partner declines to use a new approved but not adopted attachment type, then claims adjudication may not be adversely affected.

FORMAT OPTIONS:

Page 55997, Column 2, Text –

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

Comment:

Comments from Accu-Med Services LLC to Department of Health and Human Services Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments

Human vs. Computer Decision Variants – Mapping of LOINC codes and Modifiers could be a large effort on a state-by-state and health plan by health plan basis. Capture of data, including images, to transmit back will be impacted by hardware infrastructure (or lack thereof), current data state, and use of proprietary systems/image formats. Also, without specification concerning the image format, the BIN segment may contain support of a multitude of binary image formats and versions. This effect will become cumbersome and have potential direct financial impact on health care providers if a health plan selects to mandate use of a proprietary image format. It is suggested that the BIN segment image format be limited. Constrained to use public/open source image formats (e.g. tiff, jpeg) and be further restricted to a minimum version level of a specific image format.

X12N 275 (004050x151) only allows for one claim attachment per 275 Transaction ST/SE pair. Submitting more than one response per 275 or claim attachment within the same transmission file requires certain segment data (e.g. receiver and submitter identifying segments) to be duplicated. This is in direct conflict with a general X12 goal of removing data duplication especially in light that X12 has a segment for Hierarchical Level support (i.e. HL segment tag).

Use of HDV with scanned images will cause submission files to become large and will negatively impact Long Term Care health care providers who may use dial-up communications. Required disk storage capacity will be negatively impacted through the need to store scanned images for inclusion in claims attachments.

COMBINED USE OF DIFFERENT STANDARDS:

Page 55998, Column 1, Text –

“7. Combined Use of Two Different Standards Through Standard Development Organization (SDO) Collaboration.”

Comment:

Accu-Med feels the merits of using the expertise of X12 and HL7 is a good idea from an electronic administrative and clinical perspective. However, oversight must be undertaken and control(s) established so the collaboration will not hamper the desired outcome of the reduction of health care administrative burden.

Page 55999, Column 1, Text –

“Over the past few years, health plan rules and policies regarding the additional data necessary to adjudicate a claim have evolved, and in fact, many health plans have begun to limit or reduce their requests for claims attachments. Therefore, it is critical that members of the health plan industry and the health care provider community actively engage themselves in the final development of this proposed rule so that the proposed attachments are indeed those which will yield significant benefits to health care providers and health plans alike.”

**Comments from Accu-Med Services LLC to Department of Health and Human Services
Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for
HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments**

Comment:

How is this possible if the rule is now in NPRM and only two of the AIS booklets have been "tested?" Additional pilot efforts, as recommended at the Second Collaborative Claims Attachment Vendor Forum held in Fairfax Virginia on August 23 - 24, 2005, or a phased regional implementation plan is needed to answer this question.

SOLICITED VS. UNSOLICITED ATTACHMENTS:

Page 55999, Column 2, Text –

"We are proposing that health care providers may submit an unsolicited electronic attachment with a claim only when a health plan has given them specific advance instructions pertaining to that type of claim or service."

Comment:

This restriction is a good idea and will help keep the volume of unneeded attachments to a minimum. However, it may also negatively impact skilled nursing home providers who already have high denial rates because of incomplete ADR submission. Therefore, if this restriction is implemented, it becomes imperative that health plans disseminate their entire claim attachment requirements and allow discretion by the provider to remit relevant supporting documentation and not be limited by a health plan's specific request.

Page 55999, Column 2, Text –

"Health plans may also request, in advance, that additional documentation (the attachment) accompany a certain type of claim for a specific health care provider, procedure, or service. The ASIG refers to this scenario, of sending attachment information with the initial claim, as an unsolicited attachment because a request was not made after the fact, using the standard request transaction."

Comment:

This methodology of submitting more than one transaction type within a submission represents a paradigm shift. Current mandates by many health plans do not permit use of more than one transaction set within a transmission file.

Page 55999, Column 2, Text –

**Comments from Accu-Med Services LLC to Department of Health and Human Services
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HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments**

“We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired “questions” and/or documentation needs relevant to that specific claim. Health care providers would be required to respond completely to the request, using one response transaction. ... The intent of these proposed requirements is to avoid inefficient, redundant processes.”

Comment:

While we understand the proposal and its justification, current claims attachments processing may in fact require a follow up question from a health plan. In general, current attachment request and response process calls for the provider to provide all requested material. However if the information provided creates additional questions, the health plan normally will request the additional clarification. Only one request/one response per claim per health plan would then cause more claims to be denied due to the inability for health plans to have a follow up process. Therefore Accu-Med suggests the adoption of a one plus one request process. This will allow health plans to have one additional request that is based on the claim attachment information rendered from the first request.

Page 55999, Column 3, Text –

Impact of Privacy Rule

Comment:

Privacy issues – Minimum Necessary vs. TPO -- How is the health care provider going to know if what the health plan has requested is reasonable without further guidance? Also, as described in the solicited vs. unsolicited comment, the health care provider may need to supply more than what was originally requested. For example, a request for supporting documentation is not within the nursing notes; however is contained within therapy notes. In addition, redact of scanned images or electronic reports are labor intensive and error-prone. Therefore a safe harbor should be considered on the information exchange between a health care provider and health plan.

Page 56000, Column 1 Text –

Impact of the Security Rule

Comment:

Security issues – The transmission of human readable text or images within the BIN segment presents an EPHI security risk without the requirement to encrypt the BIN segment or transmission file.

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Page 56000, Column 2Text –

Connection to Signatures (Hard Copy and Electronic)

Comment:

A health plan's ability to obtain signatures in the proposed rule should be constrained – specifically, their ability to request a paper copy of the signature. If this provision remains intact, a health plan could routinely delay adjudication process merely by requiring a manual document be copied and submitted. Accu-Med recommends this practice be governed and available only when there is a specific concern. We recognize health plans need to determine required signatures are obtained, and accordingly, recommend that health care providers be permitted and health plans accept use of a code indicting a signature is on-file until an eSignature standard can be agreed upon as a reasonable solution.

PROVIDER VS PLAN PERSPECTIVE:

Page 56001, Column 2, Text –

“It would be helpful if health care clearinghouses were among the first of all entity types to come into compliance with these standards so that testing between trading partners—health care providers and health plans—could be executed in a timely fashion.”

Comment:

Clearinghouses are asked to be ready first, whom will they test? With what will they test? Will there be certification and/or a data repository to validate against? A phased implementation plan complete with validation data similar to the clinical MDS validation data would have the greatest probability for success.

ATTACHMENT CONTENT AND STRUCTURE:

Page 56001, Column 3, Text –

“The implementation guide for the X12 275 response transaction permits up to 64 megabytes of data in a single transaction.”

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Comment:

Is the "64 megabytes of data" a limit or recommendation? Per the proposed X12N 275 specification it is a recommendation. Also this recommendation is on the BIN segment, not a single transaction.

Page 56001, Column 3, Text –

"... the proposed standards are those that have been under development for over eight (8) years by the HL7 ASIG. Meanwhile, the health care industry itself has undergone significant change."

Comment:

It is correct to say the development of the X12N 275/277 and HL7 ASIG standards have taken a long time; however, the documents proposed in this NPRM do not take into account all recommendations or results from WEDI and the CMS pilot. For example, the recommendations from WEDI and the CMS pilot regarding use of companion acknowledgement transactions within the proposed X12N guides are not taken into account.

ALTERNATIVES CONSIDERED: CANDIDATE STANDARDS:

Page 56001, Column 3, Text –

"Health plans would be required to be prepared to receive and send only the standards specified in § 162.1915 and § 162.1925 for the identified transactions. No other electronic transaction format or content would be permitted for the identified transactions."

Comment:

Is this statement not in conflict with the previous statement on Page 55997 concerning trading partner agreements to use approved but not adopted attachment types?

Page 56005, Column 1 and 3, Text –

"We are proposing to adopt the ASC X12N 004050X150 (ASC X12N 277—Health Care Claim Request for Additional Information) transaction to convey the request for the electronic claim attachment."

**Comments from Accu-Med Services LLC to Department of Health and Human Services
Regarding NPRM 45 CFR Part 162 [CMS-0050-P] RIN 0938-AK62 for
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"We are proposing to adopt the ASC X12N 004050X151 (ASC X12N 275— Additional Information to Support a Health Care Claim or Encounter) as the response transaction to convey the claim identification and related data, such as individual name, provider name, date and type of service, that are needed to match the information to the original claim."

Comment:

The NPRM proposes adoption of two X12N 4050 guides that have updated 5010 versions. Like the use of HL7 CDA Release 1 for the AIS booklets, Accu-Med believes use of the X12N 5010 release of these guides, known as TR3s, should be considered. In addition to removing the need to support two X12N release levels is a relatively short time; use of the 5010 277/275 TR3s would synchronize the 277/275 to the probable next general HIPAA approved X12N Transaction Set (e.g. 270, 271, 835, 837, etc.) release level.

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS:

Page 56014, Column 1, Text –

"We expect that the HL7 ASIG will continue to develop new standard AISs using the HL7 CDA Release 1.0 framework, and these will be approved under the established DSMO process."

Comment:

This sentence states all new standard AISs will be CDA 1.0 though this may not be true. Due to ongoing HL7 CDA release development and a stated goal to not limit adoption of new attachment types, we recommend replacement of "HL7 CDA Release 1.0" with "HL7's currently approved CDA Release."

Is there a proposed time frame for adoption of new or modified attachment types by HL7? Is it yearly, quarterly, etc? We understand the formal adoption process for HIPAA, because this process is clearly defined. However, like the X12 process, the HL7 adoption process for attachment types is not widely publicized and the public comment periods on proposed standards are not well-known and rather short duration. If updated and new attachment types are to be relevant to the entire health care industry, HL7 must make an effort to enlist all sectors and give ample time for each sector to digest, respond, and vote on proposed attachment types without the need to be a member of HL7. In this manner the adoption process may occur as a matter of facts in use rather than as a reaction to new types that have little to no relevance.

Submitter : Ms. Cyndee Weston
Organization : American Medical Billing Association
Category : Health Care Professional or Association

Date: 01/16/2006

Issue Areas/Comments

GENERAL

GENERAL

Anytime a claims processor has additional information they believe will help clarify a claim, they should be able to submit such information. It should not be based only on a solicited or controlled (unsolicited) use. If the use of attachments are only available under controlled situations, claims will be delayed when it could have possibly been prevented. We believe that attachments should be available for use under any circumstances when additional information is available. We estimate that our members attach additional information to paper claim submissions on 15 to 20 percent of all claims they submit under unsolicited situations to try and head off delays. The information is generally submitted as a stapled paper attachment that is mailed to carriers. Additionally, we have estimated that 15% of claims submitted with no additional information require a paper response to the carrier.

Submitter : Mrs. Mary Lou Jackson
Organization : Group Health Cooperative
Category : Health Plan or Association

Date: 01/17/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-72-Attach-1.DOC



www.cms.hhs.gov/regulations/ecomments

January 10, 2006

CMS-0050-P

EFFECTIVE DATES

Covered entities must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule unless they are small health plans. Small health plans will have 36 months from the effective date of the final rule to come into compliance.

COMMENT:

We agree with the timeline outlined, however, the timing of the Final Rule released is critical. If these dates are in conflict with the ICD-10 ruling it may prove to be problematic for organizations to implement these two items concurrently.

Now that we have experience with the transactions defined by HIPAA, we have observed that many software vendors are tying these transactions to new modules or new versions of their products. With the notice that went out in November the target date for releasing the Final Rule is September 2008. This date will occur after most organizations have closed their budget cycle for requests for new funding to support new requirements. Due to the already incurred expense most organizations have adopted a policy of not funding capitol expense or operational expenses until after the Final Rule is published. If the Final Rule is published in September, it may not be possible to get the funding for implementation until the next budget cycle, so the request would not be considered until late summer 2009 and funds released early in 2010; we may have lost over a year on this timeline.

Consideration when determining a timeline must be given in conjunction with the time of year the NPRM is published in order for both Health Plans and Health Care Providers to work their respective budget cycles to meet the regulated implementation dates.

ELECTRONIC CLAIMS ATTACHMENT TYPES

Comments are invited as to whether the six proposed attachment types are still the most frequently requested by health plans, and if there are others that are equally or more pressing for the industry. In the future, any new electronic attachment types, or changes to the six attachments standards proposed here,

would require the Department to follow the usual rulemaking process. If changes are requested of the six proposed attachments standards, as a result of public comments during the period between the proposed and final rule, it is highly likely that HL7 would be able to make and ballot such changes in time for their adoption in the final rule. New electronic attachment standards approved by the DO but not adopted by the Department may be used on a voluntary basis between trading partners, but there is no regulatory authority over their use.

COMMENT:

As both a payer and a provider we have experienced a small reduction in the need to provide or receive paper attachments, with the implementation of the electronic 837 claims. The electronic claim format has aided in the ability to provide most of the data required to adjudicate and pay claims.

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

COMMENT:

We feel there will be added expense connected with the introduction of electronic attachments, in developing additional processes to safely protect and store the additional data. We would like for you to consider further enhancing the electronic claim to include more of the data elements required to adjudicate claims and potentially eliminate the need for as many electronic attachments.

COMBINED USE OF STANDARDS

Claims attachment transactions contain both administrative and clinical information. Thus, attachment data could come from a health care provider's clinical record system, whether paper or electronic, as well as from its practice management or billing system. Historically, these two distinct areas (clinical vs. administrative) have been the domain of two different SDOs: HL7 focuses on clinical data standards, while X12 concentrates on administrative data and transactions. In 1997, a joint effort between HL7 and X12 produced several options that would facilitate the communication of both clinical and administrative data, as well as smooth the transition from paper to a standardized electronic process for health care claims attachment information. However, because these two standards have not been used together before, we solicit industry feedback regarding this strategy.



From the health plan perspective, the requirements for use of the two standards can be met with a low impact implementation for claims adjudication, based on a person looking at the content of the electronic attachment in a text/readable format, regardless of how it is submitted. While the proposed process supports auto-adjudication, it does not require it for compliance.

ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT BUSINESS USE

Attachments may be requested or submitted when the supplemental medical information is directly related to the determination of benefits under the subscriber's contract, or when directly related to providing medical justification for health care services provided to the individual when that medical justification can affect the adjudication of payment for services billed by the provider of health care services. Although additional clinical or administrative information may be required following adjudication of claims, such as for post-adjudication review to support quality control, fraud and abuse, or other post-adjudication reviews and reporting requirements, we do not consider these post-adjudication requests for claims-related data to be part of the claims payment process. Therefore, post-adjudication processes are not covered by this proposal.

COMMENT:

As a payer we find the majority of our requests for attachment data is in the post-adjudication processing. We are finding in receiving approximately 250 thousands claims per month we are only needing attachment data on about 100 claims prior to being able to adjudicate and pay the claim. However, in much discussion around the industry we are finding the term "post-adjudication" is being interpreted differently by many payers as well as providers, it would serve the industry well, if this term were further defined in the final rule.

1. ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT VS. HEALTH CARE CLAIMS DATA

Electronic health care claims attachments must not be used to convey information that is already required on every claim. Information needed for every claim is "claims data" that must be conveyed in the appropriate standard claim transaction. The purpose of a claims attachment is to convey supplemental information that is directly related to one or more of the services billed on the claim submitted by the health care provider when further explanation of those services is required before payment can be made by the health plan.

COMMENT:

As both a Health Plan and a Health Care Provider we have found the number of Claims Attachments has been drastically reduced when the 837 Health Care Claims were implemented. We have found most of the data required for adjudication is now contained in the 837, with a just few exceptions. Again, we would encourage the enhancement of the electronic claim to contain more of the data required to adjudicate the claims and reduce the number of electronic attachments the industry would have to deal with.

2. SOLICITED VS. UNSOLICITED ATTACHMENTS

In general, health care providers will submit their electronic health care claims attachment information to the health plan for certain claim types, upon request, after the health plan has received and reviewed the claim. This follows the course of claims adjudication today. Health plans may also request, in advance, that additional documentation (the attachment) accompany a certain type of claim for a specific health care provider, procedure, or service. The ASIG refers to this scenario, of sending attachment information with the initial claim, as an unsolicited attachment because a request was not made after the fact, using the standard request transaction. We are proposing that health care providers may submit an unsolicited electronic attachment with a claim only when a health plan has given them specific advance instructions pertaining to that type of claim or service.

We are proposing such a restriction around "unsolicited" electronic attachments, because we believe that there are legal, business, and technical implications for health care providers, health plans, and their business associates for Handling and processing unsolicited attachments without prior direction. If health care providers were permitted to submit unsolicited electronic attachments with any claim without prior arrangement with the health plan, there would be a number of issues, including compliance with the Privacy Rule's minimum necessary standards, and identifying the new business and technical procedures health plans would need to develop to review, evaluate, store, return, or destroy the unsolicited documents. Similarly, health care providers would need systems and processes to track submissions and returns.

We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired "questions" and/or documentation needs relevant to that specific claim. Health care providers would be required to respond completely to the request, using one response transaction. The intent of these proposed requirements is to avoid inefficient, redundant processes. A health Plan would

not be able to extend adjudication through a lengthy process of multiple individual attachment requests for the same claim: submitting one LOINC request code at a time, receiving the health care provider's response, and then submitting another transaction with another LOINC code.

COMMENT:

As a payer we already we already have a process in place by which we advise our providers to only send paper attachment when requested. This is published in our Providers Guide. Our systems are set up to match the attachments to the claims based on the Claim number we provide in the request. Receiving electronic attachments unsolicited could actually result in delaying payment of more claims as we try to get a claim number assigned to the inbound claim and then link up the attachment with the claim number.

When attachments are sent in the unsolicited model along with the claim, we have some concern as to how to handle the attachment if the claim is rejected. Since the attachment will be separated from the claim and go through different processing, the attachment data has the potential to become orphaned data in our systems. Our Privacy Officer feels this is EPHI that we are not entitled to view and store, so we would somehow need to remove the data and return it to the providers.

We are requesting some clarifications from CMS on exactly how this should be handled in order to comply with the Privacy and Security Regulations..

As a provider, we feel it would be very difficult to produce the claim from one system and the attachment from a different system and then package them together in the same transaction. We are finding with the 837 claim transaction less than 6% of our claims actually require data that would be contained in the attachment.

As both a health plan and a provider we would find it hard to believe we could recoup our return on the investment this transaction would require in a normal expected time frame.

3. COORDINATION OF BENEFITS

With respect to electronic attachment requests and responses in a COB scenario, we assume that the primary health plan will request only the attachments it needs to adjudicate its portion of the claim. The secondary health

plan would request its own attachments in a separate (X12N 277) transaction sent directly to the health care provider. In health plan-to-health plan (also known as payer-to-payer) COB transactions, the primary health plan may not know the secondary health plan's business rules, and therefore would not be expected or required to request an attachment on behalf of the secondary health plan.

COMMENT:

We totally agree with this section, it would not be a sound business practice to get into trying to manage electronic attachments in the payer-to-payer COB situation. We believe this would add such an additional cost to development of this transaction it would not justify any perceived gains it could offer.

4. IMPACT OF PRIVACY RULE

Health care providers often sent the individual's entire medical record to the health plan for the purpose of justifying a Claim. Health plans and health care providers indicated that this practice reduced instances for which follow-up Requests for more information were needed, since all possible information was supplied at once. That practice was often wasteful and time consuming, and it is now generally inconsistent with the 'minimum necessary' standards

These standards require covered entities to 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 or disclosure. In situations where the minimum necessary standard applies, such as when a covered health care provider discloses protected health information to a health plan for payment, the standards prohibit disclosure of the entire medical record unless the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the disclosure. The Privacy Rule exempts from the minimum necessary standard any use or disclosure that is required for compliance with the Transactions Rule (45 CFR 164.502(b) (2)); thus, the minimum necessary standard does not apply to any required or situationally required data elements in a standard transaction

However, the minimum necessary standard would apply to data elements for which health plans or health care providers may exercise discretion as to whether the information should be provided or requested in the transaction. For example, health plans must apply the minimum necessary standard when selecting the attachment information to be requested in a particular electronic attachment request transaction.

For health care providers who choose to submit attachment information in the form of scanned documents, efforts will need to be made to ensure that those documents do not contain more than the minimum necessary information. We solicit comments on the extent to which the use of the proposed electronic attachment standards will facilitate the application of the "minimum necessary" standard by covered entities when conducting electronic health care claims attachment transactions.

COMMENT:

In discussions with our Privacy Office, she has expressed many concerns in regards to receiving an excess of EPHI. While the preamble states providers should take special care to assure excess data is not transmitted, the reality of the situation is that most providers will not have the technical capabilities to effectively address this situation. We believe we will need to put additional safeguards in place to protect this data. This may include some additional software, training and auditing capabilities. This in turn will up the costs to implement a transaction that will be used only by the most sophisticated providers.

5. IMPACT OF THE SECURITY RULE

Most covered entities (with the possible exception of small health plans) will be in compliance with the Security Rule by the time of this proposed rule; and all health plans will have fully implemented their security programs by the time the final rule is published for electronic health care claims attachments.

COMMENT:

We agree with this statement as both a payer and s provider we have implemented security safeguards, we will need to evaluate the processes designed to accommodate electronic attachments to assure they are in place for the new processes..

6. CONNECTION TO SIGNATURES (HARD COPY AND ELECTRONIC)

This regulation does not propose requirements for Electronic Signatures (e-signatures) because a consensus standard does not presently exist that we could propose to adopt, nor does any Federal standard currently govern the use of electronic signatures for private sector health care services.

We are aware that virtually all health plans, including the Medicare and Medicaid programs, require signatures certifying certain types of services, such as

sterilization, certain rehabilitation plans, and authorization for certain types of equipment. For example, health plans may request a paper copy of the signature page of a rehabilitation plan, or they may accept the response code indicating that the signature is on file.

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

COMMENT:

In most cases if a referral has been received prior to the treatment a signature is not required. In the limited cases where a signature is required we will need to complete further investigations on the proper method to be used for our organization.

7. CONNECTION TO CONSOLIDATED HEALTH INFORMATICS INITIATIVES

This program is known as the Consolidated Health Informatics (CHI) initiative. In 2003, CHI targeted 24 "domains" for data and messaging, from laboratory results to vocabulary for nursing, to medications. Furthermore, the work and outcome of CHI related activities do not conflict with HIPAA. Indeed, CHI has adopted HIPAA standards as the Standards for the exchange of administrative information.

No comment on this section.

8. PROVIDERS VS. PLAN PERSPECTIVE

Health care providers and health plans regard claims attachments quite differently. Health care providers would prefer to keep attachments to a minimum and regard requests for additional claims-related information as unnecessarily lengthening the payment cycle. Health plans consider the use of attachments as a necessary tool to ensure appropriate payment decisions, maintain quality assurance, and minimize fraud and abuse.

This rule does not propose to set out requirements for the appropriateness of requests for additional information. However, the proposed attachment standards are designed to reduce miscommunication and multiple requests for information by providing specificity to both the request for information and the response, and by establishing specific limits to the content of the attachment.

So, for example, a health care provider may direct a health plan to send any request for additional documentation to it or its business associate in standard

form, for those attachment types for which a standard has been adopted here, and the health plan must do so. The health care provider may also request that the health plan accept the attachment information in the standard response transaction. However, as we have stated in the past, we do not believe that the use of a standard transaction can create a business relationship or liability that does not otherwise exist.

9. HEALTH CARE CLEARINGHOUSE PERSPECTIVE

Health care clearinghouses are covered entities under HIPAA, and must be able to accept and transmit a standard transaction when asked by a health care provider or health plan for whom they serve as a business associate for those functions. It would be helpful if health care clearinghouses were among the first of all entity types to come into compliance with these standards so that testing between trading partners—health care providers and health plans—could be executed in a timely fashion.

COMMENT:

We agree with this premise, even though many clearinghouses professed to be ready for the first round of electronic transactions, experience found they were in actuality not ready and we requesting a great many exceptions to the standard format. It is our belief that if providers have the mechanism in place to get the data required in the attachments to a clearinghouse, they probably have the capabilities to conduct this transaction direct with their payers.

E. ATTACHMENT CONTENT AND STRUCTURE

There are two separate transactions associated with the electronic claims attachment. One transaction is a health plan's request for health care claims attachment information, and the other is the health care provider's response, which includes submission of the attachment information.

Thus, the standards we are proposing for any of the named electronic Attachments types will specify:

- The administrative information contained in the request and response;
- The attachment information (also referred to as the additional information specification) contained in the response;
- A code set for specifically describing the attachment information;
- A code set modifier for adding specificity to the request; and
- The format that will contain all of this information.

The implementation guide for the X12 275 response transaction permits up to 64 megabytes of data in a single transaction. Industry comment on file size is also welcome.

COMMENT:

While we have mixed feeling on this limitation, we are in support of maintaining the limitation in the final rule. We do feel that it might be a good idea and save many unnecessary debates if CMS would offer some guidance in the final rule as to the proper handling of transactions when the size limit is exceeded.

It is, therefore, critical that appropriate industry representation reviews and then weighs in on these standards: The attachment content, and format, and the transaction's function.

COMMENT:

We have experienced in our review of this transaction, the concept of the HL7 booklets is so foreign to what business people are familiar with, we have just not had the time, money and resources to completely educate the business process owners on even the basic concept of how to read the documents and fully understand the requirements. The use of LOINC codes, while we agree it the best option, tends to overwhelm the business representatives, the vast amount of education required for people to make completely informed decisions about the content of the attachments has just not been available. Management has not been willing to let people move away from their normal day to day jobs to focus on this transaction.

G. PROPOSED STANDARDS

We are proposing certain industry consensus standards that, when used together, provide the functionality necessary for the electronic health care claims attachment. No other industry standards are in use today for this purpose. The proposed standards are usually compatible with the other ASC X12 and HL7 standards and can be translated to and from various systems using software programs (commonly referred to as "translators" and "interface engines") that are increasingly used by industries using ASC X12 transactions and HL7messages.

We support the recommendation, and have included the adoption of LOINC codes as a part of this proposed rule. HL7 has created companion LOINC modifiers that would add further specificity to the LOINC code itself. These

modifiers refine the requests in terms of time frame; for example, on, before, or during a particular encounter, or in terms of item modifiers, such as abnormal, worst, first, last, etc. We therefore also propose to adopt the LOINC modifiers as national standards for the electronic health care claims attachments.

COMMENT:

While we do believe the combination of X12, HL7 and LOINC are probably the best option for this specific transaction. We can see the benefit of the standards and feel in the long term this will be a cost savings to the Health Care Industry

However, as a payer, experience has taught us that only the very most sophisticated providers will avail themselves of this opportunity for cost savings. In reality we continue work on a daily basis with many small providers who continue to struggle with getting their 837 Claims correct. We are receiving about 72% of our inbound claims in the 837 transaction, only about 30% of our external providers are able to receive and post an 835. For the other electronic transactions we have only 7 trading partners who are interested in conducting these, and only 3 of these are actually trying to implement the 270/271. Based on these statistics we believe most of the providers we do business with today will have little or no interest in developing this transaction.

As a provider of health care services, to date we cannot see the return on investment would not be there to fully justify the cost of system upgrades and new modules and development and implementation of this transaction. Currently our efforts are focused and working towards fully developing an electronic health record, which eventually will support the use of this transaction.

As both a payer and a provider we are concerned about the many future planned regulations as outlined by CMS. Currently, we are working to implement the NPI. The proposal to switch to ICD-10 and the version upgrade for all existing transaction to support ICD-10 will continue to consume resources and budgets in the next few years. While we continue to struggle for funding and resources that are required just to keep the organization functioning and the cost of health care down, we feel the cost of this transaction is not warranted based on the very small number of attachments required in today's environment.

Thank you for considering our comments,



Federal Register/Vol.70, No.184/ Friday, September 23, 2005/ Proposed Rule
Health Care Claims Attachments

Mary Lou Jackson
Sr. Project Director – HIPAA TCI
Group Health Cooperative
Seattle, Washington
1-206-901-6803

Submitter : Ms. Alix Goss
Organization : Washington Publishing Company
Category : Health Care Industry

Date: 01/17/2006

Issue Areas/Comments

GENERAL

GENERAL

The correct "physical" mailing address for the Washington Publishing Company (WPC) is:
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Suite 107
North Bend, WA 98045

Submitter : Mr. George Arges
Organization : National Uniform Billing Committee
Category : Other Association

Date: 01/18/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-74-Attach-1.DOC



National Uniform Billing Committee

George Arges, Chair
Senior Director Health Data Management
American Hospital Association
One North Franklin Street
Chicago, IL 60606

December 7, 2005

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

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

Dear Dr. McClellan:

The National Uniform Billing Committee (NUBC) 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).

The NUBC was formally organized in 1975. The NUBC's responsibilities include development and maintenance of the data set known as the Uniform Bill (UB). The current version of the UB is the UB-92 as approved by the NUBC in 1992. The UB data set is reported for both the electronic and paper standards for institutional billing. The NUBC is one of four organizations mentioned in the Health Insurance Portability and Accountability Act of 1996 for a special consultative role for standards developed under the administrative simplification provisions of HIPAA. The NUBC welcomes many of the recommendations in the proposed rule and offers the following attachment contains detailed comments to specific sections of the proposed rule.

The NUBC appreciates this opportunity to comment on the proposed rule. If you have any questions or concerns about the comments presented here, you may contact me at (312) 422 -3398 or garges@aha.org.

Sincerely,
George Arges

George Arges,
Chair

Alliance for Managed Care
American Health Care Association
America's Health Insurance Plans
American Hospital Association
American National Standards
Institute's Accredited Standards
Committee X12
Blue Cross Blue Shield Association
Center for Healthcare Information
Management
Centers for Medicare & Medicaid
Services
Federation of American Healthcare
Systems
Florida Hospital Association
Health Insurance Association of
America
Healthcare Association of New York
State
Healthcare Financial Management
Association
Illinois Hospital Association
National Association for Home Care
& Hospice
National Association of State
Medicaid Directors
National Uniform Claim Committee
Public Health Data Standards
Consortium
TRICARE

NUBC Secretary

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NUBC COMMENTS

DEFINITIONS (p. 55993)

We agree with the definitions of the terms as stated in the preamble of the proposed rule and would like to see these same definitions repeated in Section 162.1900 of the regulation text.

EFFECTIVE DATES (p. 55994)

We find the timeframe outlined seems adequate for the implementation of the claims attachment transaction, however, concerns have been expressed regarding the industry's need for training, budgeting, and testing. The Department of Health and Human Services (HHS) should consider developments with other HIPAA and health information technology projects at the time the final rule is published and adjust the effective and implementation dates taking these things into consideration.

As discussed in the NPRM, covered entities have already implemented other X12 transactions and set up the business agreements for translator services, submission and receipt protocols, and testing. Since this standard is being implemented as the second-round of transaction standards, we believe that most of the infrastructure should already be in place. The fact that the solution allows various grades of technical specification should facilitate implementation and allow a measured progression from a simple imaged document to a fully automated and codes adaptation.

We are basing our opinion, in part, on the fact that the Electronic Claims Attachment Project through Empire Medicare Services was able to implement and conduct claims attachment transactions within a six-month period of time. Although we recognize that this project was much more limited in scope, we believe that it demonstrates the ability for the industry to implement the proposed transactions within the timeframe specified in the rule.

In addition, we support the work of the WEDI SNIP Claims Attachment Workgroup in developing an implementation plan for the industry related to this standard.

OVERVIEW OF CLINICAL DOCUMENT ARCHITECTURE (p. 55995)

We recommend moving to CDA Release 2, assuming that there is an adequate pilot of Release 2 that demonstrates its acceptable functionality. It is our understanding that the following are benefits of CDA Release 2:

- More technical consistency with all new standards coming from HL7 including, but not limited to genomic reporting, adverse event reporting, and the care record summary used for continuity of care.
- More consistency with code being developed by EHR developers (vendors and users) for standard and other applications based on the CDA
- More ability to use off-shelf software being developed by health care vendors
Improved technology for validating computer-decision variant instances of attachments (when this is required)
- Compliance with the U.S. Federal Consolidated Healthcare Informatics initiative

TRANSACTIONS FOR TRANSMITTING ELECTRONIC ATTACHMENTS (p. 55996)

We strongly support the use of structured, as opposed to unstructured, content in electronic data interchange and we believe that the HL7 standards provided this much needed structure.

In reviewing the language in the preamble, we noted that the language regarding Binary Data (BIN) segments does not specify that it conveys the HL7 CDA standard. We believe that this clarification should be made so that implementers are clear that the HL7 standards are required for use in the BIN segment. Absent specific language to this effect, implementers may think that imaged data and text, for example, could be in the BIN segment without the CDA structure. This clarification is needed with each reference that is made to the BIN segments throughout the proposed rule.

ELECTRONIC CLAIMS ATTACHMENT TYPES (p. 55996)

We support the six attachment types being proposed in the NPRM. In addition, we recommend industry education on the existing processes to identify future attachment needs as they arise.

FORMAT OPTIONS (p. 55997)

We strongly support the flexibility being allowed in the proposed rule for using either the human or computer decision variant options of the HL7 CDA. We noted that the language regarding the human and computer decision variants does not specify that they are part of the HL7 CDA standard and we believe that this clarification should be made in the final rule.

COMBINED USE OF DIFFERENT STANDARDS (p. 55998)

We strongly support the use of standards for electronic data interchange, versus non-standard approaches. We support the collaborative efforts of HL7 and X12 in developing the format and content of the transactions in this proposed rule.

**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.

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

We want to see a strengthening of the reporting of claims data in the claims process. We want the claims attachments to remain as an exception and not become a rule with each claim. 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)

1. 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.
2. We find the language in the preamble allowing the health plan to submit only one request for additional information to be too restrictive. This allowance does not appear to be repeated in the regulatory text in 162.1910 (c) and this needs to be clarified.

The regulatory text states that the health plan's request must be "complete". The regulatory text does not specifically state that the health plan can only make one request. It is possible for the health plan to make a "complete" request initially, but upon receipt of the response, identify a further need for information. The language in the preamble would not allow for the health plan to make a subsequent request, but the regulatory text is not as clear about this.

Although we have concerns about a potential for endless requests by the health plan resulting in the need for the provider to respond, we also recognize that there may be a genuine need for a subsequent request by a health plan. We believe that the final rule should allow for a subsequent request by the health plan to avoid a potential denial by the health plan because they do not have enough information to adjudicate the claim. We recognize that the appeals process adds administrative burden to both the health plans and health care providers and would like to avoid any potential situation that could cause an increase in their occurrence.

COORDINATION OF BENEFITS (p. 55999)

We see the potential of the claims attachment process to further streamline the adjudication process. For instance, with regard to the coordination of benefits, it would be beneficial to have an electronic attachment for a secondary payer questionnaire.

We are in support of the language in the preamble that states that any secondary health plan would send an attachment request separate from a request made by the primary health plan. In other words, Payer #1 is not required to forward the attachment information to Payer #2. We would like to see this reiterated in the regulatory text.

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.

IMPACT OF THE SECURITY RULE (p. 56000)

We believe that any efforts to comply with the Security Rule should be effectively incorporated into electronic attachment processing. With this new standard, there is a need for HHS to provide further guidance to the industry to help with understanding the additional concerns on security, as well as privacy, specific to the claims attachment process.

CONNECTION TO SIGNATURES (HARD COPY AND ELECTRONIC) (p. 56000)

We concur that there is no interoperable standard for electronic signatures. The term electronic signature is broadly understood to include a variety of technical approaches that vary in technological complexity and forensic accountability. Some representative technological approaches include:

- simply transmitting a data field that indicates that the sender has a "wet" signature on file
- simply transmitting a data field that indicates that an authenticated user of an electronic has performed an overt act that would serve as a "signing ceremony"
- transmitting an image of a document, or a portion thereof, that includes a wet signature
- strongly authenticating a computer user and using digital signature technologies to record the electronic act of signing a document and associate it with the electronic document itself in a manner that allows subsequent verification that only the authorized signer could have performed the act of signing and the electronic document has not been subsequently altered.

The choice of approach depends on the specific business use, applicable legislation and governmental regulations and the policies of the parties exchanging electronically signed documents.

We further concur that there is an important business requirement to share signatures electronically as information in support of a healthcare claim. The signature that must be shared is often not the signature of the author of the electronic attachment document. For example, a consent signature is generally that of the patient or the patient's agent and a rehabilitation plan may include the signatures of multiple providers not all of whom are the authors of the plan.

The "signature cd" element of CDA Release 1 is only defined for case (b), above, and only describes the signature of the author of the CDA document.

It is important that the standard for additional information in support of a claim support multiple approaches to signature so that the correct approach may be chosen that is practical, cost-effective and consistent with the federal, state and local legislation, regulations and policy. For example, there are regulatory and practical concerns that rule out approaches (a), (b) and (d) for consent forms, since policy makers have indicated that a "wet signature on file" is not adequate and it is unlikely that the person providing the signature will usually be an authenticated user of a healthcare provider's electronic system, much less a strongly authenticated user.

We would propose, therefore, that the final rule and commentary either be silent on electronic signature or indicate that individual attachments should specify the approach to electronic signature appropriate to the business needs for that attachment.

ATTACHMENT CONTENT AND STRUCTURE (p. 56001)

We do not have the expertise to recommend the amount of data permitted in a transaction. We do support that the health plans and clearinghouses be required to adhere to the maximum size allowed in the final rule.

CODE SET (p. 56004)

Because LOINC is adopted as a Medical Code Set, the regulation needs to clarify the use of which LOINC codes are used in each of the AIS documents. There is a concern that absent this clarification, entities may attempt a legalistic position that any LOINC code may be used for any attachment. We recommend that the regulation be clarified as follows:

- For those AIS documents that contain static content (e.g., Ambulance, Emergency Department, Rehabilitation, Medications), the regulation must be clear that only the LOINC codes enumerated in the AIS are allowed.
- For those AIS documents that reference the LOINC database, the regulation should clarify that only the LOINC class as described in the LOINC database (i.e., Laboratory or Clinical Reports) defined for that AIS is allowed.

In addition, 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 recommend 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.

REQUIREMENTS (HEALTH PLANS, COVERED HEALTH CARE PROVIDERS AND HEALTH CARE CLEARINGHOUSES) (p. 56012)

1. The preamble of the NPRM states that “No other electronic transaction format or content would be permitted for the identified transactions.” In addition, the regulatory text in Section 162.1905 states that when using “electronic media” a covered entity must comply with the applicable standards. We would like further clarification of what constitutes “other electronic transactions” and “electronic media.” Currently, some health plans and health care providers have systems in place in which the health plan can access patient information from the provider through a web portal. In this situation, there is no exchange of information between the health plan and provider. The health plan is able to obtain the information they need through the viewing capability. In addition, some providers respond to requests for additional information by emailing the scanned document to the health plan. We would like to see more specific language in the final rule that addresses whether or not these types of information exchanges will be allowed under the claims attachment final rule.
2. We request clarification of the second paragraph in this section, which states that the “use of the standard electronic health care claims attachment would not preclude the health plan from using other processes or procedures to verify the information reported in the attachment documentation.” If the intent of this language is to address a post-payment review, then this should be more clearly stated. If the intent is to allow for non-electronic verification of claims attachment information without any specific limitations to when the verification can be requested, then there would be an undue burden to the health care provider to respond to the claims attachment request and later verify the attachment information either via the phone or paper submission.

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. Conversations that committee members have had with health plans and health care providers regarding the claims attachment process has indicated that providers will likely send a large number of attachments at the time the claim is submitted.

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. The process being allowed by this language is not a workflow that was considered in the development of the standard.

162.1920 (d) (p. 56024)

The final rule text reads that “Response information may be free text, scanned documents, or an embedded document within the BIN segment of the response transaction.” The language should be “In accordance with the HL7 CDA, response information may be free text, scanned documents, or an embedded document within the BIN segment of the response transaction.”

Health Care Provider vs. Health Plan Perspective (p. 56001)

The NUBC would like further clarification on the following language: “a health care provider may direct a health plan to send any request for additional documentation to it or its business associate in a standard form, for those attachment types for which a standard has been adopted, a health plan must do so.”

- Is the language indicating that a health plan must send a request for additional information using the electronic standard?
- In the case of a health plan that does not have a current business model that sends requests for additional information (electronic or hardcopy), is the health plan required to use the 277 Request For Additional Information if a provider requests that it be used?

Modifications to Standards and New Electronic Attachments (p. 56013)

The NUBC is concerned with the length of time it takes to adopt or modify a standard through the current regulatory process. We would like to see the process expedited to allow for more timely adoption and modification of a standard in order to better meet the changing needs of health care. We would suggest that HHS include language in the upcoming notice for proposed rulemaking on emergency and maintenance modifications. The language should contain an outline for streamlining the process for handling the adoption of new releases to existing standards. This process should involve DSMO review and coordination with the appropriate SDO.

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.

Other Overall Comments

Because the NPRM contains a number of areas where it is soliciting for viewpoints or an approach to certain aspects of the attachment standard, it is difficult for the industry to comment on such proposals. As such it would be best for the Department to issue an interim final rule containing the overwhelming comments from the NPRM for those areas where it solicited such comments. This would provide the industry an opportunity to react to a more specific set of recommendations. We propose an interim final rule be used as the basis for providing this direction.

Submitter : Ms. Robert Bergin
Organization : Ohio Dept. of Job and Family Services
Category : State Government

Date: 01/18/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-75-Attach-1.DOC

CMS-0050-P-75-Attach-2.DOC

HIPAA Administrative Simplification: Standards for Electronic Health Care
Claims Attachment
Comments to Proposed Standards
Ohio Department of Job and Family Services
January 18, 2006
File Code: CMS-0050-P

162.1900 Definitions

We propose that the classification of "Ambulance Services" be changed to "Medical Transportation Services" so the attachment can also be used for payers and providers who cover/render lower level medical transportation services. State Medicaid programs are required to provide transportation services for individuals who are wheelchair-bound or with disabilities that require special transportation services other than stretcher transportation. Transport reason codes should also be adapted to include those reasons justifying the payment of other medical transportation services.

General Comments Regarding the Ambulance Services Attachment

Many of the elements contained in the Ambulance Services attachment duplicate ambulance/transportation information that can be found in the CR and CRC segments of the 2300 loop of the ASC X12N 837. The department has no objections to this information being included in the attachments as long as the information currently available on the 837 (e.g., initial trip, round trip, transfer, etc.) continues to be available on the 837 claim without an attachment. This information is necessary on any transportation attachment to support post-payment reviews, prior authorization or pre-payment reviews (i.e., prior to claims adjudication) or for quality reviews.

Submitter : Jean Narcisi
Organization : National Uniform Claim Committee
Category : Health Care Industry
Issue Areas/Comments

Date: 01/18/2006

GENERAL

GENERAL

See attached letter.

In addition to posting our comment letter here, we will also be mailing our letter with the results of a claims attachment survey that we recently conducted.

CMS-0050-P-76-Attach-1.DOC

NUCC

National Uniform Claim Committee

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Member Organizations

Alliance for Managed Care
American Association for Homecare

America's Health Insurance Plans
American Medical Association

American National Standards
Institute Accredited Standards
Committee X12 Insurance
Subcommittee

Blue Cross and Blue Shield
Association

Centers for Medicare and Medicaid
Services
Dental Content Committee

Health Level Seven

Medical Group Management
Association

National Association of State
Medicaid Directors

National Uniform Billing Committee

American Academy of Physician
Assistants

Public Health/ Health Services Research
Centers for Disease Control
and Prevention (Federal)
Midwest Center for HIPAA (State)

State Medical Association
Minnesota Medical Association
Texas Medical Association

January 18, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Sir or Madam,

The National Uniform Claim Committee (NUCC) is pleased to provide the Centers for Medicare & 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.

The comments contain in this letter are in addition to the comments we submitted electronically and via mail on November 22, 2005.

The NUCC was formally organized in May 1995. The goal of the NUCC is to promote the development of a uniform electronic claim "form" for use by the non-institutional health care community to transmit related claim and encounter information to and from all third-party payers. The NUCC is chaired by the American Medical Association (AMA), in consultation with CMS. The committee includes representation from key provider and payer organizations, as well as standards setting organizations, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

The following are our additional comments on the Claims Attachment NPRM.

HEALTH CARE PROVIDER VS. HEALTH PLAN PERSPECTIVE (p. 56001)

We would like clarification on the language that “a health care provider may direct a health plan to send any request for additional documentation to it or its business associate in a standard form, for those attachment types for which a standard has been adopted, a health plan must do so.” Is the language here indicating that it is mandatory for a health plan to be able to send a request using the electronic standard? In the case of a health plan that does not have a current business model that sends requests for additional information (electronic or hardcopy), does the health plan have to use the 277 Request For Additional Information if a provider requests it to be used?

MODIFICATIONS TO STANDARDS AND NEW ELECTRONIC ATTACHMENTS (p. 56013)

We are aware of concerns in the health care industry regarding the length of time it takes to adopt or modify a standard through the current regulatory process. 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 would suggest that the Department of Health and Human Services (HHS) include language in the upcoming notice for proposed rulemaking on emergency and maintenance modifications of the existing standards and an outline for streamlining the process for handling the adoption of new releases to existing standards. This would involve Designated Standards Maintenance Organizations (DSMO) review and coordination with the appropriate Standards Development Organization (SDO).

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.

162.1951 (b) (2) (p. 56024)

It has been brought to our attention that recent concerns have been raised by some NUCC members as well as some members of the HL7 Emergency Care Special Interest Group regarding the content in the Emergency Department attachment type. We request that HHS further investigate these concerns before including this attachment type in the final rule.

GENERAL COMMENT

Because the NPRM contains a number of areas where it is soliciting for viewpoints or an approach to certain aspects of the attachment standard, it is difficult for the industry to comment on such proposals. As such it would be best for HHS to issue an interim final rule (or its equivalent) containing the overwhelming comments from the NPRM for those areas where it solicited such comments. This would provide the industry an opportunity to react to a more specific set of recommendations. We propose an interim final rule (or equivalent rule) with a comment period to be used as the basis for providing this direction.

Claims Attachment Survey Data

The Claims Attachment Subcommittee of the NUCC and NUBC conducted a survey of providers and payers regarding their current practices related to claims attachments and plans for implementing the proposed standard. There were 351 valid responses from providers and 48 valid responses from payers. Enclosed you will find an overview of the data in PowerPoint slides and the de-identified data from providers and payers in Excel spreadsheets. We hope that you will find this data useful in answering some of the questions that were posed in the NPRM, such as whether or not the six proposed types are currently being used, what other types the industry would like to have developed, the workload associated with attachments, and costs for implementing the proposed standard. The NUCC will be happy to work with you on further interpreting the results of the survey data or in conducting additional surveys.

The NUCC appreciates this opportunity to provide you with our comments on the Claims Attachment NPRM. Should you have any questions concerning our comments, please contact me directly at (312) 464-4713.

Sincerely,

Jean Narcisi
Chair, National Uniform Claim Committee

Cc: Lorraine Doo, CMS

Enclosures

Submitter : Mr. Larrie Dawkins
Organization : Wake Forest University Health Sciences
Category : Physician

Date: 01/18/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-77-Attach-1.RTF

January 18, 2006

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

Wake Forest University Health Sciences is submitting comments on 45 CFR Part 162 HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule. Wake Forest University Health Sciences is a School of Medicine employing around 625 providers.

Comments on NPRM

p. 55997 II.C.6 FORMAT OPTIONS

We support the availability of both the Human Decision Variant and the Computer Decision Variant implementations and the freedom that entities have to choose which to implement. Requiring that the Computer Decision Variant also be capable of being rendered into human-readable form will greatly simplify implementation and increase inter-operability.

p. 55999 II.D.2 SOLICITED vs UNSOLICITED ATTACHMENTS

"We are proposing that health care providers may submit an unsolicited electronic attachment with a claim only when a health plan has given them specific advance instructions pertaining to that type of claim or service."

Also p. 56024 Section 162.1920(e)

"A health care provider may submit an unsolicited response transaction only upon advance instructions by a health plan"

As providers, we are concerned that there is no requirement for payers to accept the unsolicited attachment with the claim if they do have types of claims that consistently require attachments. All the payer has to do to avoid implementing this option is to never give "advance instructions" for unsolicited attachments. This will force the provider to wait to receive the request for the attachment, even if the provider knows that it will be needed. For example, payers always request documentation if it is not sent with the claim when a provider uses "unlisted procedure" or a CPT modifier 22 (unusual procedural services). In many cases, these are surgical procedures that would require an operative report to evaluate, so the Claim Note (NTE) segment is not sufficient. Payment will be delayed unnecessarily.

What incentive is there for the payer to change its systems to process unsolicited attachments if the rule provides this easy way to opt out?

"However, with respect to electronic attachment requests and responses in a COB scenario, we assume that the primary health plan will request only the attachments it needs to adjudicate its portion of the claim."

We support that a payer should not have to handle claims attachments for a secondary payer with which it conducts payer-to-payer COB. However, in the case where a payer is acting as a "clearinghouse" and simply routing claims to another subpart or business associate of its organization, it should be required to forward claims attachments that it receives. For example, providers send all BCBS claims to their local BCBS organization, and it routes them to the appropriate state BCBS. Any unsolicited attachments sent with the claims should be forwarded to the appropriate BCBS as well. Also, third party administrators should be required to forward any claims attachments they receive on to the payer or employer.

p. 56000 II.D.4 Impact of Privacy Rule

"A health care provider may rely, if such reliance is reasonable under the circumstances, on a health plan's request for information, or specific instructions for unsolicited attachments, as the minimum necessary for the intended disclosure. Such reliance is not required, however, and the covered health care provider always retains the discretion to make its own minimum necessary determination."

We support the provider having the choice to rely on a payer's request as the minimum necessary or to make its own minimum necessary determination, effectively leaving it to the provider to make the final decision. If a payer routinely asks for an attachment that was not necessary to adjudicate the claim, this would be a violation of the HIPAA minimum necessary standard.

"For health care providers who choose to submit attachment information in the form of scanned documents, efforts will need to be made to ensure that those documents do not contain more than the minimum necessary information."

Please insert "reasonable" before "efforts." This will prevent an interpretation that "every" effort should be made, which could be very time-consuming and not cost-effective. The Privacy Rule does emphasize the efforts should be "reasonable."

p. 56005 II.G.2 Electronic Health Care Claims Attachment Request Transaction

II.G.3 Electronic Health Care Claims Attachment Response

We support the selection of the ASC X12N 277 Health Care Claim Request for Additional Information and the ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter. However, we recommend that the 5010 version be adopted instead of the 4050. There are a number of errors in the 4050 which are corrected in the 5010 and the instructions are clearer in the 5010. In addition, the 5010 does not require that both the 837 and the 275 transactions be contained in the same file

interchange when sending unsolicited attachments. Sending two different transaction types in the same interchange is not widely supported by provider billing systems and would be a significant cost for very little benefit, if any.

p. 56012 II.H. Requirements (Health Plans, Covered Health Care Providers and Health Care Clearing houses)

Covered Health Care Providers

"In either case, covered health care providers would continue to have the option of using electronic or manual means of conducting business, including responding to a request for attachment information electronically or on paper."

We support the provider's ability to choose either the paper or electronic method to send attachments or receive requests for attachments. A requirement to conduct either transaction electronically could cost more than a small provider could absorb.

p. 56024 Section 162.1920 Electronic health care claims attachment response transaction

(d) *"Response information may be free text, scanned documents, or an embedded document within the BIN segment of the response transaction"*

We support the variety of response formats available. Providers will be able to implement more quickly and begin receiving the benefits of this transaction by implementing the simpler response types first.

Additional comment:

Please include a **recommendation** to use a standard acknowledgment transaction to report receipt of the attachment to the provider. If providers are assured that the attachments are received, they are not likely to send a duplicate attachment on paper when payment does not come in the normal time period. This would also provide proof that the payer received the attachment, so that it could not be requested again.