20 January 2006

TO:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P

via: Electronic Comments @ http://www.cms.hhs.gov/regulations/ecomments

References: 70 FR 184, 9/23/2005, pages 55989-56025

Following are written comments on the proposed rule for HIPAA Administrative Simplification Standards for Electronic Health Care Claims Attachments from Vanderbilt University Medical Center. Most of these comments were derived from the VUMC Claims Attachment team. Compilation by Grace Upleger.
Comment Number: Vanderbilt - 1

Criterion: PROVIDERS WANT CERTAINTY OF FORMAT AND CONTENT FOR WHAT THEY MUST TRANSMIT

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.01)

- Health care providers want single straight-forward precise implementation specifications that direct them on what to send, under what situations, and using a precise format.
- Health care providers want these single implementation specifications to be independent of any and all actual or potential recipients. Health care providers do not want to have to contact or be contacted by each potential recipient to determine or negotiate anything at all regarding what they are to send.
- Health care providers certainly don’t want to have to send different contents or different formats to different receivers based on any trading partner agreements or other multiple sender-receiver pair “companion guides”.

Comment Number: Vanderbilt - 2

Criterion: ADDITIONAL INFORMATION SPECIFICATION 0002: EMERGENCY DEPARTMENT ATTACHMENT

- The following LOINC’s are either: 1) not captured now for billing, 2) are not collected in our systems, or 3) are at least partially captured on paper and thus we request that they be removed from the available LOINC’s:
  - 11459-5 EMS SYSTEM, TRANSPORT MODE
  - 18704-7 PROVIDER, ED REFERRING PRACTITIONER
  - 11319-1 EMS SYSTEM, TRANSPORT UNIT IDENTIFIER
  - 11318-3 EMS SYSTEM, TRANSPORT AGENCY IDENTIFIER
  - 11293-8 ED REFERRAL, SOURCE
  - 11454-6 FIRST RESPONSIVENESS ASSESSMENT
  - 11324-1 FIRST GLASGOW SCORE EYE OPENING
  - 11326-6 FIRST GLASGOW SCORE VERBAL
  - 11325-8 FIRST GLASGOW SCORE MOTOR
  - 18690-8 FIRST BODY WEIGHT
  - 11372-0 INJURY, ACTIVITY ASSOCIATED WITH
  - 11457-9 INJURY, SAFETY EQUIPMENT USED DURING
Comment Number: Vanderbilt - 3

Criterion: ADDITIONAL INFORMATION SPECIFICATION 0006: MEDICATIONS ATTACHMENT

• The following LOINC’s are either: 1) not captured now for billing, 2) are not collected in our systems, or 3) are at least partially captured on paper and thus we request that they be removed from the available LOINC’s:
  - 18617-1 MEDICATIONS ED DISCHARGE

Comment Number: Vanderbilt - 4

Criterion: ADDITIONAL INFORMATION SPECIFICATION 0004: CLINICAL REPORTS ATTACHMENT

• The following LOINC’s are either: 1) not captured now for billing, 2) are not collected in our systems, or 3) are at least partially captured on paper and thus we request that they be removed from the available LOINC’s:
  - 28581-7 CHIROPRACTOR INITIAL ASSESSMENT General
  - 28580-9 CHIROPRACTOR PROGRESS NOTE General
  - 18762-5 CHIROPRACTOR VISIT NOTE General
  - 28622-9 NURSE HOSPITAL DISCHARGE ASSESSMENT General
  - 29753-1 NURSE INITIAL ASSESSMENT General
  - 28623-7 NURSE INTERVAL ASSESSMENT General
  - 28651-8 NURSE TRANSFER NOTE General
  - 28621-1 NURSE-PRACTITIONER INITIAL ASSESSMENT General
  - 18734-4 OCCUPATIONAL THERAPY INITIAL ASSESSMENT General
  - 11507-1 OCCUPATIONAL THERAPY PROGRESS NOTE General
  - 28578-3 OCCUPATIONAL THERAPY VISIT NOTE General
  - 18735-1 PHYSICAL THERAPY INITIAL ASSESSMENT General
  - 11508-9 PHYSICAL THERAPY PROGRESS NOTE General
Comment Number: Vanderbilt - 5

Criterion: ADDITIONAL INFORMATION SPECIFICATION 0003: REHABILITATION SERVICES ATTACHMENT

- The following LOINC's are either: 1) not captured now for billing, 2) are not collected in our systems, or 3) are at least partially captured on paper and thus we request that they be removed from the available LOINC's:
27676-6 PHYSICAL THERAPY TREATMENT PLAN, DATE ATTENDING MD
REFERRED PATIENT FOR TREATMENT
27613-9 OCCUPATIONAL THERAPY TREATMENT PLAN, DATE ATTENDING MD
REFERRED PATIENT FOR TREATMENT
(This data is available with the physician’s referral for therapy but not contained in the 700/701 or equivalent document).

• There is a potential discrepancy with Attending physician signature and Therapist signature since signatures are collected both electronically and by hard copy in many sites. Does a scanned electronically signed document receive credit for signature or would this have to be accompanied by the hospital’s electronic signature file?

27677-4 PHYSICAL THERAPY TREATMENT PLAN, DATE ATTENDING MD SIGNED
27679-0 PHYSICAL THERAPY TREATMENT PLAN, SIGNTURE OF RESPONSIBLE ATTENDING MD ON FILE

• Since 700/701 forms or equivalent documents (evaluation/progress documents containing same content as 700/701) are industry standards and would be likely utilized for the Scanned documents for Human Decision Variants; LOINC responses utilized should match 700/701 fields descriptions.

Comment Number: Vanderbilt - 6

Criterion: MORE EXPLANATION IS NEEDED REGARDING THE RESTRICTIONS BEING PLACED ON PROVIDERS SUBMITTING UNSOLICITED ATTACHMENTS

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.07)

• No such restrictions or requirements for advance instructions presently exist for paper attachments that providers routinely send along with paper claims because they know from experience that they are needed to obtain timely payment. Notwithstanding the discussion on page 55999 of this NPRM, wouldn’t the same rationale apply to electronic attachments?

• Alternatively, if such advance coordination is really needed, suggest that this NPRM be modified to allow providers to send at any time descriptions of certain types of claims, procedures, or services for which they might send unsolicited attachments, and, unless or until each health plan specifically case-by-case objects in writing, such
unsolicited attachments must be received and appropriately processed.

Comment Number: Vanderbilt - 7

Criterion: EFFECTIVE DATES

(We are seconding portions of the comment that the AHA made on 11-22-05 – regarding 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.

Comment Number: Vanderbilt - 8

Criterion: PROVIDERS WHO HAVE ALREADY INVESTED IN HL7 DON'T WANT TO BE FORCED TO USE ANOTHER VARIANT OF HL7

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.03)

- In spite of several years of marketing and entreaties, United States health care providers who are already using HL7 version 2 series messages have almost universally declined to convert to HL7 CDA. This decision is economic: CDA provides essentially no additional functionality over what is already being achieved using HL7 version 2.
• Moreover, HL7 version 2 isn’t broken – just not as new as CDA and XML. Unfortunately, this NPRM would force these health care providers to expend resources to add use of CDA only for claims attachments – without converting their other HL7 interfaces. As a consequence, use of CDA for claims attachments adds an additional interfacing methodology for these providers – with its attendant ongoing costs of operation in addition to the start-up costs noted in this NPRM. The same discussion applies equally to the creation of Human Decision Variant transactions instead of just continuing to use HL7 version 2 standard data element messages.

Comment Number: Vanderbilt - 9

Criterion: PROVIDERS DO NOT WANT THE PAYERS TO DECIDE WHICH VARIANT THE PROVIDERS SHOULD SUBMIT WITH – THIS HAS TO BE THE PROVIDER’S DECISION.

(We are seconding portions of the comment that the AHA made on 11-22-05 – Format Options -- Human vs. Computer Variants (pg 55997))

• 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.

Comment Number: Vanderbilt - 10

Criterion: HUMAN DECISION VARIANTS NEED EXPLICIT SPECIFICATIONS THAT OVERCOME THE UNSTATED ASSUMPTIONS ON WHICH THEY ARE BASED

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.04 and of the AHA, 11-22-05, Impact of Privacy Rule (pg 55999))
• Providers want clear mandates on what will be a successful transmission of images. What is a good quality image that is decipherable? Could there be a standard put in place so that payers and providers alike would know what to transmit and what to expect?

• Moreover, it also seems to be presumed that scanned images are of only machine-created documents – are handwritten documents and sketches be imaged and then transmitted?

• Health care providers are conscious of the HIPAA Privacy rule, but do believe that submitting 1 page of scanned data that has the appropriate requested LOINC information AND additional data should meet the reasonableness factor. This has to be clear in the rule. The AHA indicated in their comments on the Impact of the Privacy rule that: “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.”

• There are no specifications for how some Human Decision Variant files are themselves to be formatted. As but one example, are PDF files to be sent as text or with embedded scanned images? Both of these techniques are commonly in use.

Comment Number: Vanderbilt - 11

Criterion: ATTACHMENT DATA SHOULD NOT BE REQUESTED BY PAYORS THAT IS ALREADY AVAILABLE ON THE 837

(We are seconding portions of the comment that the AHA made on 11-22-05 – Electronic Claims Attachment Types (pg 55996-7))

• The ambulance and rehabilitation therapies attachment types 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 OR professional 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.

Comment Number: Vanderbilt - 12

Criterion: CAN OTHER STANDARDS BE CONSIDERED INSTEAD OF THE LOINC CODE SET?

- Our current EMR and billing systems do not store or pass LOINCs now. We would much rather have codes that our systems recognize if we are to receive requests from payers via these codes. We know that the NPRM indicates that: “On May 6, 2004, the Secretaries adopted standards for 20 domains and subdomains; among others, these included: HL7 messaging standards for clinical data, NCPDP standards for ordering from retail pharmacies, IEEE1073 to allow health care providers to monitor medical devices, DICOM to enable images of diagnostic information to be retrieved and transferred between devices and workstations, LOINC for the exchange of clinical laboratory results, SNOMED CT for certain interventions, diagnosis and nursing terminology, and a variety of terminologies for medications........There was virtually no depth in the pool of available code sets for consideration to request or send information—at least not one individual code set with everything that might be needed for electronic health care claims attachments. Thus, the original candidate for the code set to be used with attachments was the X12N version of health care claims status reason codes, tied to the X12N 837 claims transaction and the claims status inquiry and response (X12N 276/277)....Ultimately, the standards organization determined that the health care claims status codes were significantly less definitive and efficient than the LOINC codes for communicating detailed or specific clinical information to supplement a claim, and made a recommendation to the Secretary to adopt LOINC for the
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Could not the health care claims status codes be updated to be more specific?

Comment Number: Vanderbilt - 13

Criterion: A MUCH MORE ROBUST AND COMPLETE PILOT MUST BE UNDERTAKEN BEFORE NPRM BECOMES FINAL.

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.03)

- The pilot project for this proposed rule showed failure of the process. 129 claim attachments processed successfully out of 222 requested in only a 58% success rate. Certainly I don’t think we would consider it successful business here if only 58% of our disputed claims were even processed.
- In view of the failure rate CMS and the sponsors of this rule needs to stop and really review things before moving forward.
- This poor success rate came despite this pilot being funded by CMS (for the Empire piece) and having extra resources, extra technical support from vendors, etc. It also involved a very small set of providers and transactions. A true pilot given the typical hospital’s constrained resources would probably have been less successful.
- What was the extra cost per claim attachment imposed on the providers to meet this rule as compared to their current methods? Added cost needs to be a factor in whether this rule moves forward – it may save payers money but prove extremely costly for providers to implement.
- The process and the costs of implementing the Computer Variant are not indicated in the pilot. A pilot should contain all attachment types, not just 2, to ensure the NPRM would work.
- The process and the costs of implementing an unsolicited 275 are not indicated in the pilot. A pilot should contain unsolicited 275’s to ensure the NPRM would work.
- The costs of acquiring, installing, and updating software to create Human Decision Variant Non-XML files are not listed. As but one example, for PDF, Acrobat Reader is indeed free, but the software to create PDF (e.g., full Acrobat, Photoshop, InDesign) is not. Additionally,
there could be recurring costs for software upgrades. Again, for PDF, Adobe can and sometimes does change the standard annually.

- The costs of acquiring, installing, and operating hardware (e.g., scanners, additional memory, cables, high speed communications lines, etc.) to use Human Decision Variant scanned images, and in some cases very large XML Computer Decision Variant files, are not listed. This is a particular concern for smaller providers.
- An estimate of the costs and other impacts of requiring health care providers and their vendors to implement and operate the completely new implementation specification paradigm – *i.e.*, CDA – proposed in this NPRM needs to be performed.

Comment Number: Vanderbilt - 14

Criterion: DIAGNOSIS AND PROCEDURE CODES

(We are seconding portions of the comment that the AHA made on 11-22-05 – 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.