Submitter : **Mr. George Benyak** **Date: 09/29/2005**

Organization : **Vincent R. Avallone, Jr D.O. (sole pract)**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I understand the purpose of HIPAA, however my concern at this time is that NOT ONE governmental agency has addressed the most important aspect for individual practices. COST I have slated 3 years for implementation of EMR. NO Insurance Company, NO Governmental agency has offered the slightest bit of help defraying the costs of EMR or EDI hardware or software. Just the opposite. reimbursements have fallen. Overhead costs have increased. Malpractice costs and health care costs have gone through the roof. SOMEONE tell me why I need to expend in order to save you and the insurance companies money. I DO NOT SEE THE NEED NOR DO I SEE THE COST EFFECTIVENESS on the part of the individual practice. I do however see the cost effectiveness for you the insurer. I WILL NOT RECOMMEND CHANGING PROCEDURES TO MY PHYSICIANS. If you want the additional supporting documentation, you will get it on paper. It is more cost effective to my practice

Sincerely,

George Benyak
Office Manager
AO Orthopedics
Vincent R. Avallone, Jr., D.O.
Donald D. Diverio, Jr., D.O.

CMS-0050-P-1-Attach-1.DOC

CMS-0050-P-1-Attach-2.DOC

Attach #1

I understand the purpose of HIPAA and feel that it was a well reasoned proposition for Medicare / CMS/ HGSA, however my concern at this time is that NOT ONE governmental agency has addressed the most important aspect for individual practices.

COST

I have slated 3 years for implementation of EMR. Cost 15k for the Raid Server, Add'l 5k for training and ancillary hardware. $10k for additional templates. On and on and on.

Benefit / Income

NONE makes our practice not 1 cent.

Savings:
Potentially if relatively smooth transition breakeven in 5-7 years. If transition is not smooth, and costs added for fixes, breakeven in 10-15 years.

NO Insurance Company, NO Governmental agency has offered the slightest bit of help defraying the costs of EMR or EDI hardware or software. Just the opposite. reimbursements have fallen. Overhead costs have increased. Malpractice costs and health care costs have gone through the roof.

SOMEONE tell me why I need to spend large amounts of capital in order to save you and the insurance companies money.

I DO NOT SEE THE NEED NOR DO I SEE THE COST EFFECTIVENESS for my practice. I do however see the cost effectiveness for you the insurer.

I WILL NOT RECOMMEND CHANGING PROCEDURES TO MY PHYSICIANS.

If you want the additional supporting documentation, you will get it on paper. It is more cost effective to my practice

Sincerely,

George Benyak
Office Manager
AO Orthopedics
Vincent R. Avallone, Jr., D.O.
Donald D. Diverio, Jr., D.O.

Attach # 2

I understand the purpose of HIPAA and feel that it was a well reasoned proposition for Medicare / CMS/ HGSA, however my concern at this time is that NOT ONE governmental agency has addressed the most important aspect for individual practices.

COST

I have slated 3 years for implementation of EMR. Cost 15k for the Raid Server, Add'l 5k for training and ancillary hardware. $10k for additional templates. On and on and on.

Benefit / Income

NONE makes our practice not 1 cent.

Savings:
Potentially if relatively smooth transition breakeven in 5-7 years. If transition is not smooth, and costs added for fixes, breakeven in 10-15 years.

NO Insurance Company, NO Governmental agency has offered the slightest bit of help defraying the costs of EMR or EDI hardware or software. Just the opposite. reimbursements have fallen. Overhead costs have increased. Malpractice costs and health care costs have gone through the roof.

SOMEONE tell me why I need to spend large amounts of capital in order to save you and the insurance companies money.

I DO NOT SEE THE NEED NOR DO I SEE THE COST EFFECTIVENESS for my practice. I do however see the cost effectiveness for you the insurer.

I WILL NOT RECOMMEND CHANGING PROCEDURES TO MY PHYSICIANS.

If you want the additional supporting documentation, you will get it on paper. It is more cost effective to my practice

Sincerely,

George Benyak
Office Manager
AO Orthopedics
Vincent R. Avallone, Jr., D.O.
Donald D. Diverio, Jr., D.O.

Submitter : Laurie Burckhardt **Date:** 10/03/2005

Organization : WPS Insurance

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

Due to the complexity of this NPRM and the number of documents that need to be reviewed in order to provide useful comments for this NPRM we would like to see an additional 60 days to gather comments. We need to educate various departments including Medical Review & Affairs about claims attachment so that they can make precise & accurate comments.

Submitter : **Date: 10/04/2005**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist in private practice and my concern with this regulation is that the field of physical therapy needs to be represented regarding the issues of this proposed regulation. Electronic claims submission is the only form my clinic utilizes. Since the entire health field will be effected, my concern is that the only representation heard will be the medical field and not physical therapy. Thank you for considering my concern.

Submitter : Ms. Michelle Barnett **Date:** 10/05/2005

Organization : HomeMed - University of Michigan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

This is a request to extend the comment period on this very important proposed rule. The final standards adopted through the finalized rule will have such an enormous effect on most Medicare healthcare providers that a thorough examination of the proposed rule is required. Hence, an extension for providers and vendors comments in order to sort through the proposal is necessary.

Submitter : **Date: 10/07/2005**

Organization : **Illinois Dept of Health Care & Family Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

The Illinois Department of Health Care & Family Services would like to see the comment period for this NPRM extended another 60 days to January 20, 2006 due to the amount and complexity of the documentation that will need to be reviewed. The scope of the material crosses into many areas, and many people will need to be involved in the review process. We need more time to coordinate that effort.

Submitter : Ms. Doreen Espinoza **Date:** 10/07/2005

Organization : Utah Health Infomation Network

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

I would respectifully request that the time period for the NPRM review be extended. UHIN as a Standard Setting Organization will be gathering industry experts to review all of the documentation. With three x12 Implementaiton guides, six - eight HL7 documents, and various code sets the review of the NPRM will be rather lengthy and very comprehensive. It would not be practical to think that we would be able to gather together in such a short time frame to review all the differnet peices of the rule and the requried documents. Thank you for your consideration in this matter.

Submitter : Mr. mike jolley **Date:** 10/07/2005

Organization : Mr. mike jolley

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

In order to provide a thorough analysis of the claims attachment NPRM, I am requesting that more time be given for the comment period.

Several items to be reviewed-
? The actual NPRM.
? The X12 transactions that would be involved in the claims attachment.
? A review of the listed HL7 CDA attachment specifications.
? LOINC modifier codes
? XML coding

Submitter : **Ms. Robert Korten** **Date: 10/10/2005**

Organization : **Cardinal Hill Healthcare System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Sec attachment

CMS-0050-P-8-Attach-1.DOC

Attach # 8.

Re: File Code CMS-0050-P
HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments

COMBINED USE OF DIFFERENT STANDARDS:
I applaud the proposal to combine the expertise of two different SDOs. I concur with the thinking that the combination of the members' expertise of X12 for administrative data and HL7 for clinical data results in a robust and extensible toolset.

We are a provider of Physical Rehabilitation on both the in-patient and out patient basis, home care, long-term acute care, and skilled nursing care. Because of the services we provide, we are often requested to forward additional documentation. We look forward to an efficient process for responding to these requests for additional information.

We were an early adapter of the ASC X12N 837—Health Care Claim format. Unfortunately, the original intent to provide a standardized claim format was diluted to the point of zero standardization when health plans were allowed to create "companion guides" stating their specific requirements for the 837 Health Claim. As the Standards for Electronic Health Care Claims Attachments are implemented I implore you to not allow health plans to create interpretations or "companion guides" for their specific implementation of the Standards for Electronic Health Care Claims Attachments. I urge you to allow only the SDOs to make interpretations and implementation guidelines for the Standards. The chaos that resulted from every payer's interpretation of Health Care Claim requirements resulted in significant implementation expense for us. We do not wish to repeat this experience as we implement the Health Care Claims Attachments.

Thank you for the opportunity to comment upon this needed tool to increase the efficiency of claim adjudication.

Robert Korten
Director of Information Systems
Cardinal Hill Healthcare System
2050 Versailles Road
Lexington, KY 40504

Submitter : Ms. Jean Narcisi **Date:** 10/10/2005

Organization : National Uniform Claim Committee (NUCC)

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-9-Attach-1.DOC

CMS-0050-P-9-Attach-2.DOC

Comment #9
Attach #1

NUCC
National Uniform Claim Committee

Jean P. Narcisi, Chair
Director, Electronic Medical Systems
American Medical Association
515 North State Street
Chicago, IL 60610
Phone: 312 464-4713
Fax: 312 464-5762
Jean.narcisi@ama-assn.org

Member Organizations

Alliance for Managed Care

American Association for Homecare

America's Health Insurance Plans

American Medical Association

American National Standards Institute Accredited Standards Committee X12 Insurance Subcommittee

Blue Cross and Blue Shield Association

Centers for Medicare and Medicaid Services

Dental Content Committee

Health Level Seven

Medical Group Management Association

National Association of State Medicaid Directors

National Uniform Billing Committee

American Academy of Physician Assistants

Public Health/ Health Services Research

Centers for Disease Control and Prevention (Federal)

Midwest Center for HIPAA (State)

State Medical Association
Minnesota Medical Association
Texas Medical Association

October 10, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-0050-P
HIPAA Administrative Simplification:
Standards for Electronic Claims Attachments
http://www.cms.hhs.gov/regulations/ecomments

On behalf of the National Uniform Claim Committee (NUCC) I would like to request that the closing date of November 22, 2005 for the NPRM public comment period of CMS-0050-P, HIPAA Administrative Simplification: Standards for Electronic Claims Attachments be extended 30 days to December 22, 2005.

One of the key purposes for the comment period extension is to obtain feedback from the NUCC on the 10 technical documents being proposed; not just the policies expressed in the NPRM itself.

Should you have any questions concerning this request, please contact me directly at (312)464-4713.

Sincerely,

Jean P. Narcisi
Chair, National Uniform Claim Committee

cc: NUCC Members
Lorraine Tunis Doo, CMS

Comment 9
Attach # 2

NUCC
National Uniform Claim Committee

Jean P. Narcisi, Chair
Director, Electronic Medical Systems
American Medical Association
515 North State Street
Chicago, IL 60610
Phone: 312 464-4713
Fax: 312 464-5762
Jean.narcisi@ama-assn.org

Member Organizations

Alliance for Managed Care

American Association for Homecare

America's Health Insurance Plans

American Medical Association

American National Standards Institute Accredited Standards Committee X12 Insurance Subcommittee

Blue Cross and Blue Shield Association

Centers for Medicare and Medicaid Services

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Public Health/ Health Services Research

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State Medical Association
Minnesota Medical Association
Texas Medical Association

October 10, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-0050-P
HIPAA Administrative Simplification:
Standards for Electronic Claims Attachments
http://www.cms.hhs.gov/regulations/ecomments

On behalf of the National Uniform Claim Committee (NUCC) I would like to request that the closing date of November 22, 2005 for the NPRM public comment period of CMS-0050-P, HIPAA Administrative Simplification: Standards for Electronic Claims Attachments be extended 30 days to December 22, 2005.

One of the key purposes for the comment period extension is to obtain feedback from the NUCC on the 10 technical documents being proposed; not just the policies expressed in the NPRM itself.

Should you have any questions concerning this request, please contact me directly at (312)464-4713.

Sincerely,

Jean P. Narcisi
Chair, National Uniform Claim Committee

cc: NUCC Members
Lorraine Tunis Doo, CMS

Submitter : **Ms. Jean Narcisi** **Date: 10/10/2005**

Organization : **National Uniform Claim Committee**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

October 10, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-0050-P
HIPAA Administrative Simplification:
Standards for Electronic Claims Attachments
http://www.cms.hhs.gov/regulations/ecomments

On behalf of the National Uniform Claim Committee (NUCC) I would like to request that the closing date of November 22, 2005 for the NPRM public comment period of CMS-0050-P, HIPAA Administrative Simplification: Standards for Electronic Claims Attachments be extended 30 days to December 22, 2005.

One of the key purposes for the comment period extension is to obtain feedback from the NUCC on the 10 technical documents being proposed; not just the policies expressed in the NPRM itself.

Should you have any questions concerning this request, please contact me directly at (312)464-4713.

Sincerely,

Jean P. Narcisi
Chair, National Uniform Claim Committee

cc: Lorraine Tunis Doo, CMS
NUCC Member Organizations
Alliance for Managed Care
American Association for Homecare
America?s Health Insurance Plans
American Medical Association
American National Standards
Institute Accredited Standards
Committee X12 Insurance
Subcommittee
Blue Cross and Blue Shield
Association
Centers for Medicare and Medicaid
Services
Dental Content Committee
Health Level Seven
Medical Group Management
Association
National Association of State
Medicaid Directors
National Uniform Billing Committee
American Academy of Physician
Assistants
Public Health/ Health Services Research
Centers for Disease Control
and Prevention (Federal)
Midwest Center for HIPAA (State)
State Medical Association
Minnesota Medical Association
Texas Medical Association

Submitter : Mrs. Chris Caras **Date:** 10/10/2005

Organization : IHC/ Utah Valley Reg. Med. / Utah HL7 Team

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I think there needs to be more time allowed, so comittees have the necessary time to thoroughly review all documents involved. Thank you.

Submitter : Ms. Karin Wittich **Date: 10/11/2005**

Organization : Amer Assoc of Oral & Maxillofacial Surgeons

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-0050-P-12-Attach-1.DOC

American Association of Oral and Maxillofacial Surgeons

9700 West Bryn Mawr Avenue • Rosemont, Illinois 60018-5701 • 847.678.6200 • 800.822.6637 • FAX 847.678.6286 • 847.678.6279

October 14, 2005

Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Boulevard
Washington, DC 20201

RE: CMS-0500-P

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is in the process of reviewing the aforementioned Notice of Proposed Rule Making (NPRM). After the first reading of this eagerly anticipated proposed rule it has become apparent that this NPRM, for Claims Attachments, is requiring a more in depth comprehensive review. The AAOMS represents approximately 6,500 oral and maxillofacial surgeons in the United States and the mission of the Association is to provide a means of self-government relating to professional standards, ethical behavior and responsibilities of its fellows and members; to contribute to the public welfare; to advance the specialty; and to support its fellows and members through education, research and advocacy.

The committees and staff responsible for reviewing this proposed rule have found it difficult to schedule a time to review the voluminous supporting documents, which must be studied prior to submission of our written comments. This comprehensive review can not be done by the 22nd of November and **we therefore request that the closing date for comments be extended by 60 additional days.**

In addition to the volumes of information that must be carefully studied, the notice that a new code set, LOINC (Logical Observation Identifiers Names and Codes) is a completely new concept and one, when instituted, will have a significant impact on the practicing oral and maxillofacial surgeon. To properly address such concepts, the AAOMS must first develop a keen understanding of their nature and use within the healthcare community.

Thank you for your attention to this request.

Sincerely,

Karin K. Wittich
Associate Executive Director

CMS-0050-P-13 **Standards for Electronic Health Care Claim Attachments**

Submitter : **Mr. David Mc Daniel** **Date & Time:** **10/13/2005**

Organization : **Veterans Health Administration**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

In order for the Veterans Health Administration (VHA) to provide quality techincal feedback on the 10 technical documents being proposed for the Claims Attachment Proposed Rule as well as the the policies expressed in the NPRM itself, VHA needs additional time to thoroughly assess these documents beyond the current November 22, 2005 close of the comment period.

Due to the complexity of this transaction, the highly technical nature of the material, the size of the documents being requested for review and the potential impacts to VHA's ability to implement this transaction to full compliance, VHA is requesting that the closing date be extended to January 15, 2006

Thank you for your consideration of this request. VHA desires to have a clear understanding of the requirments outlined in this Proposed Rule before making comments on its content.

C. David Mc Daniel
Veterans Health Administration
HIPAA Program Office
Chief Business Office
202.254.0337

CMS-0050-P-14 **Standards for Electronic Health Care Claim Attachments**

Submitter : **Mr. Philip Heinrich** **Date & Time:** **10/13/2005**

Organization : **California Department of Health Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Representatives from California requests the review period for attachments be extended from 60 days to 120 days. This request is made for several reasons. First, the proposal introduces a 'new' methodology (LOINC) and a 'new' technology (xml) to the California review team. Learning new concepts while reviewing a technical proposal is time consuming. Secondly the volume of material under consideration is substantial. The California team intends to perform a comprehensive review of the claims attachments proposal. In order to perform this task, additional time is required.

CMS-0050-P-15 **Standards for Electronic Health Care Claim Attachments**

Submitter : **Ms. Sheila Frank** **Date & Time:** **10/15/2005**

Organization : **Delta Dental Plans Association**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-15-Attach-1.DOC

DELTA DENTAL

October 14, 2005

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0050-P
Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

RE: **HIPAA Proposed Rule for Electronic Health Care Claims Attachments**

To Whom It May Concern:

I am writing on behalf of the Delta Dental Plans Association ("DDPA") to request extension of the 60-day comment period for the proposed rule establishing standards for electronic health care claims attachments. See 70 Fed. Reg. 55989 (September 23, 2005).

Claim attachments are critically important to the adjudication of dental benefit claims. Most dentists are not participating in electronic claims transactions, and these proposed standards will become the basis for future system development. A claims attachment standard is under development with respect to periodontal care.

We appreciate the Secretary's efforts to develop a proposal for this very complicated matter. However, we do not believe that 60 days will provide an adequate opportunity for meaningful review and responsive comment. The proposed transaction and messaging standards documentation is quite lengthy, and to do an adequate review, we must educate our stakeholders and give them time to understand and analyze this complex material.

We would also like to have an opportunity to review the as-yet-unpublished final report of the Medicare Proof of Concept Study conducted by Empire Blue Cross Blue Shield. At a minimum, we believe that an additional 60 days would be necessary to provide DDPA and its members an adequate opportunity for meaningful review and comment.

Sincerely,

Sheila Lynn Frank

Sheila Lynn Frank
Director of Health Information Standards

Delta Dental Plans Association
1515 West 22nd Street, Suite 450
Oak Brook, Illinois 60523

Telephone 630-574-6001
Facsimile 630-574-6999

Submitter : Mr. Frank Pokorny **Date:** 10/18/2005

Organization : Dental Content Committee of the ADA

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

As Secretariat and on behalf of the Dental Content Committee (DeCC) of the American Dental Association I would like to request that the closing date of November 22, 2005 for the NPRM public comment period of CMS-0050-P, "HIPAA Administrative Simplification: Standards for Electronic Claims Attachments" be extended 60 days to January 23, 2006.

The DeCC finds that there are approximately 1,000 pages of documentation, in total, that must be studied in order to provide comprehensive and considered comments on the subject NPRM. By formal motion the DeCC requests that the closing date for comments be changed from November 22, 2005 to Monday, January 23, 2006. This will provide an additional 60 days to prepare proper comments, and recognizes that the 60th day falls on a non-workday (Saturday). This additional time is necessary as the NPRM seeks comments not only on the policies expressed therein, but also the ten technical documents included by reference. These technical documents also contain concepts (e.g., LOINC [Logical Observation Identifiers Names and Codes]) that are new and novel to members of the dental profession, and the dental community at large. To properly address such concepts the DeCC must first develop an understanding of their nature and use within the healthcare community.

Should you have any questions concerning this request, please contact me directly at (312)440-2752 or pokornyf@ada.org.

Submitter : Mr. Bruce Rodman

Date: 10/20/2005

Organization : National Home Infusion Association

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-0050-P-17-Attach-1.PDF

National Home Infusion Association
Providing solutions for the infusion therapy community

October 17, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0500-P, Mail Stop C4-26-05
Baltimore, MD 21244-1850

Ref: CMS-0500-P Proposed HIPAA Rule on Claims Attachments
Request for Extension of Comment Period

Dear Dr. McClellan:

The National Home Infusion Association ("NHIA") is intending to submit comments on the proposed rule for HIPAA Claims Attachments as issued in the Federal Register on September 23, 2005.

NHIA is a national membership association for clinicians, managers and organizations providing infusion therapy services for patients in home care and outpatient settings. Our members include independent local and regional home infusion pharmacies; national home infusion provider organizations; and hospital-based home infusion organizations. Generally, infusion pharmacies can be defined as pharmacy-based, decentralized patient care facilities that provide care in alternate sites to patients with either acute or chronic conditions. Currently, NHIA has more than 2,000 members.

NHIA appreciates the substantial work on development of standards for claims attachments and proposal of a rule by CMS and all others involved in development of the proposed standards, especially within the X12 and HL7 standards organizations. We understand this has been a very lengthy seven year effort by many parties.

From our initial efforts to analyze the proposed rule including all ten of the technical documents incorporated by reference, we have realized understanding and commenting on what is proposed involves review of at least 1,000 pages of material. Much of this material presents new and complex technology such as XML/CDA and standards for which many are generally unproven by use, which will have highly significant cost-benefit tradeoff impact for all participants in the health care industry. Of course, NHIA is especially concerned with impact on home infusion providers and their technical vendors. We note that our constituency fulfills a critical role in a segment of alternate-site health care that typically has unique needs as compared other categories of health care providers.

Given that development of these complex standards and proposed rule have taken seven years and the very high potential impact on the entire health care industry, NHIA urges CMS to extend the comment period by at least 120 more days, i.e. a 180 day comment period. This delay is essential for CMS to receive thorough and quality comments from all parties that would be involved in using these HIPAA standards—to ultimately achieve the desired benefits.

Sincerely,

Bruce E. Rodman
Director, Health Information Policy

100 Daingerfield Road • Alexandria, VA 22314 • Phone: 703-549-3740 • Fax: 703-683-1484 • www.nhianet.org

Submitter : **Ms. Margaret Garikes** **Date: 10/20/2005**

Organization : **American Medical Assocaition**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-18-Attach-1.DOC

October 20, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-0050-P
HIPAA Administrative Simplification:
Standards for Electronic Claims Attachments
http://www.cms.hhs.gov/regulations/ecomments

On behalf of the American Medical Association (AMA) I would like to request that the closing date of November 22, 2005 for the NPRM public comment period of CMS-0050-P, HIPAA Administrative Simplification: Standards for Electronic Claims Attachments be extended 30 days to December 22, 2005. The AMA would like the extension in order to review the ten technical documents being proposed.

Should you have any questions concerning this request, please contact me directly at (202) 789-7409.

Sincerely,

Margaret Garikes
Director, Division of Federal Affairs

Submitter : Ms. Brenda Bryant

Date: 10/21/2005

Organization : Utah Medicaid

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

I respectfully request that the time period for the NPRM review be extended. Utah Medicaid is a member of a Regional Health Information Organization and as a Standard Setting Organization will be gathering industry experts to review all of the documentation. With three x12 Implementation guides, six - eight HL7 documents, and various code sets the review of the NPRM will be rather lengthy and very comprehensive. It would not be practical to think that we would be able to gather together in such a short time frame to review all the different pieces of the rule and the required documents. Thank you for your consideration in this matter.

Submitter : Dr. Frank Kyle **Date: 10/28/2005**

Organization : American Dental Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

RE: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments ? 45 CFR Part 162 ? (File Code CMS-0050-P)

These comments are also provided as an attached word document letter from the Executive Director of the American Dental Association.

The American Dental Association (ADA), as a named Designated Standards Maintenance Organization and consultant to the Secretary of Health and Human Services on HIPAA Administrative Simplification standards [Public Law 104-191? Health Insurance Portability and Accountability Act of 1996, Title II, Subtitle F, Part C, Section 1172 (c) (3) (B) (iv)], has received and is undertaking a review of the referenced Notice of Proposed Rule Making (NPRM). The ADA is the world?s oldest and largest dental professional organization representing over 152,000 member dentists or approximately 72 percent of the dentists in practice across the United States. Because of the importance this NPRM for Claims Attachments has for the profession, the ADA appreciates the opportunity to make comment.

The ADA finds that there are approximately 1,000 pages of documentation, in total, that must be studied in order to provide comprehensive and considered comments on the subject NPRM. The limited time available in the notice will prevent the careful study necessary for a thorough response to the regulatory preface, the regulatory text, the implementation specifications and other the documentation included within the NPRM. We therefore request that the closing date for comments be changed from November 22, 2005 to Monday, January 23, 2006. This will provide an additional 60 days to prepare proper comments, and recognizes that the 60th day falls on a non-workday (Saturday).

This additional time is necessary as the NPRM seeks comments not only on the policies expressed therein, but also the ten technical documents included by reference. These technical documents also contain concepts (e.g., LOINC [Logical Observation Identifiers Names and Codes]) that are new and novel to members of the dental profession, and the dental community at large. To properly address such concepts the ADA must first develop an understanding of their nature and use within the healthcare community.

Please feel free to contact Mr. Frank Pokorny, Manager, Dental Code Standards and Administration, at 1-312-440-2500 X-2752, email pokornyf@ada.org or Dr. Frank Kyle, Manager, Legislative and Regulatory Affairs at 1-202-789-5175, email kylef@ada.org.

CMS-0050-P-20-Attach-1.DOC

American Dental Association
www.ada.org

October 31, 2005

Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Boulevard
Washington, DC 20201

RE: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments – 45 CFR Part 162 – (File Code CMS-0050-P)

The American Dental Association (ADA), as a named Designated Standards Maintenance Organization and consultant to the Secretary of Health and Human Services on HIPAA Administrative Simplification standards [Public Law 104-191– Health Insurance Portability and Accountability Act of 1996, Title II, Subtitle F, Part C, Section 1172 (c) (3) (B) (iv)], has received and is undertaking a review of the referenced Notice of Proposed Rule Making (NPRM). The ADA is the world's oldest and largest dental professional organization representing over 152,000 member dentists or approximately 72 percent of the dentists in practice across the United States. Because of the importance this NPRM for Claims Attachments has for the profession, the ADA appreciates the opportunity to make comment.

The ADA finds that there are approximately 1,000 pages of documentation, in total, that must be studied in order to provide comprehensive and considered comments on the subject NPRM. The limited time available in the notice will prevent the careful study necessary for a thorough response to the regulatory preface, the regulatory text, the implementation specifications and other the documentation included within the NPRM. We therefore request that the closing date for comments be changed from November 22, 2005 to Monday, January 23, 2006. This will provide an additional 60 days to prepare proper comments, and recognizes that the 60th day falls on a non-workday (Saturday).

This additional time is necessary as the NPRM seeks comments not only on the policies expressed therein, but also the ten technical documents included by reference. These technical documents also contain concepts (e.g., LOINC [Logical Observation Identifiers Names and Codes]) that are new and novel to members of the dental profession, and the dental community at large. To properly address such concepts the ADA must first develop an understanding of their nature and use within the healthcare community.

Please feel free to contact Mr. Frank Pokorny, Manager, Dental Code Standards and Administration, at 1-312-440-2500 X-2752, email pokornyf@ada.org or Dr. Frank Kyle, Manager, Legislative and Regulatory Affairs at 1-202-789-5175, email kylef@ada.org.

Thank you for your attention to this request.

Sincerely,

James B. Bramson, D.D.S
Executive Director

211 East Chicago Avenue Chicago, Illinois 60611-2678
p 312-440-2500 f 312-440-7494

Submitter : Matt Klischer

Date: 11/01/2005

Organization : CMS

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

scc attachment

CMS-0050-P-21-Attach-1.DOC

CMS-0050-P
Comments on the Claims Attachment NPRM from CMS

Comment Number	Page Number	Section	Comment	Response
1	55990	(Dates)	To ensure complete analysis of the NPRM to the Medicare contractor processing environment, we request extending the comment period an additional 60 days.	

Submitter : Peter Gysegem **Date:** 11/01/2005

Organization : Beaver Creek Software

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS:
Section III-C appears to be open-ended permission to use any of the named attachment types for any other business purpose the payer chooses. Even though the example given describes a DME attachment specification that is "finalized, balloted, and approved by HL7," nothing in the language implies the necessity of any kind of standardization. In my experience, when payers are given this latitude, they use it as a means to deny a claim or delay its adjudication and payment. This usage is described as being voluntary, but in practice it means that it is voluntary on the part of payers, not necessarily on the part of providers.

Submitter : Mr. David Feinberg **Date:** 11/11/2005

Organization : Rensis Corporation - A Consulting Company

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-0050-P-23-Attach-1.DOC

David A. Feinberg, C.D.P.
3662 SW Othello Street • Seattle, Washington 98126-3246
206 617-1717 • DAFeinberg@computer.org

11 November 2005

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: (a) 70 FR 184, 9/23/2005, pages 55989-56025
(b) CMS-0050-P
(c) RIN 0938-AK62

Please extend the public comment period on the Notice of Proposed Rule Making (NRPM) for HIPAA Administrative Simplification Standards for Electronic Health Care Claims Attachments to at least **9 January 2006**.

Because of the interrelationships between what the NPRM does not state and what the HL7 Implementation Guide {CDAR1AIS0000R021 Additional Information Specification Implementation Guide, Release 2.1, May 2004} and related documents do say, development of potential comments has been arduous and slow over the past seven weeks since the NPRM was published.

While I'll submit those comments that are ready by the present closing date of 22 November 2005, I need more time to continue my analyses, and would like to ensure that upcoming holiday season activities don't adversely impact the quality of any additional submissions.

Thank you for considering the requested extension, and please use any of the methods shown above should you wish to contact me about this request.

Yours truly,

David A. Feinberg

David A. Feinberg, C.D.P.
President, Rensis Corporation

Rensis Corporation

Intelligently Linking Information Systems

Submitter : Ms. Joan Boyle **Date: 11/11/2005**

Organization : The TriZetto Group, Inc.

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

Reference ? Submitting Comments, 70 FR 184, 9/23/2005, pages 55989-56025
See attachment.

CMS-0050-P-24-Attach-1.DOC

CMS-0050-P-24-Attach-2.DOC

CMS-0050-P-24-Attach-3.DOC

TRIZETTO

November 11, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: **CMS-0050-P**

Via electronic comments at http://www.cms.hhs.gov/regulations/ecomments

Reference – Submitting Comments, 70 FR 184, 9/23/2005, pages 55989-56025

We request additional time to submit comments on the proposed rule and ask that you extend the comment period until January 31, 2006.

Neither the HL7 transactions nor the LOINC codes that this rule introduces have been used previously by payers and their vendors. TriZetto believes the industry needs additional time to allow us to seek input from people experienced with these transactions so that we may properly evaluate the impact of implementing them. Given the challenge of reviewing these documents and the upcoming holidays, we believe an extension to January 31, 2006 would be most helpful.

With additional time for thoughtful review by the industry, we may avoid the need to issue addenda to the transactions after the final rule is published.

Many thanks for your consideration of this request.

Joan

Joan Boyle
Privacy Officer and HIPAA Compliance Manager
The TriZetto Group, Inc.
PO Box 1730
Grand Lake, CO 80447
Joan.boyle@trizetto.com
970-627-1675

November 11, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: **CMS-0050-P**

Via electronic comments at http://www.cms.hhs.gov/regulations/ecomments

Reference – Submitting Comments, 70 FR 184, 9/23/2005, pages 55989-56025

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Many thanks for your consideration of this request.

Joan

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November 11, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: **CMS-0050-P**

Via electronic comments at http://www.cms.hhs.gov/regulations/ecomments

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Submitter : Mr. David Pittman
Organization : Zenith Administrators, Inc.
Category : Other
Date: 11/17/2005

Issue Areas/Comments

GENERAL

GENERAL
see attachment

CMS-0050-P-25-Attach-1.DOC

David Pittman
Director of Compliance
Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210
Columbia, MD 21044
(410) 884-1416

November 16, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

Re: SOLICITED vs. UNSOLICITED ATTACHMENTS

This comment concerns § 162.1910(c) of the proposed rule:

> "A health plan that conducts a health care claims attachment request transaction using electronic media, must submit complete requests and identify in the transaction, all of the attachment information needed to adjudicate the claim, which can be requested by means of the transaction."

This comment also concerns the purpose of this proposed provision, as stated in the preamble (page 55999 of the Federal Register, September 23, 2005):

> "We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired "questions" and/or documentation needs relevant to that specific claim.... The intent of these proposed requirements is to avoid inefficient, redundant processes. A health plan would not be able to extend adjudication through a lengthy process of multiple individual attachment requests for the same claim.... We propose this because it seems contrary to the goals of administrative simplification for covered entities to engage in a continuous loop of query and response in order to have a claim processed."

These references to a "lengthy process" and a "continuous loop" imply that the goal of Administrative Simplification is to minimize *time* (i.e., the elapsed time between submission and adjudication) rather than *costs*.

With this provision, HHS proposes to solve a problem without offering any evidence that such a problem exists. Before adopting such a standard, HHS should provide evidence not only that such a "continuous loop" actually occurs (or

would occur) with a significant frequency, but also that it is a cost-related problem in need of a solution. It is contrary to the purpose of Administrative Simplification, or any other regulatory scheme, to impose regulations for the purpose of solving a problem that has not been shown to exist.

If such a problem exists, HHS should also consider whether existing regulations and other incentives are adequate and whether the proposed new regulation would contribute significantly to solving it. There are at least three types of existing requirements and/or incentives for the purpose of minimizing unnecessary delays in the claim adjudication process.

- The Department of Labor's Claims Procedure Rule (29 C.F.R. § 2560.503-1) requires ERISA group health plans to process post-service claims within 30 days of receipt, and limits when and for how long an extension may be taken.
- Other than Idaho, all states and the District of Columbia impose "prompt pay" requirements and/or incentives on insurers and claim administrators (see http://www.karenzupko.com/Resources/tools/prompt_%20pay_%202004.doc).
- Contracts, such as those between a PPO and its member providers, include requirements and/or incentives for prompt payment for services.

HHS should consider the effectiveness of these existing measures when evaluating the likely benefit of adding yet another requirement in pursuit of the same goal. Furthermore, HHS should consider whether limiting payers' ability to request just six types of attachments is the best way to achieve its stated goal of avoiding a potentially "lengthy process" when existing obligations and regulations more directly address the same goal.

HHS should also reconsider whether it is *reasonable* to prohibit a payer from transmitting a new request for a claim attachment after receiving a response to an initial request. Sometimes, the information received in response to the initial attachment request may prompt additional questions that could not have been previously anticipated. When this occurs, a prohibition against a second request might necessitate denial of the claim. It seems contrary to the goals of Administrative Simplification to leave the payer no choice but to deny the claim when a second request and response would facilitate full adjudication.

HHS's proposal seems to be based on a flawed model of how claims are actually processed. A single medical condition or incident may lead to several claims being submitted by multiple providers for various services such as ambulance services, emergency room care, hospital admission, surgery, etc. If the payer has questions about the incident or diagnosis and the necessity or appropriateness of the care for that condition, the same "attachment" information may be relevant to more than one claim. Under such circumstances, there may not be a one-for-one relationship between a particular claim and a particular request for additional information. Any regulation that is based on that paradigm is therefore flawed.

Finally, adopting such a standard might exceed the Secretary's authority under HIPAA, which states at § 1172(b):

> "Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care."

Before adopting the proposed standard, HHS should consider whether it is necessary for the purpose of achieving the goal of reducing administrative costs. HHS's cost/benefit analysis does not directly address the costs or benefits of this particular aspect of the proposed rule. Imposing any new regulatory requirement increases costs in the short run, and should therefore be shown to provide a significant benefit over time.

Payers, who have no interest in increasing their own administrative costs, are capable of determining for themselves whether an internal policy of limiting claim attachment requests to one per claim would reduce their own administrative costs.

David Pittman
Director of Compliance

Submitter : **Ms. Deborah Fritz-Elliott** **Date: 11/17/2005**

Organization : **Blue Cross Blue Shield of Michigan**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-26-Attach-1.DOC

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore MD 21244-8014

November 17, 2005

RE: Comments on Proposed Rule: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments NPRM CMS-0050-P (45 C.F.R. Part 162) (70 Fed. Reg. 55990, September 23, 2005)

Dear Secretary Leavitt:

This response is on behalf of Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN), a wholly owned subsidiary Health Maintenance Organization (HMO), to provide you with comments on the September 23, 2005 Notice of Proposed Rulemaking (NPRM) referenced above. BCBSM is a nonprofit, prepaid health care corporation offering group and individual health coverage to approximately 4.7 million members in Michigan and across the United States. BCBSM is an independent licensee of the Blue Cross Blue Shield Association (BCBSA), which represents 39 independent Blue Plans with over 93 million members (nearly one-in-three Americans).

While the complete document is a detailed response to the Electronic Health Care Claims Attachment Standards Notice of Proposed Rule Making, please note that the following four items represent our most critical concerns:

1. The final regulation needs to allow an unsolicited 275 transaction to be submitted independently from the claim – *not* within the same interchange or transmission.

2. Expediting the decision to move to HL7 CDA Release 2 is *crucial* as we are considering early voluntary adoption.

3. Health plans need the capability to send additional requests for information if the original response from the provider did not answer the payer's questions or prompted new questions whose answers are necessary to adjudicate the claim.

4. The content of the ambulance and emergency department attachments do not meet our medical policy / administrative requirements.

EFFECTIVE DATES

We recommend moving to Clinical Document Architecture (CDA) release 2 assuming that there is a pilot that uses CDA release 2. Changes will need to be made to the HL7 Implementation Guide and each AIS developed to address CDA release 2.

We agree with the 24-month implementation timeframe from the effective date of the final rule.

We recommend that CMS decide and announce early if CDA release 2 will be the version so that vendors do not have to wait until the final rule to begin their development.

We recommend that the WEDI sub-workgroup on claims attachments develop a national rollout plan. We recommend that the regulation support a WEDI proposed national rollout plan.

ELECTRONIC CLAIMS ATTACHMENT TYPES

We agree that the six initial attachment types proposed in the rule are significant, important to the industry and should be adopted as standards.
We recommend that the quality of scanned image documents should be defined more clearly than "clear enough" as stated in the rule. If a quality standard is available, then it should be considered for use. If not, we suggest language should be added to indicate that the electronic image should be as readable as the original.

We recommend that an attachment for DME (including Prosthetics & Orthotics) be developed and mandated in addition to the six already proposed.

FORMAT OPTIONS

We agree that the final rule should adopt both the Computer Decision Variant (CDV) and the Human Decision Variant (HDV).

COMBINED USE OF DIFFERENT STANDARDS

We agree with the approach in using standards developed by X12 and HL7 and the LOINC code set as outlined for these basic purposes.

We recommend that the content of the BIN segment does not have to be validated for the data that is not being used.

We recommend that receivers of this transaction implement flexibility in receiving imperfect transactions (specifically BIN01).

There are some data elements in the proposed ambulance attachment that already reside in the 837 claim. This is also the same for some therapy services. We recommend that CMS work with the two standard bodies to resolve this situation.

We recommend that the regulation not be interpreted to disallow health plans from collecting information via the claims attachment process for purposes other than those defined in this rule, such as post-adjudication purposes. We recommend removal of the requirement that this can only be done using trading partner agreements.

Because LOINC is adopted as a Medical Code Set, the regulation needs to clarify the use of which LOINC's are used in each of the AIS documents. The clarification should separate those AIS documents with static content from those that are non-static.

We recommend that a technical correction in the AIS booklets that reference the LOINC database to clarify how to determine the appropriate subset of LOINC codes.

We recommend that the 275 Implementation Guide be changed to remove usage of the 102 transaction. Our reasoning is that the 102 transaction is a supplemental text transaction and not intended to be an acknowledgement transaction.

We recommend that health plans only have to respond with a 997 Functional Acknowledgement to a 275. Although use of the 999 and 824 are in line with WEDI Acknowledgement PAG recommendations, many of our provider customers are not currently capable of handling the 997 let alone these additional acknowledgement transactions.

SOLICITED vs. UNSOLICITED ATTACHMENTS

We agree that payers should endeavor for completeness of the request to ask all known questions in the initial request, with the understanding that further questions may need to be asked based on information contained in the initial response.

We recommend replacement of the term "instructions" with "prior arrangement" when referring to solicited attachments.

We agree that a provider, based on prior arrangement and/or experience with a health plan, may send unsolicited attachments until that plan issues either advance instruction to clarify its requirements or explicitly instructs the provider that attachment is not required for the type of claim in question. If the plan instructs the provider that an attachment is not required but resumes requesting the attachment, the provider may resume sending an unsolicited attachment.

We recommend that the regulation allow the ability to send the unsolicited attachment separately from the 837 claim, instead of bundled in the same interchange or transmission file (ISA/IEA) as long as they are sent in the same daily cycle.

We recommend that language be added to the COB section that will specifically state that if a payer receives an attachment, there is no requirement to forward the attachment on to subsequent payers.

Clarification is needed on whether a provider will be required to do both the solicited and unsolicited models if they are submitting attachments electronically.

Clarification is needed for situations when the health plan has published advance specific attachment instructions and claim was received without required attachments. Is the health plan required to request the attachment or can it deny the claim?

Clarification is needed on whether a claim submitted with an unsolicited attachment is considered a "clean claim" and therefore would need to be processed within a specified timeframe. In addition, what if unsolicited attachment did not meet our prior arrangement criteria?

PROVIDER vs. PLAN PERSPECTIVE

We recommend that providers not be allowed to request different routing or use of requests for additional information based on claim attachment type.

Clarification is needed on whether health plans will still be able to deny a claim for a reason of "needing additional clinical information." Can appeals or requests for medical records continue to be supported in a post-adjudication environment? Alternatively, does the request for that information now have to come through a 277 request for information?

Clarification is needed on whether a health plan that does not have a current business model that sends requests for additional information (electronic or hardcopy) is required to use the 277 if a provider requests it to be used. An example of this would be when a health plan uses the unsolicited business model, thus publishing the criteria for the providers in advance and expecting the 275 with the claim.

Clarification is needed to describe the workflow in situations where a health plan may make such a request in advance of submission of the health care claim.

We recommend that there not be any requirement for clearinghouses to be ready first even though it would be beneficial to facilitate testing between providers and health plans. Other clearinghouses have had issues with this approach and we concur.

ATTACHMENT CONTENT AND STRUCTURE

We recommend that 64 MB be left as a recommendation and not be a standard or a maximum. Technology will continue to change so we do not want to make this a standard.

We further agree that the granularity of the proposed LOINC questions and answers satisfy our medical policy requirements, in some cases.

We believe that there needs to be a clear understanding of the maintenance and update schedule of the LOINC code set.

The content of the ambulance attachment does not meet our needs. We recommend adding questions to request justification for air ambulance vs. ground ambulance, reason for waiting time, reasons for multiple patients and their names, reasons for non-transport (ex. Deceased patient or patient refuses).

The content of ER department attachment does not meet our needs. We recommend adding a question to request the reason why the same patient had services performed more than once in ER on same day.

The content of the proposed attachments does not meet our needs to identify benefit design-specific policy (ex. Some contract-specific services are only payable if referred by plant clinician that may or may not be a physician).

The content of the proposed attachments does not meet our needs to request information from a secondary source other than billing provider (ex. Referring provider).

ALTERNATIVES CONSIDERED: CANDIDATE STANDARDS

We believe there needs to be a clear process on access to the LOINC codes used for the HIPAA specific code set.

We recommend replacement of the term "verify" with "clarify" when stating that the use of the standard electronic health care claims attachments would not preclude the health plan from using other processes or procedures to verify the information reported in the attachment documentation.

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS

We believe there should be a goal to move the regulatory process forward more quickly. To achieve this goal, for new attachment types and revisions to current attachment types, we recommend that the DSMO be authorized to adopt those that are developed, balloted, and published by HL7 through the DSMO process. The process should be stopped at that point instead of going through the full regulatory process. The process needs to include provisions for outreach and comments in the HL7 SDO processes. In addition, notification and rollout time between adoption and the implementation date needs to be added after the HL7 publication. More time is needed to implement new types than for changes to existing ones.

IMPACT ANALYSIS

We recommend that the results of the Empire Attachment Pilot be included in the preamble of the final rule.

COSTS AND BENEFITS

We believe that the cost and benefits section may overstate the benefits and understate cost. Long-term benefits of auto adjudication using CDV may not be achieved if a high percentage of providers choose not to use that variant.

Submitter :

Date: 11/17/2005

Organization : **Claredi Corporation**

Category : **Private Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-27-Attach-1.DOC

Claredi Corporation Comments to CMS on the Proposed Standards of September 23, 2005, for Electronic Health Care Claims Attachments CMS–0050–P NPRM (45 CFR Part 162)

November 17, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Claredi Corporation is pleased to offer comments and recommendations on the Centers for Medicare and Medicaid Notice of Proposed Rule Making (NPRM) of September 23, 2005, that proposes standards for electronically requesting and supplying additional health care information in the form of an electronic attachment to support submitted health care claims data.

Regards,
Kepa Zubeldia, M.D.
President and Chief Technology Officer
Claredi Corporation

	Page	NPRM Section	Category	Comment
1	56023 56024 56024 56025	162.1002 (LOINC) 162.1915 162.1925		We agree that the proposed X12 and HL7 standards, and the LOINC Code Set (to identify the questions and answers) named in the NPRM should be adopted in the final rule. We agree that the proposed 6 attachment types named in the NPRM should be adopted in the final rule.
2	55993			Center Column states: "The 4050 versions of the X12 Implementation Guides are compatible with the current X12 4010 guides adopted for HIPAA transactions – version 4010-1a so that the two transactions can be used together as necessary. In other words, a claims transaction (837 version 4010-1a)..." Comment: The current version of the X12 837 guides are noted as "4010A1".
3	55994		Effective Dates	We recommend that the Final Rule contain an effective date 18 months after the date the Final Rule is published, followed by the usual 26 month implementation window, to allow adequate time for the industry stakeholders to implement.
4	55995			Center column states: "In fact, each HL7 AIS for the electronic claims attachment standards will include a fully functional XSL stylesheet for use by covered entities."

				Comment: Please note that there is only one style sheet needed, which will work for all of the 6 attachments and it will be available from HL7.
5	55995			Right-hand column states: "We invite comment on the pros and cons of each CDA release, the issues related to the use of a style-sheet to permit use of either CDA release..." Comment: CDA Release 1 (R1) and Release 2 (R2) are sufficiently different that a single XSLT style-sheet for both is probably not realistic. In addition, because the images are external to the CDA R1 but are internal XML in CDA R2, the processing of the CDA would be different enough between R1 and R2 to require separate implementations. It is not a simple matter of upwards migration, such as when the HIPAA X12 standards were migrated with the Addenda; rather they are a completely different implementation. 1. Before CMS considers making a decision on whether to adopt CDA R1 or CDA R2, it is necessary that the industry conducts at least a proof of concept pilot implementation with several trading partners to determine the feasibility of implementing R2 for the six proposed standard attachments. Without a proof-of-concept pilot with positive outcome, CMS should not consider for adoption the CDA R2 as a standard. 2. Over the last few years, all the Attachment work has been done under CDA R1. The adoption of CDA R2 could have some advantages over R1, but it would require new Implementation Guides for all the standard attachments, possibly delaying the adoption process by two or more years. Most importantly, uncertainty about which standard would cause all progress on Attachments to cease until this uncertainty is resolved. 3. CMS should adopt CDA R1 immediately and indicate it may consider CDA R2 for new attachments and future versions of the initial six attachments. 4. Any proof of concept pilot and development of new Implementation Guides under CDA R2 must be conducted using the HL7 and X12 standards setting processes so that the entire industry can participate in these developments. Only after the standard setting bodies recommend CDA R2 should CMS consider its adoption. CMS should not consider adoption of a standard that has not been recommended by the SDO when the standard recommended by the SDO, CDA R1, is available for use. 5. CMS should give a unambiguous, immediate indication of its adoption of the CDA R1 Implementation Guides as currently published so that the industry can get on with the work of implementing the attachments without uncertainty over which version will be adopted.

6	55997		Electronic Claims Attachment Types	Left hand Column states: The effect of adopting a limited number of attachments standards at first is to permit covered entities time to gain experience with new standards and to evaluate the technical and business impacts of such transactions. Comment: We recommend that a national roll-out plan is created by the WEDI SNIP Claims Attachments Sub-Workgroup and that the Regulation supports this plan.
7	55997-55998		Format Options	NPRM II.C.6. We concur that both the Human Decision Variant (HDV) and Computer Decision Variant (CDV) be named in the Final Rule. We concur that payers be required to accept both Human Decision Variant (HDV) and Computer Decision Variant (CDV).
8	55999			Left-Hand column states: "1. Electronic Health Care Claims Attachment vs. Health Care Claims Data. Electronic health care claims attachments must not be used to convey information that is already required on every claim." Comment: There is some matching data that is repeated in the 275. Comment: Need to revive the 837, 275, TR3 Joint Workgroup from years ago that laid out the foundation of the steps to be followed when data, such as ambulance and rehabilitation, is housed in an attachment. Need to work on migration plan. Need to determine plan for removal of 837 elements when in the 275. The 837 5010 TR3 does not include instructions on this, nor was it commented on in Public Comment. What will be the interim instructions when it exists in both?
9	55999 56024		Solicited vs. Unsolicited Attachments	There are several references to the method by which a provider would know that the payer expects an attachment to be sent with the 837 claim. We suggest the use of the phrase "prior arrangement" to show the collaborative approach between payers and providers.
10	55999		Solicited vs. Unsolicited Attachments	Center Column states: We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired ''questions'' and/or documentation needs relevant to that specific claim. Comment: Are there any situations where a duplicate 277 Request for Information is permissible? In the following scenario, a Health Plan sends a 277 Request for Additional Information. For some reason, the Provider did not route it to the correct area for completion, and later sends a 276 Request for Claim Status, asking about the claim. The Health Plan responds in the 277 Claim Status Response that additional information was requested. Can the Health Plan then send out a duplicate 277 Request for Additional Information?
11	55999	COB		Comment: If the payer receives an attachment, we recommend that they are not required to send it on to the subsequent payer.

12	56001		Provider vs. Plan Perspective	Center Column states in section II.D.9: It would be helpful if health care clearinghouses were among the first of all entity types to come into compliance with these standards so that testing between trading partners—health care providers and health plans—could be executed in a timely fashion. Comment: Clearinghouses are unable to fulfill the type of 'early testing' role that is indicated by the language here, since they, like providers and health plans, need their trading partners up-and-running before they can test. Claredi supports the idea of certification for the purpose described; so we suggest the important entities to be ready first are 3rd party testing and certification vendors. These vendors would enable providers, health plans and clearinghouses with an early test facility so that, as the NPRM language says, "testing between trading partners could be executed in a timely fashion." Entities are then able to schedule testing independently of other entities.
13	56001		Attachment Content and Structure	Right Hand column states: The implementation guide for the X12 275 response transaction permits up to 64 megabytes of data in a single transaction. Comment: This is an incorrect reference. Is should have stated: "The implementation guide for the X12 275 response transaction **recommends** up to 64 megabytes of data in a single **BIN segment**." We recommend that the recommendation of 64MB remain as is. It is sufficient for the attachment types listed in the NPRM.
14	56002		Alternatives Considered: Candidate Standards	Center column states: Thus, X12 and HL7 determined that it was more expedient and practical to create a new transaction standard designed for the specific purpose of requesting an attachment rather than trying to modify one designed as a response transaction. Comment: A new Implementation Guide was created for an existing standard. A new standard was not created.
15	56005	G. 2.		Section G. 2. should have listed the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be used in a 277 Request. Section G. 2. should have listed the "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide", since it describes the definitions of terms used in the AIS booklets and contains an explanation of LOINC and the Data types, which is needed helpful information in creating the X12 277 request. Also, G.2.a., c., and d. indicate "LOINC code tables" while G.2. b., e., and f. indicate "LOINC codes". All of these should have the same reference.
16	56005	G.3		Right - hand column states: The LOINC code set provides a set of subject modifier codes that are categorical; that is, an identifier code can apply to a group of related reports. For example, Clinical reports can be identified by the type of equipment used (for example, CAT

				scan report); the body part examined (report of x-ray of left wrist), the subdivision of the laboratory performing the analysis (microbiology), or a challenge to the system (cardiac stress test). Comment: These examples are not examples of the LOINC Modifiers identified for the 6 proposed attachments. The only LOINC Modifiers used in Claims Attachments are the TIME WINDOW MODIFIERS and the ITEM SELECTION MODIFIERS.
17	56006	G.3		In Left - hand Column: There are 3 HL7 AIS references that should have a numeric Zero rather than an Alpha O in the 14th position of the number of the AIS. CDAR1AIS0000RO21 should be CDAR1AIS0000R021 CDAR1AIS0001RO21 should be CDAR1AIS0001R021 CDAR1AIS0002RO21 should be CDAR1AIS0002R021
18	56013 56023			There are 4 references that state: Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD, 20852. Comment: According to our research on the 837 5010 TR3, the address should be changed to: Washington Publishing Company,301 W North Bend Way, Suite 107, North Bend WA 98045
19	56014			What is the process for maintenance of LOINC code sets? How will changes and additions be identified and distributed? Is there a set schedule of updates?
20	56014			Left hand column states: Use of such new codes is permitted by the AIS for laboratory results, clinical reports and medications in both the request and the response transactions. Comment: Use of new codes in the request transactions is not permitted in the Medicaton AIS. The generic questions that are asked are static: Current medications, Discharge medications, and Medication Administered. Only the answer in the response transaction can contain new medications as they are introduced.
21	56024	162.1915		Section 162.1915 should list the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be used in a 277 Request. Section 162.1915 should list the "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide", since it describes the definitions of terms used in the AIS booklets and contains an explanation of LOINC and the Data types, which is needed helpful information in creating the X12 277 request.
22	56024	162.1925		Right Hand Column, letter b) states: (b) The HL7 Additional Information Specification Implementation Guide Release 2.1 (incorporated by reference in §162.920) for implementing the HL7 Additional Information Specifications to convey attachment information within the Binary Data segment of the ASC X12N 275 (004050x151).

				Comment: The "HL7 Additional Information Specifications" was omitted from 162.1925 and should be listed. In this section, it should also include the version number, "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide". Comment: Section 162.1925 should list the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be reiterated back in a 275 Response.
23				Attachments need high bandwidth, need Internet. We believe that attempts to implement attachments over low-speed communications such as dial-up will not succeed. During the pilot multiple lines were tied up for hours. The most reasonable solution is to employ broadband access to the Internet. The Internet solution must be a secure, open standard for multi-trading partner environment, not a proprietary technology. We strongly support use of the Internet for all transaction types, including attachments.
24				Recommendation: We recommend use of the X12 standard acknowledgment transactions: 999 for syntax reporting; 824 for implementation guide rules and the HL7 reporting. We recommend removal of references to the X12 102 in the 275 implementation guide. Recommendation: We recommend moving to the 5010 versions of the X12 277 and 275 and therefore instructions on the acknowledgements and other improvements can be added to the 5010 TR3's.
25				The NPRM states that the provider has a choice of whether or not to send attachment data electronically. However, if the X12 837 is revised in the future to remove the attachment data found in both transactions, the provider will need to use the electronic attachment or lose the benefits of electronic filing. Since ASCA requires EDI for most providers filing to Medicare, this would force the providers to use the attachment to be able to send the data.
26				Need clarification: If a health plan does not have a current business model that send requests for additional information (electronic or hardcopy), is the health plan required to use the 277 if a provider requests it to be used. Example, the health plan uses the unsolicited business model.
27				Need clarification: Some health plans deny the claim if it does not contain information that is required by the health plan that was previously communicated by Bulletins and other means of communication. Can this continue? Or do they need to use 275?
28				Need clarification: If a provider chooses to do either unsolicited or solicited, are they required to do both?
29			HL7	Need to clarify MIME packaging instructions in the HL7 documentation. Images must be sent as a multipart MIME package in the BIN segment. The standard requires the first object of MIME to be

				HL7 encoded in XML, the images are considered a separate body. The XML encoded HL7 and the image are wrapped in one MIME package.
30			HL7	Better examples of 275 with MIME packages should be included in the AIS Booklets
31			HL7	HL7 Stylesheets for the BIN segment of the CDA need to be revised to remove incorrect references.
32			HL7	XML namespace used in the CDA may overlap with the XML namespace in the resultant file. Need to revise examples to avoid collision on elements that have the same name but are defined in different vocabularies. (X12 vs. HL7)
33			HL7	Need to correct the discrepancies in the HL7 Ambulance specification between the LOINC code descriptions in Section 2.3 and Section 3.
34			HL7	In the HL7 Ambulance specification the answer part for 15513-5 should be 18814-4.
35			HL7	Need to correct the discrepancies in the HL7 Emergency Department specification between the LOINC code descriptions in Section 2.3 and Section 3.
36			HL7	In the HL7 Emergency Department specifications the LOINC code of 18693-2 is missing the LOINC answer part. The answer part should be 18702-1.
37			HL7	Need to expand the instructions in the HL7 IG to describe the situations when to use the NASK, ASKU and OTH as valid response codes.
38			HL7	The HL7 Emergency Department Specifications is missing the code table for HL70161.
39			HL7	Need to correct the discrepancies in the HL7 Rehabilitation Services specification between the LOINC code descriptions in Section 2 and Section 3. Example: LOINC code 27678-2
40			HL7	In the HL7 Rehabilitation Services specifications for the Cardiac discipline, the cardinality for 27547-9 should be 1, 1.
41			HL7	In the Rehabilitation Services specifications for the Physical Therapy discipline, the answer part for 27542-0 should be changed to 27678-2.
42			HL7	In the Rehabilitation Services specifications for the Physical Therapy discipline, the answer part for 27548-7 should be changed to 27684-0.
43			HL7	In the HL7 Rehabilitation Services specifications for the Psychiatric discipline the cardinality for 18658-5 should be 1, 1.
44			HL7	In the Rehabilitation Services specifications for the Respiratory Therapy discipline, the answer part for 27717-8 should be changed from 27768-1 to 27717-8.
45			HL7	In the Rehabilitation Services specifications Section 5 includes the incorrect OID code for the ISO+ tables. The OID code should be 2.16.840.1.113883.5.141.
46			HL7	In the Rehabilitation Services specifications Section 5 includes the incorrect OID code for the NDC table. The OID code should be 2.16.840.1.113883.6.69.

47			HL7	In the Rehabilitation Services specifications, Page iv lists Tables 5.1 through 5.7. Pages 59 through 62 show Tables 5.1 through 5.12. Page iv needs to be updated to include Tables 5.8 through 5.12.
48			HL7	In the Clinical Reports specifications, Section 5 references the CPT-4 Table. However, some of the procedures are HCPCS. Need to an OID for HCPCS that is inclusive of CPT.
49			HL7	Need machine-readable sample X12/HL7 files. The current PDF documentation does not allow these examples to be used for internal testing.
50			HL7	In the Rehabilitation Services specifications page 11 states "27715-2 Respiratory Therapy Treatment plan, date attending MD referred patient for" This description is not complete. Change to: "27715-2 Respiratory Therapy treatment plan, date attending MD referred patient for treatment".
51			HL7	In the Rehabilitation Services specifications page 17 states "27505-5". This is a typo. Need to revise LOINC code 27505-5 to read 27505-7.
52			HL7	In the Rehabilitation Services specifications page 7 states "27539-6 Cardiac Rehabilitation Treatment plan, continuation status". Page 20 states "27539-2 Cardiac Rehabilitation Treatment plan, continuation status." The correct number is 27539-6. Need to revise LOINC code 27539-2 to read 27539-6.
53			HL7	In the Rehabilitation Services specifications page 9 states "27686-5 Physical Therapy Treatment plan initial assessment". Page 30 states "27685-5 Physical Therapy Treatment plan initial assessment (Narrative)" and the LOINC database states "27686-5 Physical Therapy Treatment Plan initial assessment. Need to revise Page 30 LOINC code 27685-5 to read 27686-5.
54			HL7	In the Rehabilitation Services specifications on page 35 the LOINC answer parts for 27713-7 are reversed. The narrative is in the correct position. Need to revise LOINC code 27739-2 to read 27738-4 and 27738-4 to read 27739-2.
55			HL7	In the Rehabilitation Services specifications on page 38 the LOINC answer parts for 27560-2 are reversed. The narrative is in the correct position. Need to revise LOINC code 27586-7 to read 27585-9 and 27585-9 to read 27586-7.
56			HL7	The HL7 specifications answer ISO+ code list does not include "LB" or "MI". Need to add ANS+ Data Type.
57			HL7	The HL7 specifications do not include any instructions for non-NPI provider number. Need to add non-NPI instructions and create a Legacy Provider Number OID.
58			HL7	The Clinical Reports AIS needs to be updated for the cardinalities of all of the questions parts.
59			HL7	The HL7 Laboratory Results Specification includes a response code table in Section 5 for the Abnormal Flags. This table is numbered HL70078. Two of the values on this table are < and >. Including these symbols within XML causes problems since all the XML tags begin

				and end with these symbols. Should use `< and >` instead of the < and > symbols. Need to update documentation.
60			HL7	The HL7 CDA required header elements include OID codes for identifiers. The OID code list does not include a code for a Patient Identification number. Need to create an OID for Patient ID.
61			HL7	Add examples and instructions for Usage of </is_known_to> and </is_known_by> for patient identifiers.
62			HL7	In "CDAR1AIS0000R021" Page 42, it states: "3.7.9 Numeric (NM) Data Type. When an Additional Information Specification specifies a numeric datum, it shall be represented in PCDATA in the <content> element formatted according to the decimal data type as described in section 3.2.3 of XML Schema Part 2: Datatypes (HL7, 02 May 2001)". This document is a W3C document, not an HL7 document. Correct the reference to point to W3C and include the URL: http://www.w3.org/TR/xmlschema-2/
63			HL7	All examples need to be updated. In particular, the ambulance example does not contain all of the data elements listed as required in the cardinality column.
64			HL7	Ambulance - DSMO 1005 stated – "There is no way for an ambulance crew to know that the patient was bed confined before OR after the transport. They can only know whether the patient was bed confined at the time of service". That is reason that code 12 was requested in the 837 claim to replace codes 02 and 03 at both the 2300 and 2400 loops. Code 12 was added - "Patient is confined to a bed or chair. Use code 12 to indicate the patient was bedridden during transport." This is based on a CMS Program Memorandum. Codes 2 and 3 were removed from the 837. Code 02 states - "Patient was bed confined before the ambulance service." Code 03 states - "Patient was bed confined after the ambulance service." Need to remove 2 LOINC's: 18591-8 EMS TRANSPORT, CONFINED TO BED BEFORE TRANSPORT 18592-6 EMS TRANSPORT, CONFINED TO BED AFTER TRANSPORT Need to create and add a LOINC for: "Patient is confined to a bed or chair.
65			HL7	Ambulance - 837 5010 TR3, Loop 2300 and 2400 CR103 Ambulance Transport Code. This data element with values: I Initial Trip, R Return Trip, T Transfer Trip, and X Round Trip is now marked "Not Used", based on industry input. Need to confirm this change and delete 15517-6 from the ambulance AIS.
66			HL7	Ambulance - The 837 5010 TR3 has added a segment: "QTY - AMBULANCE PATIENT COUNT - Required when more than one patient is transported in the same vehicle for Ambulance or non-emergency transportation services." Need to add a LOINC for this business purpose.
67			HL7	Rehabilitation – Page 61. Section 5.9, the OID is incorrect. Should be 2.16.841.1.113883.5.141.
68			HL7	Rehabilitation – Page 61. Section 5.10, the OID is incorrect. Should be 2.16.841.1.113883.6.69.

69			HL7	Name space errors in CDA R1 (eliminate the name space in R1). The Oct. 5 Email from HL7 explained the "Errata Identified in CDA R1 and the informative schema". Need to update all schemas, example files and style sheet, and examples in the guides.
70			HL7	Need to add references to ICD10 in all booklets.
71			HL7	Add instructions for usage of a persistent body part attribute to be used to identify a pointer to a document in subsequent BIN segments, instead of sending the same image multiple times.
72			X12	The HL7 specifications do not include an optional element to identify the attachment as a Computer Decision Variant. For the pilot, an optional CDV element indicator was added in the MIME header. For the long term solution, we concur with the X12 275 Workgroup's recommendation to revise the CAT segment, using CAT02 elements as follows: HL= CDV, TX= HDV (Marked up TXT- XML), and IA= Images.
73			X12	The 275 BIN segment does not include guidance for data communication. The X12 guides need to address communication issues. Since the BIN segment is a binary segment and data communication is usually in text mode, the BIN01 count may be incorrect which would cause a 275 failure. The text mode could add/remove invisible control characters at the end of each MIME encoded line. This could cause a change in the byte count in the BIN01 element.
74			X12	277 – 2100E NM107 - Compare the note "Required when the value in NM102 is 1 and the person has a suffix" with the note on page 67 for the subscriber "required when the value in NM102 known". Revise notes to match.
75			X12	277 – 1000D REF02 – Page 127 - Claim ID for Clearing House -The 277 should limit this data element to 20 positions. The 275 (page 63) states: The value carried in this element is limited to a max of 20 positions. The 837 also includes this limit. Need to revise 1000D REF02.
76			X12	277 – 2220E – Page 145 - Missing note, See page 100 for first note for this element. Need to add note.
77			X12	275- 2000A TRN02 - Page 67 - Beginning of 2 paragraphs: "When the value in BGN02 is 11", and "When the value in BGN02 is 02". Typo. Should state "BGN01", not "BGN02".
78			X12	Since the State of California now has a requirement to indicate why additional information is being asked, the 277 and 275 IG's need to allow for a third LOINC modifier.
79			X12	In the X12 275 - Page 70 – STC11 – The element note states: "This element is required when the 277 STC10 is used. This element is used to return the values found in the STC of the 277. If not required, do not send." It should state: "This element is required when the 277 STC11 is used. This element is used to return the values found in the STC of the 277. If not required, do not send."
80			X12	We recommend that receivers implement flexibility in BIN count errors.

Submitter : **Mr. Patrick Edwards** **Date: 11/17/2005**

Organization : **Arkansas Blue Cross and Blue Shield**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-28-Attach-1.DOC

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Attention: **CMS-0050-P**

Comments from Arkansas Blue Cross Blue Shield on 45 C.F.R. Part 162 (HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments)

Proposed Rule issued Federal Register / Vol. 70, No. 184 / Friday, September 23, 2005 p. 55990

Submitted via electronic mail: November 18, 2005

Arkansas Blue Cross Blue Shield (ABCBS) appreciates the opportunity to respond to the HHS Office of the Secretary request for comments regarding the HIPAA Electronic Health Care Claim Attachment proposed rule. ABCBS is a mutual insurance company serving over 900,000 individuals in Arkansas and across the nation. We agree that the adoption of electronic standards for health care claim attachments has the potential for streamlining processes, which may eventually lead to an overall reduction in operating costs in Arkansas provided adoption by covered entities reaches certain levels.

Section II.D.2 --- Solicited vs. Unsolicited Attachments (pg. 55999)

Proposed Rule: We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired "questions" and/or documentation needs relevant to that specific claim.

Issue: There are common situations within the health care industry where the provider's response to a request from a health plan for additional information leads to more questions. In other situations, a provider's response leads to a need for information from another provider. As stated in the proposed rule, it is also possible for a provider to invoke a HIPAA Privacy "minimum necessary" judgement that is in fact less information than the health plan requires.

ABCBS feels strongly that in practice, limiting requests to one transaction will force health plans to 1) routinely ask for the entire patient medical record to ensure enough information will be received to adjudicate the claim, or 2) deny the claim citing a need for additional information, or 3) request additional information through a manual process. All of these options would unnecessarily increase administrative workload when an efficient electronic mechanism would be in place to address the need for additional information.

Please note that all Blue Cross and Blue Shield licensees are business associates of one another. In coordination of benefits processing, it could appear to a provider that they have received multiple requests for claim information from the same health plan, but in fact, the subsequent request was from another Blue plan with slightly different claim information requirements. In this case, the subsequent request for additional information is actually being made by a business associate of the second plan.

ABCBS Recommendation: The final rule should require the initial request from a health plan be a complete request to the best of the plan's knowledge at the time of the request. If it should be discovered at a later time that additional information is required to correctly adjudicate the claim, additional requests for information and additional responses would be permitted electronically.

Section II.D.3 – Coordination of Benefits (pg. 55999)

Proposed Rule: Assumption that primary health plan will request only the attachments it needs to adjudicate its portion of the claim.

Issue: There could be significant issues relating to the HIPAA Privacy "minimum necessary" requirements if health plans were required to pass claim attachment information to plans paying in a secondary position. However, health plans should be permitted to exchange attachment information provided that HIPAA Privacy requirements are met.

ABCBS Recommendation: The final rule should state that health plans are not required to pass claim attachment information to other plans paying in a secondary or tertiary position. Health plans should be permitted to share claim attachment information provided that HIPAA Privacy requirements are met and a business relationship has been established.

Section II.D.4 – Impact of Privacy Rule (pg. 56000)

Proposed Rule: The covered health care provider always retains the discretion to make its own minimum necessary determination.

Issue: The original HIPAA Transaction and Code Set rule states that "minimum necessary" requirements do not apply to covered HIPAA transactions. This provision was established so that computer systems could be designed to transmit all of the "required" data and help ensure efficient processing on the receiver's system. A similar approach will be needed in the claim attachment rule if efficiencies are to be realized.

Perhaps there are instances today when a health plan requests excessive information by unnecessarily requesting entire medical records. The HIPAA Enforcement Rule complaint process should be utilized in those cases to resolve the suggested abuse. With the proposed requirement to use LOINC codes for claim attachment requests, there may be times when the amount of information requested comes into question. However, to achieve the desired efficiencies, providers will need to rely on the health plans to an additional degree for determining if the appropriate amount of information was requested.

Ease of implementation will be key to provider adoption of this rule. Providers should not be required to "black out" certain data items on claim attachments that were not specifically requested. As required today, the health plan receiving the request would be required under the HIPAA Privacy rule to protect all PHI in its possession.

ABCBS recommendation: The final rule should state that health plans are required to use the most specific LOINC codes available to request the "minimum necessary" amount of information needed for adjudication of a claim. As systems become increasingly capable of responding to electronic requests, providers should be encouraged to reply automatically to the request. If a provider perceives a pattern of abuse by a health plan that routinely requests too much information, they should follow the HIPAA Enforcement provisions to resolve the potential violation.

Section II.H – Covered Health Care Providers (pg. 56012)

Proposed Rule: If they [providers] choose to receive and send requests and responses electronically for any of the six proposed attachments.

Issue: The proposed rule could be interpreted to mean that a provider may choose to implement one or more of the 6 proposed claim attachments, but not all. If this is the case, health plans must not only keep up with whether a provider participates in the electronic claim process, but also for which claim attachments they are capable of responding. This will lead to additional administrative overhead and potential for errors.

ABCBS recommendation: The final rule should state that providers participating in the electronic claim attachment process must accept all requests for health care claim attachments electronically. Providers participating in the electronic claim attachment process should respond electronically to any of the claim attachment types named in the final rule.

Section II.H – Covered Health Care Providers (pg. 56012)

Proposed Rule: In either case, covered health care providers would continue to have the option of using electronic or manual means of conducting business, including responding to a request for attachment information electronically or on paper.

Issue: To realize the expected efficiencies of the health care claim attachment rule, the complete model designed by WEDI must be followed. Permitting a provider to elect electronic claim attachment requests but also permitting responses via paper will lead to numerous implementation issues. For instance, a health plan may show that an electronic request has been sent, but an electronic reply has never been received. Conversely, allowing a provider to respond to a manual request electronically may also result in the manual process not detecting that a response has been received.

Providers should not be permitted to partially participate in the electronic claim attachment process based on the media type for which the original health care claim submitted. Permitting this option would lead to additional administrative overhead and increase processing errors.

ABCBS Recommendation: For the named claim attachment types, covered health care providers participating in the electronic claim attachment process must accept requests electronically and respond electronically. This requirement should exist regardless of how the original claim was submitted, either on paper or electronically. For claim attachment types not named in the final rule, trading partners are permitted to define business rules for conducting those transactions.

Section VI.B.1 – General Assumptions, Limitations, and Scope (pg. 56017)

Proposed Rule: 50 percent of all claims attachments are likely to be represented by the six attachment types named here.

Issue: ABCBS feels that the six named claim attachment types will accommodate over 80 percent of the requests currently needed for our business rules. This is a good first step in the implementation process. Trading partners should be free to implement other attachment types once the core system changes have been installed and tested.

ABCBS Recommendation: Mandated adoption of new claim attachments and version changes should always go through the formal rule making process. Successful implementation of HIPAA transactions relies on the health care industry having an opportunity to comment on potential business issues and industry impacts which are not thoroughly addressed within the DSMO

process. The industry also needs clear compliance dates for these changes so that implementation is as smooth as possible during transition periods to new format versions.

162.1910 – Request Transaction (pg. 56024)

Proposed Rule: A health plan may make such a request (1) upon receipt of a health care claim (2) in advance of submission of a health care claim (3) through instructions for a specific type of health care claim which permit a health care provider to submit attachment information on an unsolicited basis each time such type of claim is submitted.

Issue: Permitting the submission of a claim attachment in advance of submission of a claim (#2) would be problematic for health plans since the claim attachment would be in reference to a claim that is unknown to the plan. This option seems to be contrary to the model defined by WEDI and was not included in the claim attachment pilot sponsored by CMS.

ABCBS agrees with the proposed rules regarding unsolicited claim attachments (#3) and strongly feels that unsolicited claim attachment submissions without clear instructions from the health plan will lead to unnecessary administrative overhead. In our organization, there is a very small number of business cases where additional information is "always" needed for a certain type of claim. Providers may have a sense for this requirement, but should wait for clarification from a health plan prior to submission of unsolicited claim attachments. Unsolicited claim attachments will most likely be a violation of the HIPAA Privacy rule "minimum necessary" provision. Health plans generally need an opportunity to perform basic claim edits prior to determining if additional information is required. For example, claims are edited to ensure that the patient has active coverage at the time of service before additional adjudication steps are performed.

ABCBS Recommendation: The final rule should state that health plans may make a request for claim attachment information (1) upon receipt of the health care claim (2) through instructions for a specific type of health care claim which permits a health care provider to submit attachment information on an unsolicited basis each time such type of claim is submitted.

162.1920 – Response Transaction (pg. 56024)

Proposed Rule: The proposed rule does not standardize acknowledge transactions.

Issue: Transactions pertaining directly to the payment of health care claims should include acknowledgment of receipt. Specifically, a health plan sending a request for claim attachments should be notified that the request was received to aid in researching issues where responses to those requests are not received. We believe the 102 acknowledgement listed in the HL7 AIS guides would not met the need of most systems currently exchanging X12 transactions.

ABCBS Recommendation: Providers participating in the claim attachment process should return a TA1 or 997 transaction, as appropriate, upon receipt of an ANSI 277 transaction. A health plan receiving an ANSI 275 transaction should return a TA1 or 997 transaction, as appropriate.

162.1925 – Response Implementation Standards (pg. 56024)

Proposed Rule: The following are permissible file types: .txt, .htm, .html, .jpg, .jpeg, .pdf, .png, .gif, .rft, .tif.

Issue: It is agreed that covered entities should be capable of exchanging these named image types. However, as technology advances, new image types are likely to be developed and may be superior in both clarity and size requirements than are the named types.

ABCBS Recommendation: The final rule should state that health plans should be required to accept, at a minimum, the image format types listed. Covered entities are permitted to exchange image types other than those listed if there is a mutual agreement to do so.

Section VI.B – Costs and Benefits

Affected Entities (pg. 56016) – Since health care providers have the option of continuing to submit paper attachment information…

ABCBS Response: This implementation model increases costs on health plans since they will need to maintain two independent processes – one for HIPAA-compliant providers and one for manual processing.

Affected Entities (pg. 56016) – Health plans will be able to automate the processing of attachment information.

ABCBS Response: This is highly unlikely since the entity sending the attachment (the provider) chooses whether to adopt the human-decision variant or the computer-decision variant. From a health plan perspective, the computer-decision variant is not cost justified without significant provider adoption of this variant and providers are unlikely to voluntarily accept this additional cost.

Cost and Benefit Analysis (pg. 56017) – The 1993 study by WEDI suggested that 25 percent of all health care claims required support by an attachment or additional documentation. […] If current attachment statistics exist, we hope the industry and/or its representatives will provide those data during the comment period.

ABCBS Response: Basing cost and benefit decisions on a study produced 10 years prior to the compliance date of the HIPAA Transaction and Code Set rule is likely to lead to a gross mis-expectation of the return-on-investment for the proposed rule. A 2005 study by our organization revealed that less than 2 percent of all health claims processed by our organization required additional information.

Cost and Benefit Analysis for Covered Health Care Providers (pg. 56018) – Covered health care providers may incur the following implementation costs: Programming systems to accommodate the new transaction types, messaging standards, and codes; Software and/or vendor fees; Practice management system vendor fees and charges; Health care clearinghouse fees.

ABCBS Response: Since the implementation date of the HIPAA Transaction and Code Set rule, observations within Arkansas have revealed that provider organizations do not typically "program" new functionality for their systems. Providers typically either purchase vendor system solutions or accept health care clearinghouse fees for translating formats. The number of direct connections with providers has been on a steady decline and providers are increasingly utilizing clearinghouse capabilities since 2002. Without significant vendor pressure to create electronic claim attachment solutions, providers will most likely continue the current manual process.

Benefits of Implementation (pg. 56020) – Next, we assume a fairly optimistic rate of adoption for the electronic health care claims attachment transactions, because, based on Medicare's experience, two years past the compliance date for the original set of transactions, 99 percent of the claims being submitted are in HIPAA compliant formats.

ABCBS Response: The assumed adoption rate will be off target by a wide margin for a few reasons. First, the vast majority of providers were already creating electronic claim transactions prior to HIPAA. The process after HIPAA generally relied on health care clearinghouses to

convert these into HIPAA-compliant formats; which tended to increase the overall cost to the health care industry as a whole. Clinical information needed for the proposed rule is not typically in electronic format today. Second, comparing the adoption of administrative transactions to the adoption of clinical transactions is not relevant. The six named attachment types will require information from systems that typically will not be currently associated with practice management systems. The integration of these disparate systems will be costly and therefore will not be voluntarily assumed by the provider community.

In summary, ABCBS certainly believes that electronic claim attachment transactions have a potential for return on investment. However, the rule, as proposed, will simply add to overall health care administrative overhead and drive up costs for all Americans. These additional costs either lead to increase in out-of-pocket expenses for the patient, or worse, cause employer groups to reduce employee benefits leaving the individual unprotected.

ABCBS Recommendation 1: The final rule should expand the definition of "business associate" to include software vendors of health care administrative and clinical systems. Software vendors that market systems that produce electronic health claim transactions should be capable of producing claims transactions as well as the other covered HIPAA transactions designed for providers in HIPAA compliant formats.

ABCBS Recommendation 2: The final rule should mandate adoption of the named electronic claim attachments by large providers. "Large" providers should be defined in the same manner as "large' health plans under HIPAA rules; which is annual revenue exceeding $5 million.

Submitter : **Ms. Sandra Savino** **Date: 11/17/2005**

Organization : **Memorial Sloan Kettering Cancer Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

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The following comments are submitted for your consideration by Memorial Sloan-Kettering Cancer Center (MSKCC). We offer our experiences and recommendations as participants in two pilots with Empire Medicare Services (EMS) in the pilot project to evaluate electronic attachments for the Centers for Medicare and Medicaid Services. We strongly encourage the reviewers consider in full, the findings available in the document Evaluation of the Electronic Claims Attachments Pilot which EMS will submit to CMS.

Thank you for the opportunity for MSKCC to present the comments which follow:

CMS-0050-P-29-Attach-1.DOC

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

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

References: 45 CFR Part 162
HIPAA Administration Simplification:
Standards for Electronic Health Care Claims Attachments; Proposed Rule
70 FR 184 9/23/05 pages – 55989-56025

The following comments are submitted for your consideration by Memorial Sloan-Kettering Cancer Center (MSKCC). We offer our experiences and recommendations as participants in two pilots with Empire Medicare Services (EMS) in the pilot project to evaluate electronic attachments for the Centers for Medicare and Medicaid Services. We strongly encourage the reviewers consider in full, the findings available in the document Evaluation of the Electronic Claims Attachments Pilot which EMS will submit to CMS.

Thank you for the opportunity for MSKCC to present the comments which follow:

Comment Number	**Page Number**	**Section**	**Comment**
1	55993-55994	2. DEFINITIONS	"2. Attachment Information means the supplemental **health information** needed to support a specific health care claim." MSKCC recommends the definition of Attachment Information be expanded to include any supplemental information required to support a claim. This should not be limited the **health information**. We often send itemized bills,

			explanation of insurance benefits, consent forms, etc. to support claims.
2	55994	EFFECTIVE DATES	Experience with the pilot indicated there will be a significant technical learning curve required to translate the 277 and return of the 275 in a production environment. The greater effort will be required on the return of the 275. For example, we learned, that because of text wrapping issues, the 275 should be created outside of a mainframe environment. While 24 months is reasonable for translation of the 277; we expect many providers may not be able to meet the requirements for producing a 275 within the timeframes required. Despite our experience with the pilot, we estimate we will need another two years to fully implement/automate this process.
3	55996	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	The section discussed that the scope of the pilot would include the provider sending both variants. It should be noted that during the pilot no participant was able to return the computer variant response. We have not demonstrated the CDA process. While we would encourage additional funds be made available for future studies on this process our organization would not be able to participate. As with many other providers whose clinical and business documentation is scanned – we unsure how to even approach the CDA at this point.

4	55996	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	As addressed in above, comment 1, MSKCC recommends expanding the attachment types to include information routinely submitted by the business office to have claims adjudicated. Most commonly, this information includes itemized bills, explanation of benefits from other health plans.
5	55997	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	With regards to the six attachment types specified, there is a call for additional definition and specificity. "Clinical Reports" can encompass progress notes or notes for specific services: radiology notes, pathology notes, etc.
6	55996	5. ELECTRONIC CLAIMS ATTACHMENT TYPES	One of the significant challenges we encountered in the pilot was that often the same document satisfied multiple LOINC codes. Following the current requirements, we submitted the same document multiple times. We strongly recommend the requirements be revised to address how this situation be handled. The ability to associate multiple LOINC codes to one 275 will allow for more conservative file size.
7	55999	7.COMBINED USE OF DIFFERENT STANDARDS	MSKCC supports the recommendation in the last paragraph of this session with regards to elicitation of relevant attachment types. While relevant, the six attachment types proposed in the current rule will not have an overwhelming impact/benefit on the receivables management cycle.

8	55999	2.SOLICITED vs. UNSOLICITED ATTACHMENTS	While MSKCC supports the ability to provide unsolicited attachments how the mechanism as proposed is unrealistic. It is unclear what the process will be for providers to obtain "specific advance instructions" from health plans. It has been our experience from implementation of other HIPAA transaction sets that it can be challenging to obtain generic, payer-specific implementation guides. It is even more challenging to arrange for specific Trading Partner agreements. When a provider's experience demonstrates a health plan regularly requires certain information, they should be allowed to append this data to the claim without advanced permission.
9	55999	2. SOLICITED vs. UNSOLICITED ATTACHMENTS	It should be noted that the pilot did not include testing of unsolicited attachments.
10	56000	4. SOLICITED vs. UNSOLICITED ATTACHMENTS	Providers who will only be able to submit scanned documents, the minimum necessary requirements will pose a challenge in our efforts to meet the standard. Our experience both in current operation and with the pilot is that required information is often not contained within the documents specifically requested today on paper or in a future 277. For example, we may receive requests for a certain document within the date range of when a service was RENDERED. We often find that the clinical order may be written in ADVANCE and be part of

			documentation outside the requested date range. As a comprehensive cancer facility it is difficult for the treatment plan of our patients to be supported by a limited presentation of the care documented in their health record. Often substantial, if not the full record is required for health plans to make accurate determinations. Submitting extensive portions of the health record may violate 'minimum necessary'. Failure to present this information impacts provider reimbursement. It necessitates additional administrative burdens associated with determination appeals we must initiate. The delay in adjudication also impacts patient service. On the converse the submission of extensive portions of the health record via the 275 create large files that impose issues related to data transmission and health plan file management.
11	56001	E.ATTACHMENT CONTENT AND STRUCTURE	With regards to file size, the 64 megabytes of data for a single transaction was acceptable for the text-based scanned images exchanged during the pilot. MSKCC strongly recommends that this limit be reassessed to include sizing for more complex images. Color, PET, MRI, etc. During the pilot an attempt was

			made to submit a color image – the health plan review found that quality of the image insufficient to render an appropriate review (processing converted the image to black and white and eliminated photographic detail).
12	56002	G.1.ALTERNATIVES CONSIDERED: CANDIDATE STANDARDS	MSKCC found the LOINC codes used in the pilot challenging for several reasons: 1) Lack of specificity: We received LOINC codes requesting information pertaining to diagnosis and a separate code pertaining to diagnosis and follow-up. We would send the same document to address both. Examples: 27660-0 PT Treatment Plan, New/Revised 27661-8 PT Treatment Plan, date onset or exacerbation of primary diagnosis PT Treatment Plan, Primary DX 27676-6 PT Treatment Plan, initial assessment PT Treatment Plan, progress note + attainment of goals 27686-5 PT Visit Note Our 'progress note' could potentially be used to answer all of the above. The description of the first LOINC, PT Treatment Plan, New/Revised, could encompass all documents for the patient as clinical staff document treatment throughout their care.

			These same documents have the potential to satisfy the other LOINC codes in whole or in part. 2) The more significant challenge is mapping LOINC codes to the codes "document types" we assign to our medical record documentation. Presently we have over 1,200 of these document types. Mapping of these to LOINC codes would be extremely challenging as the same document type could satisfy more than one LOINC. However, not in every situation would you necessarily have to include the document type to satisfy a LOINC. For example, in some instances an order may be included in a progress note. If we receive a 277 for the ORDER, without human intervention/review we are unsure if there is a separate order or if the order is contained within another document.
13	56005	3. ALTERNATIVES CONSIDERED: CANDIDATE STANDARDS	The patient control number and medical record must be included on the 277. This is the primary key many facilities use to identify patient.
14	56007	B.WHITE PAPER FROM HL7	The proposals set-forth in the document require extensive consideration. We question the availability of application tools to facilitate the conversions and transfers diagrammed. Our pilot

			experience demonstrated a large effort was required to create a tool – that we would not consider to be near production ready. It is unclear who we would approach the marrying of the images to our billing systems as the proposals suggest. This suggests to us that full implementation in the timeframes specified will be challenging from a both a human and financial resource perspective. Our concern would be our efforts/expense to develop a process that may not prove to be rewarding if the attachment types are not expanded and the requirements for unsolicited attachments relaxed. Additionally, these scenarios are based on those the workgroup prepared over 10 years ago. The industry (providers, health plans, and vendors) must reconvene to discuss solutions.
15	56013	MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS	MSKCC strongly agrees with the recommendation for industry to re-identify relevant attachment types from both the HDA and CDA perspective.
16	56017	1. COSTS AND BENEFITS	MSKCC strongly agrees that re-evaluation of the statistics regarding requirement for health claims attachments is needed. It may be difficult for providers to determine statistics as often request data for administrative and health documentation are stored on separate, unlinked systems. MSKCC proposes health plans may be able to

			extract this data more readily from their centralized claims adjudication systems.
17	56018	4. COSTS AND BENEFITS	MSKCC's evaluate of cost/benefit focused on the expected savings in time related to receipt of an automated request. The 277 will eliminate delays associated with handling and mailing. Focusing on the attachments specified in the pilot – we estimated an average savings in 10 days per request. This is significant and why MSKCC is a proponent of moving forward with the 277 and 277U. We strongly encourage CMS to give consideration to allowing the health care industry flexibility to implement the 277 request without the 275. However, once the request was received there was no improvement on the turn-around time for processing of the request. As discussed above –mapping LOINCS to our document types – determining what information really satisfied the request did not create any efficiencies or savings because of technical difficulties within the pilot.

Finally, we would strongly encourage additional pilot testing. Despite tremendous efforts by all participants only 13 files were accepted between all providers. Our attempts to send 22 files, resulted in only 1 acceptance. The samples size is vastly insufficient.

Submitter : Ms. Penny Sanchez **Date: 11/18/2005**

Organization : National Medicaid EDI HIPAA (NMEH) Workgroup

Category : State Government

Issue Areas/Comments

GENERAL

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The attached document contains the comments to the Claims Attachment NPRM from the National Medicaid EDI HIPAA (NMEH)workgroup. The NMEH is comprised of representatives from the 50 state Medicaid agencies and their fiscal intermediaries/agents. Approximately 35 states participated in the formulation of these comments. These are comments where a consensus was reached among the states. Individual states will also be submitting comments individually.

CMS-0050-P-30-Attach-1.DOC

NMEH Comments to: CMS-0050-P
NPRM Release: 9/23/2005
Comments Due: 11/22/2005

Commenting Organization: ___ National Medicaid EDI HIPAA Workgroup (NMEH)_
Date Comments Submitted: ___ November 17, 2005_

Contact Person Name: __ Penny Sanchez and Mary Kay McDaniel (NMEH Claims Attachment SWG Co-chairs)_
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#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
1	Federal Register	N/A	N/A	N/A	The National Medicaid EDI HIPAA (NMEH) workgroup would like to request that the 60 day public comment period for CMS-0050-P be extended from 60 days to 120 days adding an additional 60 days. This is to ensure that a thorough review of the numerous standards documents and the NPRM policy statements can be made for impact to our systems and processes. This rule will play a significant role in our claims adjudication process and ensuring that the data contents of the attachments adequately meets our needs will require a clinical review our of individual state policy requirements. In addition, the policy statements outlined in the NPRM need to be reviewed for comment and feedback. The NMEH would like to be able to provide substantiated feedback to some of the questions posed by the department in the NPRM. We believe that the additional time will allow us to make this thorough review and provide the type of feedback the department is looking for.	This has already been sent in by Robert Pozniak on behalf of the NMEH.

NMEH Comments to: CMS-0050-P
NPRM Release: 9/23/2005
Comments Due: 11/22/2005

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
2	Federal Register	N/A	N/A		The Final Rule should make it clear that Prior Authorization attachments are not included as part of this regulation, but could be done using a similar approach not governed by HIPAA.	
3	X12 275 (004050X151)	9	1.3.2		The NMEH recommends that the final rule adopt the 5010 versions of the X12 275 and 277 Implementation Guides for the following reasons: 1) 5010 is the most recent version being developed at X12, 2) **the 5010 275 supports the ability to send the 275 and 837 in separate interchanges for unsolicited attachments,** 3) the 5010 275 supports the ability to identify the type if information being sent in the BIN via the CAT02 segment (CDV, HDV-image, HDV-text or non-CDA image) 4) the 5010 takes advantage of changes made as a result of the EMS pilot, and 5) 277 5010 corrects numerous errors from the 4050 version. We support the movement to 5010 as long as it goes through the appropriate X12 public comment period giving all parties the opportunity for input into the final product.	Willing trading partners should be able to send the 275 separate from the 837 for unsolicited attachments.
4	Federal Register CDA R1 vs R2	55995	siiC2: col3		The NMEH supports the adoption of CDA Release 2 if it is in alignment with recommendations from Health Level Seven.	

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
5	Federal Register ELECTRONIC CLAIMS ATTACHMENT TYPES	55997	sii C5: col1		Please clarify in the final rule that providers and health plans can continue to do attachments not named in the regulation voluntarily using the proposed standards or by any other means.	Some people have interpreted this proposal to mean that only attachments named in this rule will be accepted.
6	Federal Register OVERVIEW OF KEY INFORMATION	55997	sii C5: col 1		If a revision to one of the six proposed attachment standards is balloted and approved by HL7, can the revision be used by willing trading partners prior to adoption of the applicable final rule?	The use of additional clinical information contained in an attachment revision would improve efficiency in claims processing.
7	Federal Register FORMAT OPTIONS	55997	sii C6: col 3		The NMEH supports the concept of both the HDV and CDV allowing that each entity has the option to choose which varaint they will implement for each attachment type.	
8	Federal Register COMBINED USE OF DIFFERENT STANDARDS	55998	sii c7: col1		Combining two different standards into one transaction and how it can be done depends in part on how or whether vendors choose to develop software that will allow it. Our ability to meet this requirement relies on vendors supporting these standards.	There is at least one vendor who has indicated they will not be supporting the combined use of the transaction. For the organization to continue, a new vendor must be found - or another solution found outside the current data flow for the organization. Either way, disruptive and requires resolution.

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
9	Federal Register BUSINESS USE	55998	siiD: col3		Regulation should not disallow health plans from collecting information via the claims attachment process for purposes other than claims adjudication, such as post payment review, fraud and abuse mitigation, quality control and reporting.	
10	Federal Register	59999	sii D1: Col 1		It is recommended that the regulation text include instruction on how the industry should implement standard attachments that have data content that overlaps elements within the claims transactions. The final rule should also provide information about a migration or roll-out plan for handling these data overlaps and the entity(ies) who should define this migration plan.	
11	Federal Register SOLICITED VS UNSOLICITED	55999	sii D2: col2		If a claim is denied because the additional information sent (solicited or unsolicited) was not adequate to justify payment of the claim, can the health plan request more information? We recommend that a health plan be able to request additional information after the initial set of attachment data is received if more data is needed to adjudicate the claim.	We understand the purpose of only allowing a single iteration for the request and response would stop providers and health plans from piecemealing the attachment information; however, if the data sent with the original reponse is not adequate to adjudicate the claim or prompts additional questions, this should not prohibit the health plan from asking for more information.

NMEH Comments to: CMS-0050-P
NPRM Release: 9/23/2005
Comments Due: 11/22/2005

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12	Federal Register SOLICITED VS UNSOLICITED ATTACHMENTS	55999	sii D2: col1		The NMEH supports the need for both the unsolicited and solicited models. Both models should be allowed.	
13	Federal Register COB	55999	sii D3: col3		The NMEH recommends that the primary payer should not be allowed to send attachment information on to the secondary payer when the payer to payer COB model is used.	The needs of the secondary payer may be different then that of the primary payer.
14	Federal Register SOLICITED VS UNSOLICITED	55999	sii D2: col2		Please clarify: If a health plan customarily denies a claim for lack of the supporting additional information, does this constitute the business practice of requesting additional information?	
15	Federal Register PRIVACY/MINIMUM NECESSARY	56000	sii D4: col 1		There is a statement in the preamble that says "the covered health care provider always retains the discretion to make its own minimum necessary determination." If a health plan requests additional information to support the adjudication of a health care claim and the provider deems that it does not meet their definition of minimum necessary, what resources does the health plan have to obtain the additional information necessary to adjudicate the claim? The final rule should make it clear that a health plan can still adjudicate the claim as appropriate per their policy based on the information received.	

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
16	Federal Register BUSINESS USE	56000	sii D4: col1		Can a health care payer request that the provider submit any named attachment supporting the provision of, and payment for, another medical service? Can the payer request multiple attachments? If so, please clarify this in the final rule.	For example, the physical therapy and occupational therapy rehabilitation attachments could be necessary for processing a power wheelchair claim and the laboratory results attachment might be needed for an enteral nutrition claim.
17	Federal Register SIGNATURES	56000	sii D6: col 3		There are currently attachments in development at HL7 that require signatures; therefore, an appropriate way to capture these signatures must be accommodated within the standard. In addition, the NMEH requests clarification from CMS wether allowance of on image of the "wet" signature within an electronic claims attachment would satisfy the federal regulatory requirement requiring that Medicaid agencies obtain certain signatures for consent forms. Currently Medicaid's must require these attachments via paper in order to obtain the federally mandated signature.	Other Federal Requirements require that we must receive

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
18	Federal Register PROVIDER VS PLAN PERSPECTIVE	56001	sii D8: col1		Request clarification on the following: The preamble states: "a health care provider may direct a health plan to send any request for additional documentation in standard form and the health plan must do so." If the health plan does not currently request additional information but instead requires that the additional information needed to adjudicate the claim be submitted at the same time as the submitted claim (unsolicited), does this rule require that a health plan implement a process to request additional information if the provider asks them to.	If yes, this would require that a health plan enter into a business process they have never performed before.
19	Federal Register ATTACHMENT CONTENT AND STRUCTURE	56001	sii E: col3, par3		File size. The existing file size should be fine in most cases, but there must be a way to either send a larger file for exceptions or link multiple attachments together if the need for more than 64 megabytes of data is required. AND there needs to be a way within the transaction to alert the receiver when a file larger than 64 megabytes is being sent [prior to the transmission of the file].	There must be a way to send more than 64 megabytes if necessary. What do you do if you find that the transaction is larger than 64 megabytes? Must have a way to handle from the beginning rather than try to figure out when you are there.
20	Federal Register PROPOSED STANDARDS	56004	sii G1: col2		We need a clear understanding of the maintenance and update schedule of the LOINC code set.	

NMEH Comments to: CMS-0050-P
NPRM Release: 9/23/2005
Comments Due: 11/22/2005

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
21	Federal Register PROPOSED STANDARDS	56006	sii G3: col2		The NMEH encourages the completion and adoption of the following attachment types as quickly as possible: Children's Preventive Health Services, Durable Medical Equipment, Consent Forms (Abortion, Hysterectomy and Sterilization) and Non-Ambulance Transportation. The NMEH also recommends that the Patient Information Unspecified Content be named for optional use.	
22	Federal Register PROPOSED STANDARDS	56006	sii G3: col2		There needs to ba a way to easily identify and extract attachment concepts for each attachment type from the LOINC database for easy integration into adjudication systems.	
23	Federal Register MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS	56014	siii B: col1		There needs to be a streamlined process to adopt new attachment types as they are developed by HL7. For new Additional Information Specifications (AIS), we recommend that the DSMO be authorized to adopt approved published HL7 AIS documents through the DSMO process without going through full federal regulatory process. This would need to include appropriate provisions for full industry input to the outreach process at HL7 during the development phase of the attachment and public input into the comment period during the HL7 ballot process. Appropriate notification and roll-out time between adoption and the required implementation date is also required.	

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
24	Federal Register MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS	56014	siii B: col1		There needs to be a streamlined process to adopt revised versions of existing attachment standards that are developed by HL7 and X12. We recommend that the DSMO be authorized to adopt revised versions of approved published HL7 and X12 standards for attachments through the DSMO process without going through full federal regulatory process. This would include provisions for industry outreach during the development of the proposed standard and appropriate public comment period during the HL7 and X12 ballot/approval process. Appropriate notification and roll-out time between adoption and the required implementation date is also required.	
25	Federal Register COSTS AND BENEFITS	56018	svi B3: col1 & col3		At this time, the states have not had the resources and time to conduct cost benefit analysis to quantify projected savings with the conversion to electronic claims attachments under this model. In addition, most states have not done a thorough enough assessment to determine implementation impacts/costs for both technical and operational.	

#	Document Number and ISSUE IDENTIFIER	Page #	Par/Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
26	Federal Register REG TEXT - DEFINITIONS	56023	162.1900		The final rule should clarify the differences between the form-based and the non-form based AIS. The Clinical Reports AIS only references a subset of the available LOINCs for Clinical Reports. The entire list of available LOINCS for Clinical Reports is obtained from the LOINC database. In addition, the LOINCS available for the Laboratory Results AIS can be found on the LOINC database. For all other AIS documents, the LOINC values in the document are the only ones available for use. These are the form-based documents. This should be fully explained in the final rule.	
27	Federal Register REG TEXT	56024	162.1915 and 1925		The NMEH supports the proposed combined solution using the X12 and HL7 standards for electronic claims attachments. In addition, the NMEH supports the use of LOINC to identify the questions and answers on the attachment.	
28	Federal Register REG TEXT	56024	162.1905		In general, we would like to see a clarification in the final rule stating that covered entities must only support these standard transactions for electronic claims attachments if they currently conduct the business function using claims attachments.	

Submitter :

Date: 11/18/2005

Organization : **Claredi Corporation**

Category : **Private Industry**

Issue Areas/Comments

GENERAL

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See Attachment. Please replace the attachment sent 11-17-05 titled "Claredi Draft Comments 111705" with this document "Claredi Comments 11 17 05".

CMS-0050-P-31-Attach-1.DOC

Claredi Corporation Comments to CMS on the
Proposed Standards of September 23, 2005, for
Electronic Health Care Claims Attachments
CMS–0050–P NPRM (45 CFR Part 162)

November 17, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Claredi Corporation is pleased to offer comments and recommendations on the Centers for Medicare and Medicaid Notice of Proposed Rule Making (NPRM) of September 23, 2005, that proposes standards for electronically requesting and supplying additional health care information in the form of an electronic attachment to support submitted health care claims data.

Regards,
Kepa Zubeldia, M.D.
President and Chief Technology Officer
Claredi Corporation

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	Page	NPRM Section	Category	Comment
1	56023 56024 56024 56025	162.1002 (LOINC) 162.1915 162.1925		We agree that the proposed X12 and HL7 standards, and the LOINC Code Set (to identify the questions and answers) named in the NPRM should be adopted in the final rule. We agree that the proposed 6 attachment types named in the NPRM should be adopted in the final rule.
2	55993			Center Column states: "The 4050 versions of the X12 Implementation Guides are compatible with the current X12 4010 guides adopted for HIPAA transactions – version 4010-1a so that the two transactions can be used together as necessary. In other words, a claims transaction (837 version 4010-1a)..." Comment: The current version of the X12 837 guides are noted as "4010A1".
3	55994		Effective Dates	We recommend that the Final Rule contain an effective date 18 months after the date the Final Rule is published, followed by the usual 26 month implementation window, to allow adequate time for the industry stakeholders to implement.
4	55995			Center column states: "In fact, each HL7 AIS for the electronic claims attachment standards will include a fully functional XSL stylesheet for use by covered entities."

				Comment: Please note that there is only one style sheet needed, which will work for all of the 6 attachments and it will be available from HL7.
5	55995			Right-hand column states: "We invite comment on the pros and cons of each CDA release, the issues related to the use of a style-sheet to permit use of either CDA release..." Comment: CDA Release 1 (R1) and Release 2 (R2) are sufficiently different that a single XSLT style-sheet for both is probably not realistic. In addition, because the images are external to the CDA R1 but are internal XML in CDA R2, the processing of the CDA would be different enough between R1 and R2 to require separate implementations. It is not a simple matter of upwards migration, such as when the HIPAA X12 standards were migrated with the Addenda; rather they are a completely different implementation. 1. Before CMS considers making a decision on whether to adopt CDA R1 or CDA R2, it is necessary that the industry conducts at least a proof of concept pilot implementation with several trading partners to determine the feasibility of implementing R2 for the six proposed standard attachments. Without a proof-of-concept pilot with positive outcome, CMS should not consider for adoption the CDA R2 as a standard. 2. Over the last few years, all the Attachment work has been done under CDA R1. The adoption of CDA R2 could have some advantages over R1, but it would require new Implementation Guides for all the standard attachments, possibly delaying the adoption process by two or more years. Most importantly, uncertainty about which standard would cause all progress on Attachments to cease until this uncertainty is resolved. 3. CMS should adopt CDA R1 immediately and indicate it may consider CDA R2 for new attachments and future versions of the initial six attachments. 4. Any proof of concept pilot and development of new Implementation Guides under CDA R2 must be conducted using the HL7 and X12 standards setting processes so that the entire industry can participate in these developments. Only after the standard setting bodies recommend CDA R2 should CMS consider its adoption. CMS should not consider adoption of a standard that has not been recommended by the SDO when the standard recommended by the SDO, CDA R1, is available for use. 5. CMS should give a unambiguous, immediate indication of its adoption of the CDA R1 Implementation Guides as currently published so that the industry can get on with the work of implementing the attachments without uncertainty over which version will be adopted.

6	55997		Electronic Claims Attachment Types	Left hand Column states: The effect of adopting a limited number of attachments standards at first is to permit covered entities time to gain experience with new standards and to evaluate the technical and business impacts of such transactions. Comment: We recommend that a national roll-out plan is created by the WEDI SNIP Claims Attachments Sub-Workgroup and that the Regulation supports this plan.
7	55997-55998		Format Options	NPRM II.C.6. We concur that both the Human Decision Variant (HDV) and Computer Decision Variant (CDV) be named in the Final Rule. We concur that payers be required to accept both Human Decision Variant (HDV) and Computer Decision Variant (CDV).
8	55999			Left-Hand column states: "1. Electronic Health Care Claims Attachment vs. Health Care Claims Data. Electronic health care claims attachments must not be used to convey information that is already required on every claim." Comment: There is some matching data that is repeated in the 275. Comment: Need to revive the 837, 275, TR3 Joint Workgroup from years ago that laid out the foundation of the steps to be followed when data, such as ambulance and rehabilitation, is housed in an attachment. Need to work on migration plan. Need to determine plan for removal of 837 elements when in the 275. The 837 5010 TR3 does not include instructions on this, nor was it commented on in Public Comment. What will be the interim instructions when it exists in both?
9	55999 56024		Solicited vs. Unsolicited Attachments	There are several references to the method by which a provider would know that the payer expects an attachment to be sent with the 837 claim. We suggest the use of the phrase "prior arrangement" to show the collaborative approach between payers and providers.
10	55999		Solicited vs. Unsolicited Attachments	Center Column states: We also propose that for each specific claim, health plans may solicit only one electronic attachment request transaction which would have to include all of their required or desired ''questions'' and/or documentation needs relevant to that specific claim. Comment: Are there any situations where a duplicate 277 Request for Information is permissible? In the following scenario, a Health Plan sends a 277 Request for Additional Information. For some reason, the Provider did not route it to the correct area for completion, and later sends a 276 Request for Claim Status, asking about the claim. The Health Plan responds in the 277 Claim Status Response that additional information was requested. Can the Health Plan then send out a duplicate 277 Request for Additional Information?
11	55999	COB		Comment: If the payer receives an attachment, we recommend that they are not required to send it on to the subsequent payer.

12	56001		Provider vs. Plan Perspective	Center Column states in section II.D.9: It would be helpful if health care clearinghouses were among the first of all entity types to come into compliance with these standards so that testing between trading partners—health care providers and health plans—could be executed in a timely fashion. Comment: Clearinghouses are unable to fulfill the type of 'early testing' role that is indicated by the language here, since they, like providers and health plans, need their trading partners up-and-running before they can test. Claredi supports the idea of certification for the purpose described; so we suggest the important entities to be ready first are 3rd party testing and certification vendors. These vendors would enable providers, health plans and clearinghouses with an early test facility so that, as the NPRM language says, "testing between trading partners could be executed in a timely fashion." Entities are then able to schedule testing independently of other entities.
13	56001		Attachment Content and Structure	Right Hand column states: The implementation guide for the X12 275 response transaction permits up to 64 megabytes of data in a single transaction. Comment: This is an incorrect reference. Is should have stated: "The implementation guide for the X12 275 response transaction **recommends** up to 64 megabytes of data in a single **BIN segment**." We recommend that the recommendation of 64MB remain as is. It is sufficient for the attachment types listed in the NPRM.
14	56002		Alternatives Considered: Candidate Standards	Center column states: Thus, X12 and HL7 determined that it was more expedient and practical to create a new transaction standard designed for the specific purpose of requesting an attachment rather than trying to modify one designed as a response transaction. Comment: A new Implementation Guide was created for an existing standard. A new standard was not created.
15	56005	G. 2.		Section G. 2. should have listed the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be used in a 277 Request. Section G. 2. should have listed the "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide", since it describes the definitions of terms used in the AIS booklets and contains an explanation of LOINC and the Data types, which is needed helpful information in creating the X12 277 request. Also, G.2.a., c., and d. indicate "LOINC code tables" while G.2. b., e., and f. indicate "LOINC codes". All of these should have the same reference.
16	56005	G.3		Right - hand column states: The LOINC code set provides a set of subject modifier codes that are categorical; that is, an identifier code can apply to a group of related reports. For example, Clinical reports can be identified by the type of equipment used (for example, CAT

				scan report); the body part examined (report of x-ray of left wrist), the subdivision of the laboratory performing the analysis (microbiology), or a challenge to the system (cardiac stress test). Comment: These examples are not examples of the LOINC Modifiers identified for the 6 proposed attachments. The only LOINC Modifiers used in Claims Attachments are the TIME WINDOW MODIFIERS and the ITEM SELECTION MODIFIERS.
17	56006	G.3		In Left - hand Column: There are 3 HL7 AIS references that should have a numeric Zero rather than an Alpha O in the 14th position of the number of the AIS. CDAR1AIS0000RO21 should be CDAR1AIS0000R021 CDAR1AIS0001RO21 should be CDAR1AIS0001R021 CDAR1AIS0002RO21 should be CDAR1AIS0002R021
18	56013 56023			There are 4 references that state: Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD, 20852. Comment: According to our research on the 837 5010 TR3, the address should be changed to: Washington Publishing Company,301 W North Bend Way, Suite 107, North Bend WA 98045
19	56014			What is the process for maintenance of LOINC code sets? How will changes and additions be identified and distributed? Is there a set schedule of updates?
20	56014			Left hand column states: Use of such new codes is permitted by the AIS for laboratory results, clinical reports and medications in both the request and the response transactions. Comment: Use of new codes in the request transactions is not permitted in the Medicaton AIS. The generic questions that are asked are static: Current medications, Discharge medications, and Medication Administered. Only the answer in the response transaction can contain new medications as they are introduced.
21	56024	162.1915		Section 162.1915 should list the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be used in a 277 Request. Section 162.1915 should list the "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide", since it describes the definitions of terms used in the AIS booklets and contains an explanation of LOINC and the Data types, which is needed helpful information in creating the X12 277 request.
22	56024	162.1925		Right Hand Column, letter b) states: (b) The HL7 Additional Information Specification Implementation Guide Release 2.1 (incorporated by reference in §162.920) for implementing the HL7 Additional Information Specifications to convey attachment information within the Binary Data segment of the ASC X12N 275 (004050x151).

				Comment: The "HL7 Additional Information Specifications" was omitted from 162.1925 and should be listed. In this section, it should also include the version number, "CDAR1AIS0000R021 HL7 Additional Information Specification Implementation Guide". Comment: Section 162.1925 should list the "LOINC Modifier Codes", since this is where the Time Window Modifiers and Item Selection Modifiers are stated that will be reiterated back in a 275 Response.
23				Attachments need high bandwidth, need Internet. We believe that attempts to implement attachments over low-speed communications such as dial-up will not succeed. During the pilot multiple lines were tied up for hours. The most reasonable solution is to employ broadband access to the Internet. The Internet solution must be a secure, open standard for multi-trading partner environment, not a proprietary technology. We strongly support use of the Internet for all transaction types, including attachments.
24				Recommendation: We recommend use of the X12 standard acknowledgment transactions: 999 for syntax reporting; 824 for implementation guide rules and the HL7 reporting. We recommend removal of references to the X12 102 in the 275 implementation guide. Recommendation: We recommend moving to the 5010 versions of the X12 277 and 275 and therefore instructions on the acknowledgements and other improvements can be added to the 5010 TR3's.
25				The NPRM states that the provider has a choice of whether or not to send attachment data electronically. However, if the X12 837 is revised in the future to remove the attachment data found in both transactions, the provider will need to use the electronic attachment or lose the benefits of electronic filing. Since ASCA requires EDI for most providers filing to Medicare, this would force the providers to use the attachment to be able to send the data.
26				Need clarification: If a health plan does not have a current business model that send requests for additional information (electronic or hardcopy), is the health plan required to use the 277 if a provider requests it to be used. Example, the health plan uses the unsolicited business model.
27				Need clarification: Some health plans deny the claim if it does not contain information that is required by the health plan that was previously communicated by Bulletins and other means of communication. Can this continue? Or do they need to use 275?
28				Need clarification: If a provider chooses to do either unsolicited or solicited, are they required to do both?
29			HL7	Need to clarify MIME packaging instructions in the HL7 documentation. Images must be sent as a multipart MIME package in the BIN segment. The standard requires the first object of MIME to be

				HL7 encoded in XML, the images are considered a separate body. The XML encoded HL7 and the image are wrapped in one MIME package.
30			HL7	Better examples of 275 with MIME packages should be included in the AIS Booklets
31			HL7	HL7 Stylesheets for the BIN segment of the CDA need to be revised to remove incorrect references.
32			HL7	XML namespace used in the CDA may overlap with the XML namespace in the resultant file. Need to revise examples to avoid collision on elements that have the same name but are defined in different vocabularies. (X12 vs. HL7)
33			HL7	Need to correct the discrepancies in the HL7 Ambulance specification between the LOINC code descriptions in Section 2.3 and Section 3.
34			HL7	In the HL7 Ambulance specification the answer part for 15513-5 should be 18814-4.
35			HL7	Need to correct the discrepancies in the HL7 Emergency Department specification between the LOINC code descriptions in Section 2.3 and Section 3.
36			HL7	In the HL7 Emergency Department specifications the LOINC code of 18693-2 is missing the LOINC answer part. The answer part should be 18702-1.
37			HL7	Need to expand the instructions in the HL7 IG to describe the situations when to use the NASK, ASKU and OTH as valid response codes.
38			HL7	The HL7 Emergency Department Specifications is missing the code table for HL70161.
39			HL7	Need to correct the discrepancies in the HL7 Rehabilitation Services specification between the LOINC code descriptions in Section 2 and Section 3. Example: LOINC code 27678-2
40			HL7	In the HL7 Rehabilitation Services specifications for the Cardiac discipline, the cardinality for 27547-9 should be 1, 1.
41			HL7	In the Rehabilitation Services specifications for the Physical Therapy discipline, the answer part for 27542-0 should be changed to 27678-2.
42			HL7	In the Rehabilitation Services specifications for the Physical Therapy discipline, the answer part for 27548-7 should be changed to 27684-0.
43			HL7	In the HL7 Rehabilitation Services specifications for the Psychiatric discipline the cardinality for 18658-5 should be 1, 1.
44			HL7	In the Rehabilitation Services specifications for the Respiratory Therapy discipline, the answer part for 27717-8 should be changed from 27768-1 to 27717-8.
45			HL7	In the Rehabilitation Services specifications Section 5 includes the incorrect OID code for the ISO+ tables. The OID code should be 2.16.840.1.113883.5.141.
46			HL7	In the Rehabilitation Services specifications Section 5 includes the incorrect OID code for the NDC table. The OID code should be 2.16.840.1.113883.6.69.

47			HL7	In the Rehabilitation Services specifications, Page iv lists Tables 5.1 through 5.7. Pages 59 through 62 show Tables 5.1 through 5.12. Page iv needs to be updated to include Tables 5.8 through 5.12.
48			HL7	In the Clinical Reports specifications, Section 5 references the CPT-4 Table. However, some of the procedures are HCPCS. Need to an OID for HCPCS that is inclusive of CPT.
49			HL7	Need machine-readable sample X12/HL7 files. The current PDF documentation does not allow these examples to be used for internal testing.
50			HL7	In the Rehabilitation Services specifications page 11 states "27715-2 Respiratory Therapy Treatment plan, date attending MD referred patient for" This description is not complete. Change to: "27715-2 Respiratory Therapy treatment plan, date attending MD referred patient for treatment".
51			HL7	In the Rehabilitation Services specifications page 17 states "27505-5". This is a typo. Need to revise LOINC code 27505-5 to read 27505-7.
52			HL7	In the Rehabilitation Services specifications page 7 states "27539-6 Cardiac Rehabilitation Treatment plan, continuation status". Page 20 states "27539-2 Cardiac Rehabilitation Treatment plan, continuation status." The correct number is 27539-6. Need to revise LOINC code 27539-2 to read 27539-6.
53			HL7	In the Rehabilitation Services specifications page 9 states "27686-5 Physical Therapy Treatment plan initial assessment". Page 30 states "27685-5 Physical Therapy Treatment plan initial assessment (Narrative)" and the LOINC database states "27686-5 Physical Therapy Treatment Plan initial assessment. Need to revise Page 30 LOINC code 27685-5 to read 27686-5.
54			HL7	In the Rehabilitation Services specifications on page 35 the LOINC answer parts for 27713-7 are reversed. The narrative is in the correct position. Need to revise LOINC code 27739-2 to read 27738-4 and 27738-4 to read 27739-2.
55			HL7	In the Rehabilitation Services specifications on page 38 the LOINC answer parts for 27560-2 are reversed. The narrative is in the correct position. Need to revise LOINC code 27586-7 to read 27585-9 and 27585-9 to read 27586-7.
56			HL7	The HL7 specifications answer ISO+ code list does not include "LB" or "MI". Need to add ANS+ Data Type.
57			HL7	The HL7 specifications do not include any instructions for non-NPI provider number. Need to add non-NPI instructions and create a Legacy Provider Number OID.
58			HL7	The Clinical Reports AIS needs to be updated for the cardinalities of all of the questions parts.
59			HL7	The HL7 Laboratory Results Specification includes a response code table in Section 5 for the Abnormal Flags. This table is numbered HL70078. Two of the values on this table are < and >. Including these symbols within XML causes problems since all the XML tags begin

				and end with these symbols. Should use `< and >` instead of the < and > symbols. Need to update documentation.
60			HL7	The HL7 CDA required header elements include OID codes for identifiers. The OID code list does not include a code for a Patient Identification number. Need to create an OID for Patient ID.
61			HL7	Add examples and instructions for Usage of </is_known_to> and </is_known_by> for patient identifiers.
62			HL7	In "CDAR1AIS0000R021" Page 42, it states: "3.7.9 Numeric (NM) Data Type. When an Additional Information Specification specifies a numeric datum, it shall be represented in PCDATA in the <content> element formatted according to the decimal data type as described in section 3.2.3 of XML Schema Part 2: Datatypes (HL7, 02 May 2001)". This document is a W3C document, not an HL7 document. Correct the reference to point to W3C and include the URL: http://www.w3.org/TR/xmlschema-2/
63			HL7	All examples need to be updated. In particular, the ambulance example does not contain all of the data elements listed as required in the cardinality column.
64			HL7	Ambulance - DSMO 1005 stated – "There is no way for an ambulance crew to know that the patient was bed confined before OR after the transport. They can only know whether the patient was bed confined at the time of service". That is reason that code 12 was requested in the 837 claim to replace codes 02 and 03 at both the 2300 and 2400 loops. Code 12 was added - "Patient is confined to a bed or chair. Use code 12 to indicate the patient was bedridden during transport." This is based on a CMS Program Memorandum. Codes 2 and 3 were removed from the 837. Code 02 states - "Patient was bed confined before the ambulance service." Code 03 states - "Patient was bed confined after the ambulance service." Need to remove 2 LOINC's: 18591-8 EMS TRANSPORT, CONFINED TO BED BEFORE TRANSPORT 18592-6 EMS TRANSPORT, CONFINED TO BED AFTER TRANSPORT Need to create and add a LOINC for: "Patient is confined to a bed or chair.
65			HL7	Ambulance - 837 5010 TR3, Loop 2300 and 2400 CR103 Ambulance Transport Code. This data element with values: I Initial Trip, R Return Trip, T Transfer Trip, and X Round Trip is now marked "Not Used", based on industry input. Need to confirm this change and delete 15517-6 from the ambulance AIS.
66			HL7	Ambulance - The 837 5010 TR3 has added a segment: "QTY - AMBULANCE PATIENT COUNT - Required when more than one patient is transported in the same vehicle for Ambulance or non-emergency transportation services." Need to add a LOINC for this business purpose.
67			HL7	Rehabilitation – Page 61. Section 5.9, the OID is incorrect. Should be 2.16.841.1.113883.5.141.
68			HL7	Rehabilitation – Page 61. Section 5.10, the OID is incorrect. Should be 2.16.841.1.113883.6.69.

69			HL7	Name space errors in CDA R1 (eliminate the name space in R1). The Oct. 5 Email from HL7 explained the "Errata Identified in CDA R1 and the informative schema". Need to update all schemas, example files and style sheet, and examples in the guides.
70			HL7	Need to add references to ICD10 in all booklets.
71			HL7	Add instructions for usage of a persistent body part attribute to be used to identify a pointer to a document in subsequent BIN segments, instead of sending the same image multiple times.
72			X12	The HL7 specifications do not include an optional element to identify the attachment as a Computer Decision Variant. For the pilot, an optional CDV element indicator was added in the MIME header. For the long term solution, we concur with the X12 275 Workgroup's recommendation to revise the CAT segment, using CAT02 elements as follows: HL= CDV, TX= HDV (Marked up TXT- XML), and IA= Images.
73			X12	The 275 BIN segment does not include guidance for data communication. The X12 guides need to address communication issues. Since the BIN segment is a binary segment and data communication is usually in text mode, the BIN01 count may be incorrect which would cause a 275 failure. The text mode could add/remove invisible control characters at the end of each MIME encoded line. This could cause a change in the byte count in the BIN01 element.
74			X12	277 – 2100E NM107 - Compare the note "Required when the value in NM102 is 1 and the person has a suffix" with the note on page 67 for the subscriber "required when the value in NM102 known". Revise notes to match.
75			X12	277 – 1000D REF02 – Page 127 - Claim ID for Clearing House -The 277 should limit this data element to 20 positions. The 275 (page 63) states: The value carried in this element is limited to a max of 20 positions. The 837 also includes this limit. Need to revise 1000D REF02.
76			X12	277 – 2220E – Page 145 - Missing note, See page 100 for first note for this element. Need to add note.
77			X12	275- 2000A TRN02 - Page 67 - Beginning of 2 paragraphs: "When the value in BGN02 is 11", and "When the value in BGN02 is 02". Typo. Should state "BGN01", not "BGN02".
78			X12	Since the State of California now has a requirement to indicate why additional information is being asked, the 277 and 275 IG's need to allow for a third LOINC modifier.
79			X12	In the X12 275 - Page 70 – STC11 – The element note states: "This element is required when the 277 STC10 is used. This element is used to return the values found in the STC of the 277. If not required, do not send." It should state: "This element is required when the 277 STC11 is used. This element is used to return the values found in the STC of the 277. If not required, do not send."
80			X12	We recommend that receivers implement flexibility in BIN count errors.

Submitter : **Mr. Philip Heinrich** **Date: 11/18/2005**

Organization : **California Department of Health Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

The attached document contains comments from the California Department of Health Services

CMS-0050-P-32-Attach-1.DOC

Commenting Organization: California Department of Health Services

Philip Heinrich on behalf of California Department of Health Services Workgroup

Date Comments Submitted: November 18, 2005

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Instructions for each field are included in the Template. Click on the red triangle at the top right hand corner for each field label.

#	Document Number	Page #	Par/Sec or Fed Reg Column	LOINC (if appropriate)	Comment or Suggested Change	Business Justification
	Comments to Policy Statements in Federal Register					
1	Federal Register EFFECTIVE DATES	55994	sii B col 2		Medi-Cal supports extending the effective date for this rule two years so that the full implementation timeframe is 48 months for large health plans. This will give us the time needed to fully map our policy to LOINC values and modify systems and operational procedures. It would potentially also prevent competing priorities with other major implementations such as ICD10 and the 5010 versions of the existing standards.	

2	Federal RegisterCDA R1 VS R2	55995	sii C2:col 3		Medi-Cal supports the move from CDA R1 to R2 to allow for industry integration to EHRs and other uses of R2. Medi-Cal believes that CDA R2 will serve the industry better since CDA R1 will be almost 10 years old by the time we are required to implement it.	
3	Federal Register FORMAT OPTIONS	55997	sii C6: col 3		Medi-Cal supports the concept of both the HDV and CDV allowing that each entity has the option to choose which variant they will implement for each attachment type.	
4	Federal Register ELECTRONIC CLAIMS ATTACHMENT TYPES	55997	sii C5: Col 1		Medi-Cal encourages the completion and adoption of the following attachment types as soon as possible: Children's Preventive Health Services (CPHS), Durable Medical Equipment (DME) and Consent forms (abortion, hysterectomy and sterilization).	

5	Federal RegisterELECTRONIC CLAIMS ATTACHMENT TYPES	55997	sii C5:col 2		Storage needs for HDV - image should not increase dramatically since we are currently storing document in an image system. Storage needs for HDV - text and CDV may increase due to the need to capture and store the XML overhead for display purposes. This will depend on the integration method and a full assessment has not been completed in order to provide the true impact to servers and storage needs.	
6	Federal Register BUSINESS USE	55998	siii D: col 3		Regulation should not disallow health plans from collecting information via the claims attachment process for purposes other than claims adjudication, such as post payment review, fraud and abuse discovery and prevention, quality control and reporting.	The ability to collect this kind of data is more effective in the discovery and prevention of fraud and abuse if collected during the claims payment process. If collection is required outside the claims payment process, additional burden is placed on both the provider and payer as

						this data would still need to be collected by some other method.
7	Federal RegisterCOMBINED USE OF DIFFERENT STANDARDS	55998	sii C7:col 2		Use of two SDO standards in the same solution: Medi-Cal doesn't believe using two different standards in the same solution poses any issues; however, it would be easier to integrate into systems if both standards were in XML. We encourage X12 to move as quickly as possible in the development of their XML-based CICA version of the 275.	
8	Federal Register SOLICITED VS UNSOLICITED ATTACHMENTS	55999	sii D2: col 1		Medi-Cal (CA Medicaid) believes that both the unsolicited and solicited models should be allowed. Medi-Cal agrees with the requirement that providers may only submit unsolicited attachments upon prior advance instructions from the health plan.	

9	Federal RegisterSOLICITED VS UNSOLICITED	55999	sii D2:col2		If a claim is denied because the additional information sent (solicited or unsolicited) was not adequate to justify payment of the claim, can the health plan request more information?We recommend that a health plan be able to request additional information after the initial set of attachment data is received if more data is needed to adjudicate the claim. This potentially would prevent unnecessary denials and encourage providers to be responsive.	We understand the purpose of only allowing a single iteration for the request and response would stop providers and health plans from piecemealing the attachment information; however, if the data sent with the original response is not adequate to adjudicate the claim or prompts additional questions, this should not prohibit the health plan from asking for more information.

10	Federal Register PRIVACY RULE/MINIMUM NECESSARY	56000	sii D4: col 1		A requirement for providers to black out sections of a document that includes more than the minimum necessary information will be so costly as to inhibit the adoption of electronic claims attachments. The requirements to meet minimum necessary should not make this so difficult that a provider cannot do image attachments. This potentially would force provider back to paper attachments.	
11	Federal RegisterSIGNATURES	56000	sii D6:col 3		HL7 currently is in the process of developing attachments that may require an image of the "wet" signature, for example consent forms; therefore, a standard way to handle signatures should be adopted. This potentially could be done within the context of the current CDA structure. This would allow for the "rendering" of the 275 portion of the transmission using an XSL style sheet for easy viewing purposes.	

12	Federal RegisterPROVIDER VS PLAN PERSPECTIVE	56001	sii D8:col 1		Request clarification on the following: The preamble states: "a health care provider may direct a health plan to send any request for additional documentation in standard form and the health plan must do so." If the health plan does not currently request additional information but instead requires that the additional information needed to adjudicate the claim be submitted at the same time as the submitted claim (unsolicited), does this rule require that a health plan implement a process to request additional information if the provider asks them to. Entities should not be required to enter into a business arrangement they currently don't support. This is consistent with the other Transactions and Code Set regulation.	
13	Federal Register ATTACHMENT CONTENT AND STRUCTURE	56001	sii E: col 3		Medi-Cal defers to X12 as to the recommended size of the BIN.	

14	Federal RegisterPROPOSED STANDARDS	56006	sii G3:col 2		Medi-Cal agrees with proposed standards defined by X12 and HL7 with the changes to content recommended in the comments submitted by Medi-Cal.	
15	Federal Register PROPOSED STANDARDS	56006	siii G3: col 2		There needs to be a way to easily identify and extract attachment concepts for each attachment type from the LOINC database for easy integration into adjudication systems.	
16	Federal Register MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS	56014	sii B: col 1		Medi-Cal recommends that DHHS adopt a solution that allows for an expedited process to implement new attachment types as they are developed by HL7.	
17	Federal Register MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS	56014	siii B: col 1		Medi-Cal also recommends that the DHHS adopt an expedited way to adopt new versions of the existing standards as industry needs change.	

18	Federal RegisterCOST AND BENEFITS	56018	svi B3:col 1 & 3		At this time, Medi-Cal has not had the resources and time to conduct a cost benefit analysis to quantify projected savings with the conversion to electronic claims attachments under this model. In addition, Medi-Cal has not done a thorough enough assessment to determine implementation impacts/costs for both technical and operational cost impacts.	
19	Federal Register REG TEXT	56024	162.1910		Need clarification: What is meant by "In advance of submission of the claim"?	
20	Federal Register PROPOSED STANDARDS	56024	162.1915		The modifiers document is not specifically mentioned in the regulation text. To avoid confusion, suggest that a specific reference to this document be included in the requests standards section of the regulation text.	
21	Federal Register COB	59999	sii D3: col 3		Medi-Cal agrees with the NPRM that the primary payer should not be required to send attachment information on to the secondary payer as the information needed by	

					the secondary payer may be different.	
22	Federal RegisterBUSINESS USE	59999	sii D1:Col 1		It is recommended that the regulation text include instruction on how the industry should implement standard attachments that have data content that overlaps elements within the claims transactions. The final rule should also provide information about a migration or roll-out plan for handling these data overlaps.	
	X12 Standards Federal Register ATTACHMENT CONTENT AND STRUCTURE	**56001**	**sii E: col 3**			
23	X12 277 (004050X150)	8	Sec 1.3		Bullet 1 should be changed to read "solicited" instead of "unsolicited"	Error in IG.
24	X12 277 (004050X150)	9	Sec 1.3.1		This section addresses the solicited model for claims attachments although it says it's for the unsolicited. Change unsolicited to solicited. Title and second sentence of	Error in IG.

					first paragraph needs to be changed.	
25	X12 277 (004050X150)	28	2.3.3		Please add a more definitive description of how the 275 interacts with this transaction.	Clarification.
26	X12 277 (004050X150)	c.4		code source 464	The "source" reference for HL7 is incorrect. It should reference the HL7 CDA standard (selected release), not version 2.3.	Correction.
27	X12 277 (004050X150)	N/A			Recommend moving to version 5010 to take advantages of revised HL structure and changes made as a result of feedback from the EMS claims attachment pilot.	
28	X12 275 (004050x151)	9	Sec 1.3.2		We recommend that the requirement to include both the 837 and the 275 in the same interchange for unsolicited attachments be removed. This should be by agreement between trading partners.	Some health plans still allow dial-up for claims submissions, but may wish to limit claims attachments (due to their size) to non-dial-up solutions.

29	X12 275 (004050x151)	10	Sec 1.4		If requirement to force both 837 and 275 in the same interchange is removed, update section 1.4 Information Flows to show various flows.	
30	X12 275 (004050x151)	24	Sec 2.3.4		Replace 102 transaction with 824 transaction as recommended by the pilot.	
31	X12 275(004050x151)	81	Sec 3.4	CAT02	Include qualifiers to identify the type of document coming in the BIN: 1)HL7 CDA CDV, 2)HL7 CDA HDV-image, 3)HL7 CDA HDV-text, or 4)image. This has already been incorporated into version 5010.	
32	X12 275 (004050x151)	84	Sec 3.4	BIN	Add clarifying language around the use of the various types of data that can come in the BIN. Especially highlight that image types should be Base64 Encoded. This has already been incorporated into version 5010.	
33	X12 275 (004050x151)	Append A			Add information from X12.6 about the BIN segment to Appendix A.	

34	X12 275 (004050x151)	c.2		code source 464	The "source" reference for HL7 is incorrect. It should reference the HL7 CDA standard (selected release), not version 2.3.	
35	X12 275 (004050x151)	Append F			Remove reference to 102. Add reference to 824 and references to how the 824 is used to acknowledge the 275 and the contents of the BIN as recommended by the EMS pilot.	
	HL7 StandardsFederal RegisterATTACHMENT CONTENT AND STRUCTURE	**56001**	**sii E:col 3**			
36	HL7 LOINC Modifiers Document	1	Sec 1, par 1		Remove references to distinct locations for Time Window and Item Selection Modifiers in the STC10/11 segments of the 277 Request for Additional Information. Either modifier type should be able to go into **either** STC10 or STC11.	
37	HL7 LOINC Modifiers Document	3	Sec 2.1		Remove reference to STC10 in title.	
38	HL7 LOINC Modifiers Document	4	Sec 2.2		Remove reference to STC11 in title.	
39	HL7 AIS IG CDAR1AIS0000R021	9	Sec 2.2		Expand the definitions to include the terms Computer Decision Variant and Human Decision Variant.	Consistency with other docs.

40	HL7 AIS IG CDAR1AIS0000R021	11	Sec 2.4.3		The narrative following the first example does not match the example.	Correction.
41	HL7 AIS IG CDAR1AIS0000R021	13	Sec 2.4.6		Can we add an attribute to the caption_cd element so that we can identify that the OID is "LOINC". Can we use the @SN attribute for this as we do in the coded_entry.value element?	This will require changes throughout all the examples in the IG and AIS documents.
42	HL7 AIS IGCDAR1AIS0000R021	23	Sec 2.7		Can we add a statement that "The following is a list of balloted, approved and published AIS documents at the time of this publication. AIS 0001 - 0006 has been adopted as a part of the HIPAA Claims Attachment Legislation at the time of this publication.	This allows for the possibility of using the IG for those attachment types balloted but not listed here.
43	HL7 AIS IG CDAR1AIS0000R021	24	Sec 2.8		Example value table has an error. Answer part 18671-8 should have a cardinality of 1,1.	
44	HL7 AIS IG CDAR1AIS0000R021	30	Sec 3.4.1(4)		If we allow "signing" by an authenticated person, we should show some examples and uses of this in the IG.	
45	HL7 AIS IG CDAR1AIS0000R021	31	Sec 3.4.4		Should the example in this section contain an @RT attribute with the id element.	

46	HL7 AIS IG CDAR1AIS0000R021	31	Sec 3.4.5		The document type is always coded both in the HDV and the CDV. Should this statement be here as this makes the reader think that the HDV and the CDV is different. This information should go into the General Header Section 3.4.1(1).	
47	HL7 AIS IGCDAR1AIS0000R021	34	Sec 3.5.3		Should the data about MIME packaging from the PIUC attachment be included in this section of 3.8.	
48	HL7 AIS IG CDAR1AIS0000R021	39	Sec 3.7.4.3		Please explain the use of the @V attribute in the coded_entry element.	
49	HL7 AIS IG CDAR1AIS0000R021	40	Sec 3.7.5.1		Please clarify paragraph 2 of this section further.	
50	HL7 AIS IG CDAR1AIS0000R021	40	Sec 3.7.5.3		Can we add an attribute to define the OID so that we can easily differentiate between NPI and Legacy Provider IDs. Can we show examples on how to use both the NPI and legacy provider ID's.	
51	HL7 AIS IG CDAR1AIS0000R021	41	Sec 3.7.6.3		Remove requirement to use dashes in the DT datatype for the CDV.	
52	HL7 AIS IG CDAR1AIS0000R021	42	Sec 3.7.8		Show examples of using the "No Information" in both HDV and CDV.	

53	HL7 AIS IG CDAR1AIS0000R021	42	Sec 3.7.9		Paragraph 2 should reference both iso+ and ans+. It would make it easier to follow if there were examples of both the CDV and HDV.	
54	HL7 AIS IG CDAR1AIS0000R021	43	Sec 3.7.10		Define the values available for the Person Name Datatype for the @V attribute.	
55	HL7 AIS IGCDAR1AIS0000R021	44	Sec 3.7.10.2		Add an example for the HDV for the Person Name datatype.	
56	HL7 AIS IG CDAR1AIS0000R021	44	Sec 3.7.11		Add examples for the ST datatype for both HDV and CDV.	
57	HL7 AIS IG CDAR1AIS0000R021	50	Sec 3.7.14		Add examples for the TX datatype for both HDV and CDV.	
58	HL7 AIS IG CDAR1AIS0000R021	51	Sec 3.8		Should the data about MIME packaging from the PIUC attachment be included in this section of 3.8.	
59	HL7 AIS IG CDAR1AIS0000R021	53	Sec 5		Add ans+ units list. Add all other OIDS referenced in the document.	

60	Federal Register DEFINITIONS and Ambulance AIS CDAR1AIS0001R021	56024 Throughout AIS	162.1900 CFR		Would like clarification on the definition of Ambulance Services? Does this incorporate both Emergency and Non-emergency ambulance services. If the definition does include both emergency and non-emergency ambulance services, then suggest removing all references to EMS (Emergency Medical Services) from the Ambulance AIS as this is misleading.	
61	Ambulance AISCDAR1AIS0001R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in the final rule.	To make the scope and purpose of this attachment type clear
62	Ambulance AIS CDAR1AIS0001R021	7	Table 3	15510-1	Add the ability to capture "Nautical Miles" in this answer part. Add note to this answer part that if the ambulance transportation was fixed or rotary wing air, the miles should be captured in Nautical Miles.	Our policy is to validate the air miles (nautical miles) billed based on the origination and destination GPS coordinates.

63	Ambulance AIS CDAR1AIS0001R021	7	Table 3	15510-1	Add new answer part to component 15510-1 for "Rationale for Excess/Additional Mileage (used for air only)". Suggested values are: weather, vectoring, terrain, equipment or other).	If the calculated miles using the GPS coordinates or address does not match the miles stated, we ask that providers justify the excess miles.
64	Ambulance AIS CDAR1AIS0001R021	7	Table 3	ADD	Add new component for "Transport Time of Day".	Reimbursement differs for ambulance responses after a certain time of day and if multiple transports are done within the same day. Having the time will allow us to make this differentiation.
65	Ambulance AISCDAR1AIS0001R021	7	Table 3	3141-9, 3142-7, 8335-2	Add ans+ to the response code set since pounds is part of this unit of measure set not the iso+ set.	Error in AIS.
66	Ambulance AIS CDAR1AIS0001R021	8	Table 3	15511-9	Add answer part to this component "Origination Site GPS Coordinate". This would only be used if the transport was fixed wing or rotary air.	Our policy is to validate the air miles (nautical miles) billed based on the origination and destination GPS coordinates.

67	Ambulance AIS CDAR1AIS0001R021	8	Table 3	15512-7	Add answer part to this component "Destination Site GPS Coordinate". This would only be used if the transport was fixed wing or rotary air.	Our policy is to validate the air miles (nautical miles) billed based on the origination and destination GPS coordinates.
68	Ambulance AISCDAR1AIS0001R021	8	Table 3	18580-1	Can Answer Part 18580-1 Origination Site Name include such names as interstate #, highway or freeway name, indian land and reservation names, bodies of water or shorelines, campgrounds, state and national theme parks, recreation areas, mountain names, farms and ranch land names? If so, can we add some of these examples to the narrative so that the readers know. If not, how can we capture this type of address information. Not all people have an actual mailing address. In addition, we have the origination site address and destination site address as required. What if the patient does not have an actual address? This is common for the	

					indigent.	
69	Ambulance AIS CDAR1AIS0001R021	8	Table 3	18812-8	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	Clarification.
70	Ambulance AISCDAR1AIS0001R021	8	Table 3	15514-3	Change component and answer part titles to: Ordering Practitioner or Agency	This could assist in accommodating an order from a 911 operator, etc. The name of the 911 operator should go in her. The identifier would include "911" and agent

						number, if applicable.
71	Ambulance AIS CDAR1AIS0001R021	9	Table 3	ADD	Add New Component: Transport Wait Time Answer Part: Wait Time Begin Answer Part: Wait Time End Answer Part: Rationale for Wait Time. Values for Rationale should be: Patient not ready for transport, Accepting facility not ready to accept patient, Other Cardinality for the component should be 0,1.	Reimbursement differs for amount of wait time.
72	Ambulance AIS CDAR1AIS0001R021	9	Table 3	ADD	Add New Component: Multiple Patient Information Answer Part: Name of Additional Patient's) Answer Part: Member ID of Additional Patient's) Cardinality at the component level needs to 0,n, Cardinality for the Name should be 1,1 and ID 1,1	Reimburse differs if there are multiple patients on board. This is to ensure that duplicate payment is not made for each patient within the same transport.

73	Ambulance AISCDAR1AIS0001R021	9	Table 3	ADD	Add a new componenent "Name of Receiving Physician Accepting Responsibility for Patient". The answer part would be just the name of the physician.	Necessary to verify that the appropriate person received the patient according to the federal requirements for MTELA.
74	Ambulance AIS CDAR1AIS0001R021	10	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
75	Ambulance AIS CDAR1AIS0001R021	14	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, ICD-10, iso+ table, ans+ table, person_name_type_cd, unique instance ID, and the example OID.	Adds consistency throughout the AIS docs.
76	Ambulance AIS CDAR1AIS0001R021	15	Table 5.1	HL79000	Add values to HL79000: Rotary Aircraft used instead of fixed wing because 1) no landing strip available, 2) fixed wing craft not available, 3) pilot not available, 4) faster response time	Providers need to justify why a rotary aircraft is used versus a fixed wing aircraft.
77	Ambulance AIS CDAR1AIS0001R021	15	Table 5.2 Code 4	HL79000	Request to change definition of code 4 of this table to read "No one available to receive the patient".	This makes this value generic enough to encompass other receiving places besides

						the home.
78	Ambulance AISCDAR1AIS0001R021	17	Table 5.5	HL79010 - Associated to Medical Reason for Unscheduled Trip	Add new value to the HL79010: Response to Call/Non-Transport	We reimburse for instances where the ambulance responded to a call, but there was no actual transport. Need to know this specifically, because reimbursement rate is different if there was actually a patient or not.
79	Emergency Department AIS CDAR1AIS0002R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in the final rule.	To make the scope and purpose of this attachment type clear
80	Emergency Department AIS CDAR1AIS0002R021	7-9	Table 3	18600-7, 18602-3, 11298-7, 18706-2	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	Clarification.
81	Emergency Department AIS CDAR1AIS0002R021	11-13	Table 3	18606-4, 18611-4, 18618-9	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code	

					sets used for drugs?	
82	Emergency Department AIS CDAR1AIS0002R021	14	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
83	Emergency Department AISCDAR1AIS0002R021	18	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, iso+ table, person_name_type_cd, unique instance ID, and the example OID (and RxNorm SBD, RxNorm SCD if these are added to the document).	Adds consistency throughout the AIS docs.
84	Rehabilitation Services AIS CDAR1AIS0003R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in the final rule.	To make the scope and purpose of this attachment type clear
85	Rehabilitation Services AIS CDAR1AIS0003R021	13	Table 3.1	27515-6, 27514-9	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.

86	Rehabilitation Services AIS CDAR1AIS0003R021	13	Table 3.1	27514-9	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
87	Rehabilitation Services AIS CDAR1AIS0003R021	14	Table 3.1	27491-0	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
88	Rehabilitation Services AISCDAR1AIS0003R021	16	Table 3.1	27524-8	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
89	Rehabilitation Services AIS CDAR1AIS0003R021	17	Table 3.1	27505-7	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
90	Rehabilitation Services AIS CDAR1AIS0003R021	19	Table 3.2	27457-1, 27518-0	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
91	Rehabilitation Services AIS CDAR1AIS0003R021	20	Table 3.2	27456-3	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
92	Rehabilitation Services AIS CDAR1AIS0003R021	20	Table 3.2	27539-2	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.

93	Rehabilitation Services AIS CDAR1AIS0003R021	21	Table 3.2	27461-3	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
94	Rehabilitation Services AIS CDAR1AIS0003R021	22	Table 3.2	27447-2	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
95	Rehabilitation Services AISCDAR1AIS0003R021	22	Table 3.3	27791-3, 27754-1	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
96	Rehabilitation Services AIS CDAR1AIS0003R021	23	Table 3.3	27787-1	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
97	Rehabilitation Services AIS CDAR1AIS0003R021	23	Table 3.3	27765-7	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
98	Rehabilitation Services AIS CDAR1AIS0003R021	24	Table 3.3	27792-1	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
99	Rehabilitation Services AIS CDAR1AIS0003R021	25	Table 3.3	27778-0	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.

100	Rehabilitation Services AIS CDAR1AIS0003R021	25	Table 3.4	27635-2, 27601-4	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
101	Rehabilitation Services AIS CDAR1AIS0003R021	26	Table 3.4	27634-5	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
102	Rehabilitation Services AISCDAR1AIS0003R021	26	Table 3.4	27612-1	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
103	Rehabilitation Services AIS CDAR1AIS0003R021	27	Table 3.4	27639-4	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
104	Rehabilitation Services AIS CDAR1AIS0003R021	28	Table 3.4	27625-1	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
105	Rehabilitation Services AIS CDAR1AIS0003R021	28	Table 3.5	27698-0, 27664-2	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
106	Rehabilitation Services AIS CDAR1AIS0003R021	29	Table 3.5	27697-2	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.

107	Rehabilitation Services AIS CDAR1AIS0003R021	29	Table 3.5	27675-8	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
108	Rehabilitation Services AIS CDAR1AIS0003R021	30	Table 3.5	27651-9	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
109	Rehabilitation Services AISCDAR1AIS0003R021	30	Table 3.5	27688-1	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
110	Rehabilitation Services AIS CDAR1AIS0003R021	31	Table 3.6	19007-4, 18631-2	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
111	Rehabilitation Services AIS CDAR1AIS0003R021	31	Table 3.6	18730-2	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
112	Rehabilitation Services AIS CDAR1AIS0003R021	32	Table 3.6	18645-2	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
113	Rehabilitation Services AIS CDAR1AIS0003R021	33	Table 3.6	18816-9	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	

114	Rehabilitation Services AIS CDAR1AIS0003R021	33	Table 3.6	18658-5	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
115	Rehabilitation Services AIS CDAR1AIS0003R021	34	Table 3.7	27740-0, 27703-8	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
116	Rehabilitation Services AISCDAR1AIS0003R021	34	Table 3.7	27736-8	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
117	Rehabilitation Services AIS CDAR1AIS0003R021	35	Table 3.7	27714-5	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
118	Rehabilitation Services AIS CDAR1AIS0003R021	36	Table 3.7	27741-8	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
119	Rehabilitation Services AIS CDAR1AIS0003R021	36	Table 3.7	27727-7	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
120	Rehabilitation Services AIS CDAR1AIS0003R021	37	Table 3.8	27587-5, 27550-3	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.

121	Rehabilitation Services AIS CDAR1AIS0003R021	38	Table 3.8	27583-4	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
122	Rehabilitation Services AIS CDAR1AIS0003R021	39	Table 3.8	27561-0	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
123	Rehabilitation Services AISCDAR1AIS0003R021	39	Table 3.8	27588-3	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
124	Rehabilitation Services AIS CDAR1AIS0003R021	39	Table 3.8	27574-3	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
125	Rehabilitation Services AIS CDAR1AIS0003R021	40	Table 3.9	29166-6, 29167-4	Add ICD-10 to the list of Response Code sets and a definition when which version is used (ICD9 or ICD10).	To accommodate future implementation of ICD-10.
126	Rehabilitation Services AIS CDAR1AIS0003R021	40	Table 3.9	29188-0	Clarify the language around when the NPI is used, when legacy provider ID's can be used and when both are valid.	For Clarification.
127	Rehabilitation Services AIS CDAR1AIS0003R021	41	Table 3.9	29171-6	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.

128	Rehabilitation Services AIS CDAR1AIS0003R021	41	Table 3.9	29196-3	Should we also make reference to RxNorm (SBD and SCD) and NDC as these seem to be the common code sets used for drugs?	
129	Rehabilitation Services AIS CDAR1AIS0003R021	42	Table 3.9	29184-9	Change cardinality to 0,1. This should only be used if it is for an "updated" plan. It would not be used on an "original" plan.	Error in AIS.
130	Rehabilitation Services AISCDAR1AIS0003R021	43	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
131	Rehabilitation Services AIS CDAR1AIS0003R021	59	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, ICD-10, iso+ table, person_name_type_cd, unique instance ID, and the example OID (and RxNorm SBD, RxNorm SCD if these are added to the document).	Adds consistency throughout the AIS docs.
132	Clinical Reports AIS CDAR1AIS0004R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in	To make the scope and purpose of this attachment type clear

					the final rule.	
133	Clinical Reports AISCDAR1AIS0004R021	1			To avoid confusion, we recommend that the tables in the Clinical Reports set be removed and a reference included that all CR information is found in the LOINC database. Some readers have misinterpreted the contents of this document as being the only values available. Also, what happens when one of the printed LOINC values in the document is deprecated or changed in the LOINC database? How does this affect the printed tables if they do remain in the document?	
134	Clinical Reports AIS CDAR1AIS0004R021	8	Table 2.5	28563-5	Under the Care Provider Notes set, request the addition of "Provider Unspecified - Medical Necessity Note"	Needed to distinctly document Medical Necessity

135	Clinical Reports AIS CDAR1AIS0004R021	8	Ex. Table 2.5	27899-4	For each of the **Specific** Diagnostic Studies (non-lab) Set, we would like to request a LOINC value to capture a Medical Necessity Statement.	Needed to distinctly document Medical Necessity
136	Clinical Reports AISCDAR1AIS0004R021	8	Table 2.5		Need a way to capture Time in Attendance for Anesthesia. This is not currently part of a normal Anesthesia record. Can you provide suggestions on how this could be captured?	
137	Clinical Reports AIS CDAR1AIS0004R021	33	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
138	Clinical Reports AIS CDAR1AIS0004R021	38	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, ICD-10, iso+ table, person_name_type_cd, unique instance ID, and the example OID (and RxNorm SBD, RxNorm SCD if these are added to the document).	Adds consistency throughout the AIS docs.

139	Laboratory Services AIS CDAR1AIS0005R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in the final rule.	To make the scope and purpose of this attachment type clear
140	Laboratory Services AIS CDAR1AIS0005R021	13	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
141	Laboratory Services AISCDAR1AIS0005R021	29	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, , iso+ table, person_name_type_cd, unique instance ID, and the example OID.	Adds consistency throughout the AIS docs.
142	Medications CDAR1AIS0006R021	1	Introduction		Suggest that verbiage be added to section 1 of the AIS to define the purpose and scope of this AIS. Recommend that this match the definition in the Final Rule or at a minimum point to the definition in the final rule.	To make the scope and purpose of this attachment type clear
143	Medications CDAR1AIS0006R021	11-14	Table 3	18605-6, 18618-9, 18611-4	Should we make references to both RxNorm (SBD and SCD) and NDC as these seem to be the common code sets	

					used for drugs?	
144	Medications CDAR1AIS0006R021	15	Section 4		Suggest adding an image example to this AIS.	Adds consistency throughout the AIS docs.
145	MedicationsCDAR1AIS0006R021	22	Section 5		Add a description of all OIDS used in this AIS (examples and elsewhere). This would include adding an OID for legacy provider ID (need to update this example), NPI, , iso+ table, person_name_type_cd, unique instance ID, and the example OID.	Adds consistency throughout the AIS docs.