NCVHS
National Committee on Vital and Health Statistics

March 2, 2012

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Claim Attachments

Dear Madam Secretary,

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS is to advise the Secretary on the adoption of standards and code sets for HIPAA transactions. The Patient Protection and Affordable Care Act (ACA) (Sec. 1104. (g)(3)), enacted on March 23, 2010, calls for NCVHS to assist in the achievement of administrative simplification to "reduce the clerical burden on patients, health care providers, and health plans."

In 1996, HIPAA, Section 1173(a)(2)(B), identified a health claim attachment as one of the transactions for which electronic standards were to be adopted. A proposed rule was published in 2005, but a final rule was never adopted, due in part to questions about the maturity of the standards being recommended for adoption and the ability of the potential users of the standards to implement them. Section 1104 of ACA directs the Secretary to publish final regulations adopting national standards, implementation specifications and operating rules for health care claim attachments by no later than January 1, 2014, with a compliance date of no later than January 1, 2016.

On November 17, 2011, NCVHS Subcommittee on Standards held a hearing on claim attachments to begin the process of gathering information regarding current industry practices, priorities, issues and challenges, current status, approaches and timeline for the completion of the development of standards and implementation specifications, and expressed interest from organizations to become authoring entities of claim attachment operating rules.

Speakers and testifiers included representatives from the Medicare program, State Medicaid agencies, Office of the National Coordinator, health care providers, health plans, clearinghouses, and standards organizations.

Below are a summary of observations and an initial set of recommendations. We intend to continue to work with the industry over the next 12 months and hold a second hearing in early 2013 to receive recommendations for the adoption of claim attachment standards, implementation specifications, and operating rules.

General Observations Regarding Claim Attachments

- The term "attachments" refers to any supplemental health documentation needed to support a specific event. This includes the submission of medical documentation to support health care claims, referral authorizations, enrollee eligibility inquiries, coordination of benefits, workers' compensation, post-payment claims auditing, and provider dispute resolution.
- A significant number of attachments are being exchanged today between providers and health plans. Some estimates report between 5 and 20 percent of all claims submitted by health care providers to health plans require one or more attachments.
- The majority of claim attachment exchanges are done in a 'solicited' manner (i.e., a request is submitted by the health plan to the provider) with some being done in an 'unsolicited' manner (provider submits the attachment along with the claim, based on common agreement between trading partners).
- In today's environment, most attachment exchanges (requests and submissions) are conducted via paper mail, fax, and phone; a few are done electronically through secure portals offered by plans (to upload documentation) or via electronic transactions.
- Not all the information required to be submitted to a health plan in an attachment is available electronically today. Not all information resides or comes from an electronic health record system. Some information comes from administrative systems. Furthermore, not all of the data that exist in electronic form are maintained in coded, structured, and computable form. Some exist in unstructured form (such as scanned images, JPEG, or PDF format). And the code sets used might be different between health plans and the electronic health record systems.

Specific Observations and Industry Findings

- A claim attachment is an advanced electronic application of provider-payer exchange of clinical information, not just a simple business transaction.
- There is strong support for moving towards a standards-based environment.
- It is very important to name a claim attachments operating rule authoring entity now. The process should start with a basic standard – a low-tech electronic mechanism to exchange data (in unstructured formats or basic structured formats), and then incrementally move over time to more complex, structured formats.
- There is a need to show early return on investment by focusing first on people, paper, postage, and process and to create a portfolio of consistent standardized building blocks (including vocabularies and value sets, documents and messages, transportation standards, and services to support exchange).
- We must ensure consistency with standard messaging content defined for EHRs; the Transitions of Care standard developed as part of Meaningful Use is an important starting point
- The submission of medical documentation to support claims should be part of normal clinical documentation and exchange. This is to say, the documentation should be integrated into the clinical and business workflows, creating a consistent data collection and standardization for both claims and supporting clinical information. The standards should also be flexible (agnostic) with respect to the transport mechanism
- There is strong support for allowing the use/submission of unsolicited claims, to speed up the adjudication process
- Strive to reduce the number of claim attachments needed, rather than foster a potential increase, if standard and operating rules are adopted, and make it easier to request a claim attachment
- Establish a limited number of standard submission operating rules for unsolicited claim attachments, defining specific submission scenarios
- Prohibit any other unsolicited claim attachments, outside of those defined in operating rules
- The current standards being considered include:
    - Requesting a claim attachment:
        - Require the use of electronic standard to request attachment, such as an ASC X12 277 additional information transaction standard
    - Responding to a requested attachment (or submitting information in an unsolicited manner):
        - Strong support for the use of HL7 CDA standard for data content
        - Support for the use of the ASC X12 275 standard as the envelop to transport a claim attachment (it identifies the sender, what the file is, and who is the intended receiver)
        - Make the claim attachment standard consistent with EDI standards and practices
        - Ensure current methods of transport established can continue to be used with limited costs
        - Allow the current use of EDI agreements that are in place to continue to cover the provider signature requirements that may be necessary for attachments

- Consider providing protections against unnecessary or excessive requests for additional information
- Define/designate standard implementation guidelines for code sets used in connection with attachments (critical); standard guidelines for code sets could also help reduce the need for attachments.
- Consider defining/using standards for attachments in response to other requests (i.e., referral authorization, eligibility/pre-determination of benefits, coordination of benefits, workers compensation, and copies of consent/authorization forms)

General Concerns

- There is a risk of excessive or unnecessary requests and submissions of medical documentation
- Establish reasonable limits, reasons, timeframes for attachment standards
- Compliance with HIPAA privacy and security regulations is critical to ensure that the privacy, confidentiality, data integrity and security of PHI exchanged under attachment transactions is no more than the minimum necessary and protected throughout the transaction.

Summary

- There is strong support from industry for the identification and adoption of useable standards for claims attachments. Further, because technical capabilities vary across industry, even with the advent of electronic health records, there are simple techniques which can be used for "human readable" versions. In time, industry will move towards the computer-based variants of attachments.
- While there is interest in moving to electronic attachments, there is also interest in reducing the number and types of attachments requested. Therefore, any standards that are proposed should focus on enabling appropriate data content that will meet most needs of trading partners. Because several industry representatives estimate that electronic attachments could reduce some costs by 50%, there is support for moving in this direction.
- With respect to available standards for attachments, several testifiers expressed their support of the ASC X12 standards in concert with the HL7 CDA for structured and unstructured documents. As you know, several of the ASC X12 transactions are in use as mandated under HIPAA. Because HHS is also required to adopt operating rules to support HIPAA standards, several testifiers spoke to the importance of HHS identifying and naming an authoring entity for the operating rule for attachments now, so that the industry knows who will be doing that work, and in which workgroups and committee(s) they should be involved.
- Finally, there are a number of industry initiatives underway that also lend support to identifying, testing, and adopting standards and operating rules. For more than six years, several covered entities in New York and Minnesota

have successfully used the ASC X12 standards for exchanging claim attachment requests and responses. All parties are enjoying significant cost reductions and efficiency improvements. Medicare is piloting the electronic transmission of claim attachments for its medical review program using the HL7 standards.

Concluding Comments

It is too early at this point to make formal recommendations to you regarding the adoption of any standard, implementation specification, or operating rule. As noted above, the purpose of this initial hearing was to gather information regarding the current status of claim attachments, the most common attachments being used, and the status of development of standards. We plan to hold a second hearing in the early part of 2013 to hear back from the industry regarding the standards to be recommended for adoption, and to prepare our recommendations regarding claim attachments accordingly.

We will continue to support your efforts to increase adoption of standards and operating rules that help move the industry forward with technology to achieve greater efficiency.

Sincerely,

/s/
Justine M. Carr, M.D.
Chairperson,
National Committee on Vital and Health Statistics

Cc: HHS Data Council Co-Chairs

Enclosure

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUMMARY OF HEARING ON HEALTH CARE CLAIM ATTACHMENTS

NOVEMBER 17, 2011

Most Common Types of Attachments

- The most common situations where attachments are being used include explanations of:
  - Miscellaneous procedure code descriptions (Not Otherwise Classified (NOC) procedures reported)
  - Operative report requests associated with 22 (unusual service) / 62 (co-surgeon) modifiers; anesthesia time over 500 minutes; multiple anesthesia procedures during a single session
  - Invoice purchase price
    - DME
    - Intravenous immunoglobulin; Radiopharmaceutical
  - Medical Necessity
    - Documentation to support quantity/dosage billed
    - Pain pump injections
    - Progress notes on physical, occupation, speech therapy
    - Skilled nursing facility claims require additional medical supportive documentation
  - Ambulance Services
    - Documentation on why air ambulance needed instead of ground transportation
    - Documentation on why transfer did not go to nearest facility
    - Documentation whether or not transport was related to illness
  - Authorization requests for referrals, procedures
  - Medical criteria under specific contract benefits

- While there are significant common areas for attachment requests across plans and providers, there are also some unique types of attachments, such as those needed by Medicaid. The most common Medicaid attachments include:
  - Third Party Liability (TPL)
  - Time filing limit situations
  - Manual pricing

- Certification statement for sterilization
- Prior authorizations
- Eligibility intake, screening and assessment
- Limited claim situations (DME, multiple surgery claims)
- Utilization reviews
- Provider enrollment
- Adjustments
- Long Term Care level of care determinations
- Medicaid Claims
  - Sterilization, hysterectomy, abortion
  - Timely filing
  - Miscellaneous codes
  - Medicare benefits exhausted
  - Ambulance – air
  - Others
- Medicaid Authorizations
  - Home health, wheelchairs, DME, Surgical, hearing aid, medication dispensers, transplants, etc

Data Being Submitted in Attachments

- Most common data being sent in attachments include:
  - Entire medical record
  - Parts of medical record (operative report, clinical notes)
  - Tests (Radiology, Lab test results)
  - Price invoices

Common Methods for Requesting and Submitting Attachments

- Two common methods of sending request for attachment information
  - Claim is pended at payer's side and a request is sent via a letter or through a 277; Provider usually has 30-60 days to respond before claim is denied.
  - Claim is denied using the 835 ERA and the additional information is communicated using a CARC/RARC code; Provider must resubmit the claim on paper with the attachment, or appeal the denial on paper with attachment.

Issues and Costs Associated with Current Paper-Based Attachments

- Most common issues of current paper-based attachment processes
  - Requests never received or lost, sent to incorrect address, internal routing slow, association of request with claim (provider) slow, association of claim with attachment (plan) slow, retrieval of medical documentation slow

- Response takes time, resources to prepare (extract data from different systems) and submit; processing adds weeks or months to adjudication

- Average cost (provider) of paper-based attachments
  - Per request: $21.34
  - Assuming number of attachments to be between 400 and 500 million (based on NPRM) – total cost today: 8.9 to 11.4 billion
  - Does not include another estimated 100 million attachments sent by hospitals and other attachments sent by other providers

- Average cost (payer-Medicare) of paper-based attachments
  - 1M claims subject to 'complex review'
  - Cost to send an Additional Development Request (ADR – a request to obtain additional medical documentation): $.071 (x 1M claims = $923K)
  - Cost to receive/review attachments and prepare medical review (manual process) = $32.5 M

Benefits of Adoption of Electronic Standards and Automation of Attachment Requests/Submissions

- Benefits of Automation
  - Providers
    - Eliminates lost requests/responses
    - Reduces staffing/costs (people, paper, postage); time spent by staff handling incoming request, pre-reading, sorting, routing, billing staff reviewing paper request, searching for, accessing and copying medical documentation, handling, mailing, postage
    - Reduces amount of supporting documentation exchanged
    - Better predictability to payer data content needs
    - Decrease days in accounts receivable; on average, paper handling of attachments add 22-30 days to the processing time of a claim
    - Improved claims reassociation
    - Reduction in appeals
    - Fewer claim denials
    - Faster processing/payment
  - Payers
    - Reduced staffing/costs
    - More complete information received
    - Increase 1st pass adjudication rate
    - ROI available by saving people, paper, postage
    - Limit early implementation costs to basic Q&A
    - Initial investment more justified by higher provider participation
    - Improved denials management

- Reduction in appeals

Solicited and Unsolicited Attachments

- Unsolicited Attachments
  - Strong consistent support for the use of unsolicited attachments
  - Significant benefits noted, including allowing providers to have predefined requirements, content predictability, anticipate requirements (allows critical data to be captured during care or during preparation of claim); allows plans to expect less irrelevant content, establish processes to adjudicate faster
  - Strong support for defining the specific scenarios for which unsolicited attachments can be established; Operating Rules play an important role here; plans also look for some flexibility, allowing trading partner agreements to handle specific situations
  - Important to allow trading partner agreements to define unsolicited attachments and not by requiring that this capability be made available by payers for all attachments, all providers

- Solicited Attachments
  - Will continue to be needed, for instances that are not as consistent as those areas for which unsolicited claims can be established

Computer vs. Human Variant and Structured vs. Unstructured Data

- Computer vs. Human Variant / Structured vs. Unstructured Data
  - These two concepts are inextricably related: Computer/structured data and Human variant/unstructured data
  - Human variant and unstructured data will be needed, particularly as a way of progressively advancing the use of the electronic attachments; in today's marketplace, not all data that are electronic are structured; human intervention is still needed in some instances
  - Submission/receipt of unstructured data will be a valuable initial step forward, as many EHR systems are still unable to produce additional information in structured format; additionally, not all data come from EHRs and not all EHRs data are stored in structured format
  - Computer variant / Structured data – will be the ultimate goal in most attachments, allowing for automated processing and auto-adjudication

Standards for Claim Attachments

- Standards

- Strong support for the use of HL7 (CDA) as the standard for data content of both unstructured and structured claim attachments
- Consistent support for the use of X12 (275) as the envelop ("wrapper") to transport the HL7 payload, for both structured and unstructured claim attachments
- Consistent support for use of 277 to submit an electronic request for attachments
- Consistent support for the use of electronic acknowledgment transactions associated with the submission of attachments
- X12 standard transactions complete and ready for use
  - 275 (both health care claim and health care service review)
  - 277 Request for Additional Information (RFAI)
  - 824 Acknowledgment
- X12 recommends using 6020 for attachments
- HL7 (CDA) standards currently being finalized, with the expectation that final standards will be ready in time for development of the regulations in 2013

Role and Value of Operating Rules for Claim Attachments

- Role/Value of Operating Rules
  - Business/Operating Rules beneficial in a number of areas
    - Scope and types of attachments
    - Timing of attachments submission
    - Scenarios/circumstances for Unsolicited attachments
    - Scenarios/circumstances for Solicited attachments
    - Structure vs. Unstructured: which attachments to be sent using either of the two methods
    - Payload size limitations/data compression
    - Security/signature
    - Transport
    - Limiting number of attachment requests per claim (assuming regulations allow flexibility to make more than one request per claim)
    - Referral authorization, eligibility, etc,
    - Although some (plans, clearinghouses) argued that other rules for use of attachments, outside unsolicited attachments, should be left to trading partner agreements, to allow flexibility

Special Issues Associated with Attachments

- Requesting specific data elements vs. full medical record documents
  - For example, requesting only one specific result (red cell counts) out of a blood test panel
  - Recommend against extracting data by specific data element

- Since number and type of data items would vary, it would be very complex for providers to match requirements of specific data elements from medical documents by payer, extract and send.

- Provider Signature and Authentication Issues
  - Currently, plans do not need provider signature/authentication because they rely on trading partner agreements and contracts that address the verification process. This process will not work in the future if the electronic exchange is done through other parties outside the agreement (as in HIEs)
  - CMS required authentication at the granular level, for post-payment auditing of claims – a major issue related to the implementation of CMS' Electronic Submission of Medical Documentation (esMD) project.

Use of Attachments in Pharmacy Industry

- Use of attachments in pharmacy industry
  - No use of claim attachments
  - Dramatic growth in the use of Prior Authorization (PA--mostly among commercial plans, less in Medicaid plans, and important jump in Medicare use of PA after Part D started in 2006)
  - There is no widely adopted, industry transaction standard for this
  - Need to have a standard to support real-time transaction
  - Another attachment type is a query for clinical information from the pharmacy to the prescriber/physician of the patient to obtain allergies, medical conditions, medications, medical histories
    - Currently use ASTM's CCR and HL7's CDA
    - Both may be attached to an NCPDP Clinical Info Response transaction
  - Medication Therapy Management request and response is another area where attachments may apply

Use of Attachments in Dental Industry

- Use of attachments in dental industry
  - Significant needs/use of attachments
  - Significant use of document management systems that send attachments via FTP or Fax and other methods of uploading electronic images

General Concerns

- Risk of excessive/unnecessary requests and submissions of medical documentation
- Need to establish reasonable limits, reasons, timeframes

- Privacy and security issues: importance to ensure that the privacy, confidentiality, integrity and security of PHI exchanged under attachment transactions is protected throughout the transaction.

Industry Recommendations

- Claim attachment – a leading edge application of provider-payer exchange of clinical information, not just a single business transaction
- Strong support for moving towards a standards-based environment
- Importance of naming a claim attachments operating rule authoring entity now
- Start with a basic standard – a low-tech electronic mechanism to exchange data (in unstructured formats or basic structured formats), and then incrementally move over time to more complex, structured formats
- Show early ROI by focusing first on people, paper, postage and process
- Create a portfolio of consistent standardized building blocks (including vocabularies and value sets, documents and messages, transportation standards, and services to support exchange)
- Ensure consistency with standard messaging content defined for EHRs; Transitions of Care standard developed as part of MU is an important starting point
- Medical documentation to support claims should be part of normal clinical documentation and exchange (integrated into work flow; consistent data collection and standardization for claims and clinical information; composable from existing clinical documents; flexible with respect to transport standards)
- Strong support for allowing unsolicited claims to speed up adjudication
- Payers should consistently request similar documents for similar services
- Providers should be responding with codified data to reduce processing costs (automated response) and enable real-time processing
- Providers' billing systems have vendor developed workflow rules to automate their submission
- Strive to reduce the number of claim attachments needed, rather than see a potential increase, if standard and operating rules are adopted and make it easier to request
- Allow for some flexibility of plans to accommodate requirements based on contracts
- Establish a limited number of standard submission operating rules for unsolicited claim attachments, defining specific submission scenarios
- Prohibit any other unsolicited claim attachments, outside of those defined in operating rules
- For each operating rule, consider drilling down to the actual purpose of the attachment request and consider using or adding data elements in the 837 to fulfill the purpose and avoid needing an attachment
- On solicited claim attachments, limit the number and purposes to a common set of business scenarios and limit the amount of data to the minimum necessary
- Standard

  - Request: Require the use of electronic standard to request attachment, using a 277 additional information transaction standard
  - Response:
    - Strong support for HL7 CDA standard for data content
    - Support for the use of the 275 as the envelop to transport a claim attachment (identifies the sender, what the file is, who is the intended receiver)
    - Consistent with EDI standards and practices
    - Ensures current methods of transport established can continue to be used with limited costs
    - Would allow the current use of EDI agreements in place to continue to cover the provider signature requirements that may be necessary for attachments
- Importance to ensure that the privacy, confidentiality, integrity and security of PHI exchanged under attachment transactions is protected throughout the transaction
- Consider providing protections against unnecessary and/or excessive requests for additional information
- Defining/designating standard implementation guidelines for code sets used in connection with attachments are critical; standard guidelines for code sets could also help reduce the need for attachments.
- Limit the number, frequency and timeframe of request of attachments to a single request per claim, to avoid continued/multiple requests
- Consider defining/using standards for attachments in response to other requests (i.e. referral authorization, eligibility/pre-determination of benefits, coordination of benefits, workers compensation, copies of consent/authorization forms)
- For pharmacy, consider establishing a standard for electronic Prior Authorization that supports real time transaction (request and response); but requiring it as a prerequisite before health care providers could e-prescribe and/or access drug formulary information may be difficult to implement and prevent providers from e-prescribing
- Original NPRM (2005) recommended six types of electronic claim attachments; recommend CMS analyze current claim standard to determine if it meets or could meet the need for collecting different types of data, to avoid attachment. Modifying standard would pose much less of a burden than requiring an attachment, when avoidable
- Need to evaluate current transactions (i.e., claims) to see if 1) full compliance with the data requirements or 2) changes in the current standard would achieve the data needed through attachments, avoid having to do attachments when possible; leverage SDO review of potential overlapping data to conduct thorough review prior to regulation
- Request X12 to simplify claim transaction and enforce consistency of data content and its location across the 837 I and P where possible
- In addition to esMD model (using 'health information handlers' and CMS gateway), strongly recommend to designate the EDI standards (X12 and HL7) for use over current EDI pathways already in operation between providers, clearinghouses, payers

#end of summary#