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National Committee on Vital and Health Statistics
Subcommittee on Standards and Security
Hubert H. Humphrey Building, Room 705A
200 Independence Avenue SW
Washington, DC 20201

Dear Subcommittee Members:

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of care, and the patients and communities they serve, the American Hospital Association (AHA) would like to thank the National Committee on Vital and Health Statistics (NCVHS) for the opportunity to submit comments about the upcoming proposed rule on attachments. We appreciate that NCVHS is focusing attention on concerns related to claims attachments and Centers for Medicare and Medicaid Services' (CMS) progress in releasing a proposed rule. The claims attachment rule is expected to contribute significantly to the operational efficiencies and costs savings of administrative simplification; and, as a result, the AHA for some time has been urging expedited release of the claim attachments proposed rule.

Congress' objective in enacting the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was reduction of the administrative costs of health care. Hospitals' share Congress' hope that greater standardization and uniformity of administrative processes possible as a result of the claims attachments and other electronic transactions rules will lead to efficiencies and improvements in the timeliness of claims processing and payment, and create real cost savings for the health care system that can be directed to the continued provision of quality patient care. These provisions of HIPAA are the only part of the law expected to result in long-term cost savings for providers and the patients they serve.

The full savings and efficiencies may not be fully realized, however, unless the rules that are expected to contribute the most to enhanced efficiency like claims attachments and health plan identifiers are written to achieve the underlying objective of reducing the administrative costs of health care and published timely in final form. Hospitals urge that the claims attachment standard be carefully crafted so that it does not become another means to delay processing of claims by health plans and thereby add unnecessary administrative costs to the system. To that end, we submit a number of recommendations that the proposed regulation should include.

First, the request for an attachment should be a rare event rather than a routine request that accompanies every claim. Today, in order to adjudicate a claim, health plans routinely make needless requests for a provider to furnish additional information that is already contained within the claim or could be derived easily from that information. An example would be a payer request for a diagnosis related group (DRG) assignment, which can be derived from diagnosis and procedure codes already included in the claim. Often these requests are made because a health plan's information system is unable to recognize and process all of the information reported on the claim or the system fails to apply the appropriate programming logic to handle all of the associated data elements found within the claim.

Health plans also request additional information from providers that would be more appropriately obtained from other sources, including the plan's own historic patient files or directly from employers or eligible beneficiaries. Health plans, for example, often ask providers to supply additional information about whether a patient has a pre-existing medical condition, make calculations related to the patient's having met co-payment and deductible amounts or spend-down limits for the Medicaid recipients, and forward information relating to whether a patient has other health insurance coverage. While providers may normally try to obtain such information by, for example, asking the patient if other insurance coverage exists, they are not always equipped to do this efficiently. Health plans, on the other hand, could efficiently retrieve much of this information from their own internal information systems by ensuring proper links to their historic patient files or by ensuring that adjudication system programming accounts for the complex reimbursement rules of the plan's existing contracts.

A claim attachment is not appropriate when the information is already on the claim or can be derived from other data submitted on the claim. Nor is a claim attachment an appropriate substitute for a health plan's improperly programmed internal processing systems that cannot take full advantage of the plan's own current and historic patient files. An attachment should be provided only under extraordinary circumstances that truly warrant the additional information requested. If certain data elements are needed on a frequent basis in order to pay claims, the standards maintenance organizations should consider recommending that these data elements be added to the 837 health care claim transaction as "situational" data elements to be provided when a certain course of events occurs.

Equally important, providers must be fully apprised of the extraordinary circumstances that might require the reporting of additional information so that when these events present themselves providers know *in advance* what information they need to collect and report. From the provider perspective, gathering information to include on the claim during the initial claims development process is a more cost-effective approach than following-up with attachment information after submission of the claim in response to an inquiry – or multiple inquiries – from the health plan. Moreover, once a patient has been

released or discharged, the provider may find it virtually impossible to collect any additional information that was not already recorded during the patient's care and treatment.

The AHA is pleased that the approach contemplated in the proposed rule as we understand it would eliminate the query and response approach that was previously under consideration. We understand that the proposed rule would allow the provider to submit attachment information using an XML standard. The XML standard allows the provider to forward to the health plan an entire document or record containing the information the health plan is looking for. Use of the XML standard alleviates the burden of the provider having to hunt for a specific piece of information that is contained within a larger document and to then identify the appropriate LOINC code to assign. The query and response approach requiring a LOINC code would necessitate that providers and health plans alike to be able to handle yet another new code set effectively. Experience to date with implementation of the transactions standards rule would suggest that adoption and efficient use of a new code set is an ambitious objective that is not be easily achievable by either providers or health plans.

The XML standard offers a more efficient way for providers to submit attachment information. The rule must state clearly that when a provider uses the XML standard to forward to the health plan an entire document or record containing the information the health plan is looking for the provider is compliant with the privacy rule's "minimum necessary" requirements.

The rule on attachments also must clearly articulate the special circumstances that might require the submission of an attachment and unambiguously identify the specific information that providers need to collect when these special circumstances present themselves. Only if the rule explicitly addresses these elements can providers ensure that they collect and include within a patient's information and/or medical records the relevant data that may be required as part of the attachment.

The AHA urges this committee to recommend that CMS adopt these suggestions for ensuring that the claims attachment rule establishes a process for the submission of only essential additional data for claims processing that is workable for hospitals and the patients they serve. Should you have any additional questions about our recommendations, please contact George Arges, senior director, Health Data Management Group at 312/422-3398 or Lawrence Hughes, regulatory counsel and director, Member Relations at 312/422-3328.

Sincerely,

Melinda Reid Hatton
Vice President and Chief Washington Counsel