AHA
Advancing Health in America

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October 13, 2003

Thomas A. Scully
Administrator
The Centers for Medicare & Medicaid Services
Attention: CMS-0008-IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Ref: [CMS-0008-IFC] Medicare Program; Electronic Submission of Medicare Claims (68 *Federal Register* 48805), August 15, 2003.

Dear Mr. Scully:

On behalf of our nearly 5,000 member hospitals, health systems, networks, and other providers of care, the American Hospital Association (AHA) welcomes the opportunity to comment on the recent interim final rule that allows Medicare reimbursement of claims to proceed only if the claims are submitted utilizing the electronic Health Insurance Portability and Accountability Act (HIPAA) standards that take effect on October 16, 2003. There are some exceptions to the requirement for the electronic submission for certain types of claims or types of providers specifically waived from such requirements. The date for implementation of the interim rule coincides with the upcoming compliance deadline for the HIPAA Transaction and Code Set (TCS) rule.

America's hospitals understand the importance of moving claims electronically and they strongly support this goal. We are concerned that in establishing this prerequisite for electronic submission, however, the Department of Health and Human Services (HHS) has failed to take into account the many complexities and difficulties that all covered entities face in complying fully with the HIPAA TCS requirements. The problem with this interim final rule is that it ignores these important difficulties as well as the current level of the field's readiness to comply with the TCS requirements, as evidenced by the lack of adequate testing being done with the new transaction standards.

On numerous occasions, the AHA and other provider organizations voiced concerns about the small volume of TCS testing as well as the need for additional guidance on how to handle various interpretations and applications of the standards. If testing is a barometer of the field's readiness for the HIPAA TCS standards, then it is clear that neither providers, nor Medicare's fiscal agents, are ready. Because the volume of testing between providers and the Medicare program is woefully inadequate, we question the wisdom of instituting this final rule so soon.

Even at this late date, we find that less than 15% of providers have been able to do direct testing with the Medicare program. More importantly, where testing has taken place, providers have noted numerous inconsistencies in the way Medicare's fiscal agents interpret the standards. The demonstrated lack of consistency and certainty in how Medicare's fiscal agents apply the HIPAA standards is a cause of serious concern. Such results create costly follow-up and rework by providers and Medicare's fiscal contractors alike as they attempt to reconcile the differences in the interpretation and application of the standard.

In the past six months alone, the AHA has repeatedly asked CMS's Office of HIPAA Standards for specific guidance to assist the field in making the transition to the TCS standards, including, for example, how to handle claim transactions that contain an error in one or a few of the many claims batched together and submitted using the transaction standards. Additionally, we have identified as problematic several other related issues that involve the handling of new data items, such as Physician Social Security Number or Tax Identification Number. Reporting these physician-related identifiers in the claim standard for institutional providers is difficult because it is almost impossible to collect the information from physicians who are wary and reluctant to furnish this information. The problems the AHA has identified remain unresolved and will cause rejection of the provider's claim because of incomplete reporting of the standard's requirements.

While this interim final rule mentions the importance of maintaining the continuity of electronically received claims volume, it does not recognize that there are remaining problems and unsolved issues related to the interpretation and use of the TCS standards that create significant impediments to the uninterrupted processing and payment of electronic claims submitted in the HIPAA standard formats. The rule merely implies that the new electronic standards for claims are simply changes from one electronic format to another. Such a simplistic view fails to take into account the continuing struggles of the field to implement the TCS requirements given existing ambiguities in the reporting requirements and a lack of information and communication about how Medicare's fiscal agents will interpret the new electronic format standard.

While maintaining the volume of claims processed electronically is important, it is far more important for providers' operations to allow them to use all possible means, including the continued submission of a paper claim as a last resort, to ensure continuity of payment as the field completes the transition to the HIPAA TCS standards. The interim final rule makes it unclear whether the paper submission of claims would be allowed if, during the transition, this were the only recourse available to providers in order to pursue payment for the services they have provided. We urge CMS to modify the rule to designate the TCS transition period as an "extraordinary circumstance" that allows providers to use paper submission of Medicare claims until the volume of successful end-to-end testing of the new HIPAA electronic claims has reached at least 85 percent. At the very least, because of the lack of guidance and assurance that Medicare's fiscal agents have successfully tested for compliance to the standard, we strongly urge HHS to use flexibility in the application and enforcement of this rule until significant TCS implementation issues can be resolved and the field successfully completes the transition to the HIPAA standard transactions.

These recommendations are entirely consistent with CMS's recently issued HIPAA contingency plan for Medicare claims which clearly allows continued acceptance of legacy formats to ensure continuity of payment to providers making a good faith effort to move ahead with TCS compliance efforts. Some providers may not have electronic capability through legacy systems and, therefore, will have to rely on paper submission of claims during this period. CMS's contingency plan would seem not to preclude the continued submission of paper claims during the transition. As written, however, the interim final rule is inconsistent with CMS's plan. It would seem to preclude any relief for providers who find they must resort to paper claims in order to preserve their cash flow. It is, therefore, imperative that CMS make clear how it will reconcile the requirements of the interim final rule with its recent guidance related to Medicare's contingency plan. CMS also must immediately provide to its fiscal agents an appropriate program memorandum to ensure they understand the relationship between the rule and the contingency guidance and are consistent in their interpretation and application of the Department's instructions.

Should you have any additional questions about the AHA's recommendations related to the interim final rule, please contact George Arges, senior director, health data management, at 312/422-3398 or Lawrence Hughes, regulatory counsel and director, member relations, at 312-422-3328.

Sincerely,

Rick Pollack
Executive Vice President