American Hospital Association

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October 14, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-0009-P, Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards

Dear Mr. Weems:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid's proposed rule to adopt updated standards (Version 5010) for electronic transactions, as originally adopted in the *Health Insurance Portability and Accountability Act* (HIPAA).

We support the adoption of Version 5010, provided that the implementation date occurs no sooner than 12 months after publication of the final rule. The current version of the electronic transaction standards (Version 4010/4010A) inhibits standardization and efficient electronic information exchange. Technical deficiencies within the standards have led many health plans to develop their own "companion guides" to address specific reporting uncertainty within the standards, leading to burdensome variation in reporting requirements among the health plans.

The instructions in the new Version 5010 of the electronic transaction standards include corrections to these technical issues and improve the standards' overall ability to meet various quality and performance reporting requirements. Our specific comments on the proposed standards follow.

CLAIMS TRANSACTION STANDARD

The new claims transaction standard contained in Version 5010 significantly improves the reporting of clinical data. Most importantly, the new version makes it possible to report ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes.

The new claims transaction standard also does a better job of making distinctions between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Other claims improvements include the ability to handle identification of "Present on Admission" (POA) diagnoses. The current version of the claims standard does not allow for direct association of POA diagnoses; consequently, a workaround was introduced. The workaround is cumbersome and relies on re-association of the POA code string to match the order and sequence of the reported diagnosis codes exactly. By contrast, Version 5010 allows POA diagnoses to be connected specifically to the corresponding diagnosis code. POA coding is a critical component in identifying hospital-acquired conditions, and eliminating this problem is an important step.

OTHER TRANSACTION STANDARDS

The AHA supports improvements made to the remittance and payment transaction standards. Version 5010 improves the remittance standard rules and increases the number of adjustment reason codes to help better explain payment adjustments. These changes should make it easier for providers to understand payment adjustments made by health plans.

The new version of the eligibility response transaction standard also provides greater clarity on health plan eligibility status, as well as patient deductible and copay obligations. We support these improvements because they help hospitals verify eligibility status and interpret any formulas a health plan has for patient responsibility amounts. These changes should reduce the need for telephone follow-up.

IMPLEMENTATION TIME FRAME

Because these are updated versions of existing standards rather than wholly new transaction standards, we agree that HIPAA-covered entities do not require two years for compliance. We support a compliance deadline of no less than 12 months after the publication of the final rule, and would support the April 1, 2010 deadline if the final rule were issued on or before March 31, 2009.

Version 5010 was first published in May 2006 and has been available for review for more than two years. The process leading to the newer standards allowed all interested organizations to participate in the development and review prior to final publication as a TR3 Implementation Guide. The Designated Standards Maintenance Organizations

along with the standards development organizations within the American National Standards Institute (ANSI) worked together to review many of the changes. The process was open to the public and fairly routine so all covered entities could prepare for these version changes well in advance.

OPPORTUNITIES FOR FUTURE IMPROVEMENT

We urge CMS to encourage ANSI's Accredited Standards Committee X12 (ASC X12) to publish an all-inclusive list of changes made to the standards. The change log currently is issued after each year's changes are approved. A newer version of the HIPAA standard requires users to incorporate multiple years of changes. Ideally, a cumulative change log that includes changes from each interim year should be provided so that all of the changes are contained in one document. This will make it easier to identify all of the changes that occurred since the last version of the HIPAA standard was adopted.

TESTING

CMS has asked for comments on the issue of testing and how it has been performed in the past. All too often the testing process occurs at or near the very end of the compliance period. This has led to frustration on the part of hospitals and inconsistencies in the deployment of testing plans. Last-minute testing causes scheduling problems and creates high uncertainty around whether the changes were applied correctly. The purpose of testing is to resolve problems before the implementation date to ensure that there are no payment delays, not to create additional burdens.

Hospitals must wait for vendors and health plans to schedule testing. Many health plans do not provide advance communication about their testing efforts or their readiness to implement the standards, and hospitals have indicated that it is difficult to obtain the name of the individual or department within the health plan responsible for conducting testing. We welcome requirements that instruct health plans to communicate their readiness for testing via mail or on their Web sites at least 90 days before the compliance date. Health plans should communicate how a provider can schedule testing and the specific dates and times available. Health plans that fail to provide testing at least 90 days ahead of the compliance date must adopt a contingency plan that ensures continuity of payment beyond the compliance date.

The AHA appreciates the opportunity to submit comments on the adoption of Version 5010 of the electronic transactions standards. If you have any questions or concerns about our comments, please contact me or George Arges, senior director, health data management group, at (312) 422-3398 or garges@aha.org.

Sincerely,

Rick Pollack
Executive Vice President