

July 1, 2003

The Honorable Tommy Thompson
Secretary of Health and Human Services
440D Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Thompson:

The coalition of providers signed below is writing to urge your prompt action to prevent the breakdown of the fiscal and administrative infrastructure of the health care system that will occur as a result of an uncoordinated implementation of the HIPAA Transaction Rule. As you are aware, on October 16, 2003, the Transaction Rule will go into effect and require that electronic health care transactions submitted by most health care providers, health care payers and clearinghouses meet new format and content specifications. The undersigned organizations, representing thousands of health care providers, are concerned that despite the best efforts of all parties, many covered entities – payers, clearinghouses, and providers – will not be able to achieve full compliance by that date due to circumstances beyond their control. Absent an implementation plan and clear guidance, or some other action from the Department, the rejection of non-standard electronic transactions and the resulting reversion to paper transactions by significant numbers of providers will lead to a major disruption of payments to providers under Medicare, Medicaid and private sector health plans.

Despite substantial progress by both payers and providers, many payers have indicated that they will not be prepared to accept standard transactions by October 16th. Many payers who say they will meet the compliance date are unwilling or unable to perform necessary testing with providers, so that providers who are prepared to submit standard transactions have no way of knowing whether their submissions can be accepted by those payers. Some of the payers who are testing the standards have adopted so stringent an interpretation of HIPAA compliance that an entire batch of claims will be returned to the provider if one claim is missing a required data element. Moreover, payers have or intend to publish payer-specific companion guides that establish additional or customized requirements for certain data elements beyond what is required by the standards and implementation guides.

In addition, the transaction standards include a number of required data elements that providers will have difficulty obtaining and including on the standard form. These new data elements are usually not necessary for adjudication of the claim but payers who do not currently require these data elements for claims processing will reject claims that do not include them on October 16th. These data elements include, for example, demographic information for the subscriber (address, city, state, zip, country code, date of birth, first and last names), demographic information for the patient, referring provider information number or social security number, and diagnosis (ICD-9) codes.

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We believe it is essential for HHS to take the following steps to prevent the impending “train wreck” on October 16th:

- HHS should make clear that for a reasonable migration period beginning on October 16th, compliance requires only that claims be in the HIPAA standard format, use the standard codes, and contain only the data elements (or data content) necessary for adjudication. This would be considered a clean claim for prompt payment purposes. HHS also should establish progressive targets for completion of more robust testing of live claims transactions in order to facilitate the transition to standard transactions with increasingly more complete data content.
- HHS should develop a process to ensure an adequate level of cash flow to providers during the implementation process. This process could include the use of claims submitted in legacy formats during the testing period while trading partners work through implementation issues with the standards.
- HHS should clarify that testing requirements include testing with each trading partner that requests it. Insurers should be required to specifically identify any HIPAA standard deficiencies in the claims a provider submits.
- HHS should work with the appropriate Designated Standard Maintenance Organizations and affected providers to propose a rule making appropriate modifications of the standard to ensure that the vast amounts of data not previously required for accurate claims processing are eliminated from the standards.

We urge you to convene a meeting of all stakeholders – health plan payers, health care providers, and health care clearinghouses – to develop and implement the above implementation plan and migration period that permits payers to continue to process and pay claims while we move forward to full compliance with the HIPAA transaction and code set standards.

Respectfully,

American Clinical Laboratory Association
American Health Care Association
American Hospital Association
American Medical Association
Premier, Inc.
VHA Inc.