



**American Hospital
Association**

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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:

On behalf of our 4,800 member hospitals, health care systems, and other health care organizations, and our 33,000 individual members, the American Hospital Association (AHA) 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).

We welcome many of the recommendations in the proposed rule but wish to emphasize the importance of having an attachment standard that also imposes specific limitations on its use. Without strict limits, we will see inappropriate use of the attachment standard. The practice of requesting an attachment should be rare and never become a routine item that would accompany all claims for a specific type of service. Health plans and others that require routine reporting of a particular piece of data have opportunities to present their requests to the appropriate data content committees. Misuse of the attachment standard will increase not only the administrative burden and costs for providers, but more importantly, the potential for privacy violations.

The proposed standards introduce several elements that are not widely used in today's billing process. As such, they will require new methods for capturing and handling clinical information at significant costs for providers. In fact, we believe the attachment standards will yield a zero net return on investment for hospitals. Moreover, the attachment standard will be far costlier to implement than the previous HIPAA claims standards.

Hospitals will need time to meet these requirements. We recommend a contingency period of at least three years after the final rule is issued to allow hospitals adequate time to prepare budgets, train staff and conduct testing with their trading partners.



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

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

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

Finally, the AHA suggests that CMS issue the rules for ICD-10 adoption prior to finalizing the rule for claim attachments. ICD-10 provides greater clinical specificity and has the ability to reduce or eliminate the reliance on claim attachments. Since resources are limited for handling new system changes, it is important to weigh carefully the derived benefits. While the claim attachment standard is estimated to benefit less than 2 percent of all claims, the adoption of ICD-10 benefits all claims and allows for a more refined reimbursement approach. It also improves public health's disease surveillance abilities and provides hospitals with better information to improve the quality of care.

The AHA appreciates this opportunity to comment on the proposed rule for adopting standards for electronic claims attachments. If you have any questions or concerns about the comments presented here or in our attachment, please contact George Arges, AHA senior director of policy, at (312) 422 -3398 or garges@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Attachment

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

Definitions (pg 55993-4)

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

Effective Dates (pg 55994)

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

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

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

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

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

Transactions for Transmitting Electronic Attachments (pg 55996)

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

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

Electronic Claims Attachment Types (pg 55996-7)

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

Of the six attachment types mentioned in the proposed rule, the one pertaining to emergency services appears troublesome. According to several large hospitals and health systems, a request by health plans for emergency room notes rarely occurs. This may be due to data elements introduced to the claim standard in recent years. For instance, the Balanced Budget Act of 1997 introduced language pertaining to emergency room services and the prudent layperson. The National Uniform Billing Committee (NUBC), which has responsibility for the data content to the institutional claim, added the “patient’s reason for visit” to the claim in 1999. This code uses the ICD-9-CM codes to describe the basis for the patient’s visit to the emergency room. Many health plans indicated this information would alleviate the need for asking for emergency room notes. We suggest CMS conduct a national survey of providers and health plans to gauge the frequency of use of the different attachment types.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Many health plans appear weak in handling the diagnosis and procedure codes reported in claims. The claim standard allows the provider to report up to 25 diagnoses and 25 procedure codes; however, many health plans, including Medicare, recognize and process only a small number of these codes. Some health plans have indicated that their claim

adjudication systems only handle the first three codes. This is extremely problematic since a patient with multiple co-morbidities or complications could easily require more than nine diagnosis or nine procedure codes to explain services provided for an episode of care. Health plans must have the ability to process and evaluate the entire number of clinical codes allowed on the claim standard. Otherwise, providers will receive requests for attachments that seek justification for the services that could have been derived if the health plans had the ability to process all of the clinical codes reported.

Coordination of Benefits (pg 55999)

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

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

Impact of Privacy Rule (pg 55999)

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

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

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

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

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