National Committee on Vital and Health Statistics
Subcommittee on Standards

November 17-18, 2011

TESTIMONY OF THE AMERICAN MEDICAL ASSOCIATION

Presented by Robert Barbour
Senior Policy Analyst

Claims Attachment Transaction

The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics' (NCVHS) Standards Subcommittee (Subcommittee) for the opportunity to provide our comments on the issue of the claims attachment transaction. We believe that the adoption of the Accredited Standards Committee (ASC) X12 275 (X12N/005010X210), Additional Information to Support a Healthcare Claim or Encounter will make significant additional inroads to the goal of administrative simplification. We recognize that the 275 provides the metadata (envelope) around the clinical information with HL7 Clinical Data Architecture (CDA) carrying the clinical information. Thus, we will use both the terms "275" and "275/HL7" to refer to this transaction. Ultimately, this transaction allows for the electronic submission of documents and codified clinical information in response to an inquiry by a payer that virtually eliminates the back and forth debate of whether a provider has responded to such a request. It reduces costs for mailings; eases copying of information; and, when coupled with the electronic request for that information via the ASC X12N 277, virtually assures that such requests are not lost in provider mail rooms or simply trashed as junk mail. As will be discussed in this testimony, the 275 adds value to more than just payers requesting additional information on claims transactions; it can be used to support responses to prior authorization requests, support payer responses to the predetermination of benefits transactions, provide additional options to address payers informing providers of potential over payments about to be recouped, and help to limit providers sending 275s preemptively in response to known historical patterns of payer requests (preferably by trading partner agreement).

Historical presentations and continuing concern

There have been numerous presentations in different forums on the value that the 275/HL7 should add to the health care industry. The fact that it has not been widely used demonstrates again that this industry rarely adopts even the most evidently beneficial standards unless they are mandated. As far back as 2003, the AMA was publically commenting on the overall value that a claims attachment transaction can bring. It also warned about how the transaction might be misused. The following is a subset of the comments the AMA, and others, have made regarding the 275/HL7 transaction:

1. Comments by AMA to NCVHS, December 10, 2003 (See Appendix A for full testimony).
    a. "The AMA believes that an attachment would include information either requested by the payer based on pre-payment or post-payment follow-up or provided by the physician at the time of submission of the claim."

b. "…physicians should have the ability to submit attachments at the time of claim submission and should not have to wait for a payer query or specific attachment requirement (e.g., to explain the unusual circumstances associated with a pattern of treatment)."
c. "Frequently, based on expectations of payer requirements, or specific written requirements, physicians submit additional information with each claim of a certain type so as not to delay reimbursement to the patient or payment to the physician. Lack of standardization across or within payers is a serious problem. Searching the patient's medical record or administrative file well after the original claim is submitted to gather the additional information and place it in the format required by the payer creates undue burdens on physicians."
d. "The AMA believes that, in some instances, these attachment and documentation requirements involve payers' legitimate needs for sufficient information to assess coverage, or justification for specific types of services, or to meet contractual or regulatory requirements. All too often, unfortunately, many physicians have concluded that these requests are intended to delay payment of claims or to provide a basis for unwarranted denial. Also, they may often reflect a desire to pressure physicians into billing at a lower level of service."
e. "In addition, it is essential to standardize when attachments are required and not just how they are submitted… This means that some payers will require a particular data item and others will not. Therefore, the AMA is concerned that the payer or governmental response to the HIPAA standardization of the claim will be an expanded use of attachment requests to circumvent claims standardization."

2. Comments made by the AMA to the Centers for Medicare & Medicaid Services (CMS) in a letter dated January 23, 2006 (See appendix B for complete copy) relative to *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule; 70 Fed. Reg. 184, 55990 (Sept. 23, 2005; File Code CMS-0050-P*.
   a. "As CMS continues to develop national standards for electronic health care claims, the AMA wants to express its long-standing concern regarding the confidentiality, integrity, and security of patient medical record information. The AMA believes that it is critical that any electronic attachment information submitted by physicians to health plans, either directly or indirectly through intermediaries, is protected throughout the transaction process by safeguards designed to limit access to, and use of, patient information."
   b. "The AMA also remains concerned about excessive and unnecessary requests for additional information, as well as unexplained delays in processing and payment by third party payers, where a completed standard claim form for reimbursement has been submitted. For this reason, the AMA believes that this rule should provide protection from unnecessary and excessive requests for additional information."
   c. "Where an electronic attachment is required for claims processing, adjudication, and payment, by a health plan that operates as a clearinghouse, or operates its own clearinghouse that must be accessed in order to submit claims and associated information to the health plan for processing, said health plan should be barred from charging for the clearinghouse service."
   d. "Although not included in the definitions section of the proposed regulations, the AMA believes that in order to encourage transparency in the process of requesting additional documentation, the term "minimum necessary" must be defined through regulation. The AMA is very concerned that absent definition, some health plans may take advantage of the electronic attachment standard to unduly burden physicians with unnecessary and attainable requests for clinical patient information.

Under HIPAA "The health plan must request no more information than it determines necessary or the purpose of the request. The physician may rely on the health plan determination and is not required to make independent determination of what information the health plan needs, unless the request is clearly unreasonable." HIPAA *does not* require physicians to give the health plan the information it requests. However, HIPAA does not provide a basis for physicians to deny requests for information either. Therefore, the AMA believes that the United States Department of Health and Human Services (DHHS) should provide some guidance to ensure health plans make appropriate requests to physicians."

e. "The AMA further believes that requests for additional documentation should be required in only certain limited circumstances and should be narrowly tailored. The AMA is concerned that health plans, under the proposed rule, will fail to be judicious in their requests for additional documentation, causing enormous burdens on physicians. Payers should recognize and respond to all claims and should be permitted to ask for additional information only when such information is deemed necessary based upon the physician's response to the first request. Failure to prohibit payers from continually and repeatedly requesting additional information from a physician for a single claim will undoubtedly result in significant delays in claims adjudication and payment, as well as untoward administrative hassles. Health plans should be permitted one request for information and then a second request if, and only if, the second request is based upon information garnered from the response to the first request. However, the AMA cautions that even this proscription could lead to situations in which an initial request and response generates dozens of follow-up requests and responses. Thus, the AMA feels that there needs to be a definitive point at which no additional information can be requested and/or has to be provided."

f. "The AMA believes that standard implementation guidelines for code sets are essential for uniform national application of the code sets. If standard guidelines for medical code sets are adopted, many attachments would be eliminated. If health plans and physicians are permitted to implement and interpret medical data code sets as they see fit, the purpose of Administrative Simplification will not be achieved. An important part of Administrative Simplification and reduced regulatory hassle includes the simplification of instructions for the coding of health care services. The overwhelming amount of paperwork to which physicians are subject could be significantly reduced if coding is standardized and electronic transactions are facilitated. Thus, the AMA believes that the CPT guidelines and instructions should be specified as a national standard for implementing CPT codes."

More than once, the AMA has noted that with the adoption of the 275/HL7 as a mandated transaction also comes cause for concern: that both governmental and private payers may potentially use that standard as a basis for increasing the number of requests for additional information. Coupled with the proliferation of electronic health records (EHRs), this streamlining of practice operations has had the unintended consequence of increasing the burden on practices in a different way. Historically, there has been a general awareness that finding, copying, and sending data in paper charts was a real burden for providers. A common reason for pushing EHRs has been the ease of access they provide to that same information. Because widespread use of EHRs and mandated use of the 275 have made obtaining that information easier, payers and other outside parties are less shy about requesting additional information from physicians and other providers. The growth in these requests could result in more prescriptions and procedures requiring prior authorizations, which will require the submission of supporting documents, and more requests for laboratory results, copies of specialists' reports, and images of X-rays and coinciding reports.

In an informative white paper by Chris Smith and Seonho Kim - ApeniMED, *NHIN And Electronic Submission Of Medical Documentation (esMD) To CMS, The Impact On HIE Sustainability By Utilization Of the NHIN For Administrative Transactions*, several insightful observations affirm the AMA's concerns regarding the possible increase in requests for additional information. These are highlighted below:

- "As Health Information Exchanges (HIEs) build infrastructure, connect stakeholders together, and become functional, there is an emphasis on HIE sustainability models and use-cases that directly impact these specific providers and stakeholders. One such use-case is the utilization of NHIN, or the Nationwide Health Information Network, to allow HIEs to directly connect to the Centers for Medicare and Medicaid Services (CMS) to electronically submit medical documentation (esMD) requested by CMS Review Contractors."
- "In September 2011, CMS unveiled a pilot project, Electronic Submission Of Medical documentation esMD), under which providers will be able to reply to CMS Review Contractors' Requests for medical documentation through secure, electronic responses employing NHIN standards."
- "CMS receives approximately 4.8 million claims per day, and the CMS Office of Financial Management estimates that improper payments totaling more than $35.4 billion dollars in Medicare and more than $22.5 billion in Medicaid are made each year. CMS has stated that most improper payments can only be detected by a human comparing a claim to supporting medical documentation. **Currently, there are over 1 million requests for supporting medical documentation per year for review and CMS expects that number to grow significantly in the coming years as CMS Review Contractors increase their efforts to find and prevent improper payments** (emphasis added)."

When one considers all these factors—the focus on reducing health care expenditures (and the resulting increase in requests for prior authorizations), the increased focus on claims audits, the impact of the upcoming ICD-10-CM coding structure that will dramatically increase the need for physician supporting documentation, and the development of technologies making the requesting and sending of additional information easier—it is rational to conclude that physicians and other health care providers will see a dramatic increase in requests. As such, the AMA again recommends that limits be placed on the number, frequency, and time frame of requests associated with specific claims (and other transactions).

With the assumption that requests for additional information will be made in good faith and not as an unintentional and uncompensated additional burden to physicians and other providers, the rest of our presentation will focus on the business/workflow benefits of the 275 transaction.

Business case for the 275/HL7

The 275/HL7 can be used for more than just responding to requests for additional information from a payer as a result of submitting a claim. Although the NPRM for the 275/HL7 limited its use to five named attachment types, it can be used:

1. To send clinical information as part of obtaining an ASC X12 278 prior authorization approval from a payer.
    a. It can be sent in parallel with the 278 transaction as supporting information.
    b. It could permit the payer to respond separately with a 275 transaction that contains the specific form it needs for the prior authorization to be more thoroughly reviewed.
    c. The AMA is moving forward with a pilot project to explore the value of using codified information to facilitate payers' efforts to increase automation of 278 requests. Thus,

future versions of the 275 could contain specific codified information (beyond the supported code sets today) related to the specific services being requested with the goal of processing most prior authorizations in real time, with the remaining be closed within one to two days.

2. In conjunction with a new transaction from X12 that supports a predetermination of benefits process that is expected to grow rapidly in usage. This new transaction allows a provider to determine, before services are actually delivered, how a claim for those services would likely be answered. This removes eligibility, coverage, in/out of network status, medical necessity, need for prior authorization, and other possible ambiguities that are often only determined accurately after the fact. But just as valuable, it can be viewed as a "heads up" to payers of what a physician or other provider is considering for the patient.
    a. As such, the payer could have the opportunity to use the 275 transaction to send information it would like to share with the providers regarding the services being considered for payment.
    b. It could use the 275 to send information for the physician to share with the patient such as missing annual survey information gathered on dependents, reducing or eliminating payment denials as a result of not having that information.
3. By payers when they periodically identify transactions that may have possible overpayments. The ASC X12 835 remittance transaction cannot fully meet the various state requirements for proper notice to physicians and other providers on a payers intent to take back an overpayment.
    a. The 275 could send a document that would fully comply with a state's written notice requirement and include additional information for a physician or other provider to evaluate the accuracy of the possible overpayment.
    b. The 275 could permit the physician or other provider to send back images of audit trails that respond to the challenge of that request.
4. By payers, in response to a request for a copy of a referral by the specialist.
5. By physicians and other providers, in response to requests by workers compensation carriers for medical reports and associated documentation to support a bill as mandated by state legislation or in response to information requests by workers compensation carriers.
6. By physicians and other providers responding to requests from payers for additional coordination of benefits detail not contained in the secondary claim they received.
7. By physicians and other providers, in response to a pharmacy's request for clinical history data (e.g., allergies).
8. By physicians and other providers to payers for copies of invoices needed by the payer to properly adjudicate a claim for certain drugs, supplies, implantables, etc.
9. By physicians and other providers in response to questions a payer may have about the use of a modifier or the submission of unlisted procedures.
10. By physicians and other providers in response to a request by payer for a copy of a consent form or sterilization form.
11. By physicians and other providers to send information to payers before it is requested based on identified patterns by payers for requesting that information. It is recommended that this practice be done by agreement between the trading partners.
12. For future attachment needs, a process to allow the development and use of other attachment types should be established. This could be accomplished by the user obtaining a LOINC code assigned for that type of document, and that document could be sent as an 'Unstructured' standard transaction. Once discrete data elements are defined, they could be included in the attachment guides for exchanging 'Structured' standards.

The 275 nicely meets the industry's need for a method of electronically sending key information to support a given transaction or business process. The need for a payer to get the information it requires to appropriately perform its fiduciary and contractual duties, either from an image or as codified data, is

a key business requirement. Likewise, physicians or other health care providers have a similar need to respond efficiently to those requests with clear, defensible audit trails. As this transaction matures in its usage, codified data will open up opportunities for payers to automatically adjudicate the data they receive, increasing the opportunity for them to respond in real time to that data. When looked at as a complete business cycle, the combination of the 275/HL7 with a requesting transaction (277 or 278) creates a complete audit trail between the trading partners of that information request process. What is not often commented on is the positive impact on lost information that the complete process provides. Payers often deny claims for failure to receive information they requested, while providers cite numerous examples of either never receiving the request, or the payers losing the information sent by mail or fax, resulting in improper denials. The submission of an unsolicited 277 electronic request for additional information, and the attending acknowledgments, greatly enhances the likelihood that it will get to the right person, as it can be workflow directed by the billing system. The submission of a 275/HL7 and the appropriate acknowledgments returned by the receiver make that part of the information request cycle unambiguous.

In addition, the lag time difference between sending a request for information and a provider's ability to respond when everything is done electronically using X12 standards has been shown to be as much as 7.5 times faster than traditional methods. (Montefiore presentation on its 275/HL7 pilot project experience with Medicare in a WEDI 2006 audiocast entitled "Pilot Experience at Montefiore Part A and Part B," presented by Nancy Sanchez-Caro). Both the 278 and 277 are HIPAA mandated; therefore the administrative simplification business cycle must be completed by including the 275/HL7 as part of the HIPAA mandated transactions suite.

The AMA strongly believes the business case for including the 275/HL7 as part of the HIPAA mandated suite of X12 transactions is clear and unambiguous, and urges NCVHS to recommend that the Secretary of Health and Human Services adopt this standard. However, the potential for a significant increase in requests for additional information by payers, auditors, and other entities cannot be ignored. As such, the AMA also urges NCVHS to place rational limits on these requests, the number of requests that can be made regarding a particular event and the time frames open for these types of requests, as has been recommended in the past by the AMA in other testimony included in the appendices.

Appendix A

Statement of the American Medical Association
to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards and Security
Regarding HIPAA Electronic Claims Attachments
Presented by Jean P. Narcisi

December 10, 2003

My name is Jean Narcisi. I am the Director of Electronic Medical Systems for the American Medical Association (AMA). It is my pleasure to appear today on behalf of the AMA before the Subcommittee on Standards and Security of the National Committee on Vital and Health Statistics (NCVHS). I would like to thank you for the opportunity to testify.

The AMA defines a claim as the submission of information by a physician or insured individual to a third-party payer using a standardized format (e.g., CMS 1500 paper claim form or HIPAA electronic format) sufficient to establish that covered health care services were provided. The claim includes a request for payment or reimbursement to the physician or insured individual.

The AMA believes that an attachment would include information either requested by the payer based on pre-payment or post-payment follow-up or provided by the physician at the time of submission of the claim. Attachments consist of information, presumably not available on the initial claim (or claim format), that provides further supporting details on the claim.

Attachment information should include (1) information that tends to be highly situational in nature (e.g., requested only for specific types of services) and (2) cannot be readily accommodated in a standardized paper or electronic claims format. Attachments should accommodate a variety of paper and electronic technologies and should allow for structured data elements, images, and free form text as appropriate. In addition, physicians should have the ability to submit attachments at the time of claim submission and should not have to wait for a payer query or specific attachment requirement (e.g., to explain the unusual circumstances associated with a pattern of treatment).

Physicians are currently asked for a variety of supporting information to adjudicate a claim. This can include information that is contained in the patient medical record such as operative notes, test results, etc., or information to substantiate the level of service provided. Other attachment data includes additional administrative information dealing with patient eligibility (e.g., copies of driver's licenses, social security cards, Medicaid cards, etc.). Many physicians are also asked to verify information of the patient's relationship with the insured and other information to assist in coordination of benefits (COB). Often, this COB information is not readily available to the physician.

In addition, some payers, especially Medicare and Medicaid, request attachment information using special forms to reflect patient consent, the medical necessity of

ordered durable medical equipment, the advanced beneficiary notice (ABN), and the cost and duration of use of drugs and supplies. The methods by which this information is requested depend on the specific payer, the physician's relationship with the payer, and their technical capabilities. Submissions can sometimes be made electronically if a payer has an electronic form in place. All too often, however, even when the claim is submitted electronically, the physician must send in the attachment information manually. In some instances, and also contributing to cost and inefficiency, payer requests can be satisfied via the telephone.

Frequently, based on expectations of payer requirements, or specific written requirements, physicians submit additional information with each claim of a certain type so as not to delay reimbursement to the patient or payment to the physician. Lack of standardization across or within payers is a serious problem. Searching the patient's medical record or administrative file well after the original claim is submitted to gather the additional information and place it in the format required by the payer creates undue burdens on physicians.

The AMA believes that, in some instances, these attachment and documentation requirements involve payers' legitimate needs for sufficient information to assess coverage, or justification for specific types of services, or to meet contractual or regulatory requirements. All too often, unfortunately, many physicians have concluded that these requests are intended to delay payment of claims or to provide a basis for unwarranted denial. Also, they may often reflect a desire to pressure physicians into billing at a lower level of service.

The AMA has found that requests do vary considerably across payers. This causes substantial cost and delay for physicians. This variation includes when attachments are requested, in what format they should be submitted, and the availability of electronic submission.

The AMA believes that considerable strides can be made on the attachments issue. The AMA also believes that standardization and electronic exchange of attachment information would reduce the workload for both the requestor and the respondent to attachments, and that this could ultimately result in cost savings. In order to work, this standardization must apply to all payers and cover both paper and electronic formats. Standardization will be more difficult in the private sector, where contractual provisions vary across and within specific companies.

In addition, it is essential to standardize <u>when</u> attachments are required and not just <u>how</u> they are submitted. The AMA is very concerned that lack of standardization in the circumstances when attachments will be required will lead to an increased burden on physicians. The current HIPAA implementation guides for the claims transactions are very complex and include many confusing statements regarding the requirement of certain data items. For example, the requirement for a physician to report certain items in a claim is conditional on a specific situation. Many of the situations are not clearly defined in the implementation guides. This means that some payers will require a particular data item and others will not. Therefore, the AMA is concerned that the payer

or governmental response to the HIPAA standardization of the claim will be an expanded use of attachment requests to circumvent claims standardization. Administrative simplification will not be achieved for physicians if each payer requests differing amounts of additional material as an attachment.

The AMA believes that standardization of formats and electronic exchange should reduce the costs of preparing and submitting attachments and enable physicians and the health care system to realize the full benefits of electronic data interchange and administrative simplification. At the same time, as indicated above, accomplishing such partial standardization without standardizing when attachments are required could make matters far worse. Given the current extent of physician use of electronic medical records, the state of standardization of such systems, and the lack of standardized links between clinical and administrative systems, the costs of obtaining attachments information from existing electronic or paper medical records and then placing it into standardized electronic formats could be prohibitive.

Fundamentally, the AMA believes that the HIPAA mandate for claims standardization, as well as electronic claims formats that were intended to be designed to be less constrained than the paper formats, provides a conceptual, regulatory, and technical framework to reduce or eliminate much attachment use. Although the HIPAA transactions recently implemented provide a standardized format to transmit a claim, the data requirements of each payer are far from being standardized. Obviously, contractual provisions vary across and within specific companies resulting in different data requirements. Nevertheless the number of "companion documents" developed by the payers makes it difficult for the physicians to determine exactly what data is necessary to process a claim for each payer.

The AMA suggests that the current system for submitting claims and other transactions in the HIPAA format should be fully operational by all payers and physicians that submit electronic transactions before the claims attachment standards are adopted as HIPAA standards. As I stated previously, it is the position of the AMA that the health care industry should standardize when attachments are required and not just how they are submitted. Guidelines also need to be established regarding the type and number of requests for information that should be permissible from payers to physicians. The attachment standard has been designed so that a payer can send an electronic request or several requests for additional information. Physicians should know up front what additional clinical information will be required for specific services so they can either submit it with the claim or when the attachment data or images are available.

The AMA also believes that there should be an organization or group, other than those responsible for developing the messaging transactions, responsible for developing the type of requests for information that should be permissible from payers to physicians as well as what additional clinical information will be required for specific services of claims attachments transactions. This organization should be representative of all parties affected by health care electronic data interchange (e.g., providers, payers, standards development organizations, regulatory agencies). Based on their structure and current and

anticipated responsibilities, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC) are appropriate to assume this task.

The NUCC has an official operating protocol that provides full due process, open meetings, and the ability for non-members to generate agenda items. Fundamentally, data content for business processes around claims submission and claims payment should be maintained through committees, like the NUCC and the NUBC, that focus on formal, balanced representation of key parties using a consensus approach to decision-making. Maintenance of the data content and their related business functions is a policy related activity. Therefore, it should be conducted through the kind of public/private partnership that these two committees exemplify. Claims and attachment standards should not be viewed as primarily technical communications standards.

In addition, the AMA believes that standard implementation guidelines for code sets are essential for uniform national application of the code sets. If standard guidelines for medical code sets were adopted, many attachments would be eliminated. If health plans and physicians are permitted to implement and interpret medical data code sets as they see fit, the purpose of Administrative Simplification will not be achieved. An important part of Administrative Simplification and reduced regulatory hassle certainly includes the simplification of instructions for the coding of health care services. The overwhelming amount of paperwork to which physicians are subject would be significantly reduced if coding guidelines were standardized within electronic transactions. The AMA believes that the CPT guidelines and instructions should be specified as a national standard for implementing CPT codes.

The instructions and guidelines contained in the CPT Book are subject to the same rigorous editorial process used to develop CPT codes. The CPT Editorial Panel and CPT Advisors consider CPT section guidelines, specific code level instructions and definitions, and the application of modifiers at the same time the language for CPT code descriptors are developed. Thus, proper use of CPT codes is based on all the associated material contained in the CPT Book. For example; simple, intermediate, and complex repair are defined in the book prior to the actual repair codes so that users understand the circumstances for reporting each. Also, coding conventions, such as add-on codes, are explained in guidelines. The use of codes and descriptors apart from this information limits the functionality of CPT and its uniform application and contributes to improper coding interpretations which are counter to the purpose of having national standard code sets.

Therefore, the AMA strongly encourages the Subcommittee and the NCVHS to recommend that the CPT guidelines and instructions for applying the codes also be included as a national standard.

As stated previously, the AMA believes that standardization of formats and electronic exchange should reduce the costs of preparing and submitting attachments and enable physicians and the health care system to realize the full benefits of electronic data interchange and administrative simplification. However, until standardization is achieved

regarding when attachments are required and not just how they are submitted, the use of the attachment standards should remain optional and based on trading partner agreements between physicians and payers.

Thank you for this opportunity to present the views of the American Medical Association. I would be pleased to respond to any questions that you might have.

Appendix B

Michael D. Maves, MD, MBA, Executive Vice President, CEO

January 23, 2006
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

Re: *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule; 70 Fed. Reg. 184, 55990 (Sept. 23, 2005; File Code CMS-0050-P*

The American Medical Association (AMA) appreciates the opportunity to provide its views on the Centers for Medicare and Medicaid Services' (CMS) proposed rule concerning *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments* 70 *Fed. Reg*. 184, 55990 (Sept. 23, 2005).

GENERAL

We appreciate CMS's efforts to develop a proposal to implement national standards for electronic health care claims attachments, and want to reiterate our longstanding interest in working to improve the efficiency and effectiveness of the health care system through implementation of certain health information technology. We believe that the inclusion of clear standards, comprehensive provisions, and strong safeguards, will facilitate the electronic transmission of relevant health information, thus improving quality of care, reducing errors, and improving communication between payers and providers.

As CMS continues to develop national standards for electronic health care claims, the AMA wants to express its long-standing concern regarding the confidentiality, integrity, and security of patient medical record information. The AMA believes that it is critical that any electronic attachment information submitted by physicians to health plans, either directly or indirectly through intermediaries, is protected throughout the transaction process by safeguards designed to limit access to, and use of, patient information.

The AMA also remains concerned about excessive and unnecessary requests for additional information, as well as unexplained delays in processing and payment by third party payers, where a completed standard claim form for reimbursement has been submitted. For this reason, the AMA believes that this rule should provide protection from unnecessary and excessive requests for additional information.

In addition, the AMA is concerned about the lack of specificity as to time frames associated with health plan requests for additional electronic attachment documentation. To date, 49 states and the District of Columbia have state laws requiring the timely payment, and in some cases, processing, of health care claims submitted by physicians, other providers of medical care, and even patients, to health plans and other entities. The AMA feels that clarification is needed regarding how the electronic attachment standards and provisions might impact these state-based patient and provider protections.

MISCELLANEOUS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), "[a] health plan that operates as a clearinghouse or requires the use of a clearinghouse may not charge for the clearinghouse service." The AMA believes that the HIPAA provisions regarding clearinghouses should apply equally to electronic attachments. Where an electronic attachment is required for claims processing, adjudication, and payment, by a health plan that operates as a clearinghouse, or operates its own clearinghouse that must be accessed in order to submit claims and associated information to the health plan for processing, said health plan should be barred from charging for the clearinghouse service.

The AMA believes that more information regarding the result of the pilot study performed by Empire Blue Cross should be shared and assessed. Findings from the study can assist in anticipating and addressing problems that are likely to arise among physicians, transmission entities, and health plans. It will provide insight into important issues such as; the frequency with which documentation is requested both initially, and as follow-up; how easily information is shared; and how difficult it is for physicians and health care entities to implement the process. Although the study was preliminary in many ways, the AMA believes that it can offer some important insights into how the electronic attachment requirements will impact the interoperability of physician practices, as well as connectivity with clearinghouses and health plans.

II. PROVISIONS OF THE PROPOSED REGULATIONS

A. DEFINITIONS

3. CLINICAL REPORTS (pp. 55994)

With respect to the definition of Clinical Reports, the AMA proposes that Clinical Reports be changed to "Clinical Information," as this terminology is more appropriate given that the physician is generally not required to provide the entire clinical report for the patient encounter. Rather, the physician is being asked for, and is providing, certain limited clinical information deemed necessary to appropriately adjudicate the claim.

Although not included in the definitions section of the proposed regulations, the AMA believes that in order to encourage transparency in the process of requesting additional documentation, the term "minimum necessary" must be defined through regulation. The AMA is very concerned that absent definition, some health plans may take advantage of the electronic attachment standard to unduly burden physicians with unnecessary and attainable requests for clinical patient information.

Under HIPAA "The health plan must request no more information than it determines necessary for the purpose of the request. The physician may rely on the health plan determination and is not required to make independent determination of what information the health plan needs, unless the request is clearly unreasonable." HIPAA *does not* require physicians to give the health plan the information it requests. However, HIPAA does not provide a basis for physicians to deny requests for information either. Therefore, the AMA believes that the United States Department of Health and Human Services (DHHS) should provide some guidance to ensure health plans make appropriate requests to physicians.

Consistent with the DHHS Privacy Brief, which states that "the major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities," and the DHHS Fact Sheet: Protecting the Privacy of Patient's Health Information, which dictates that "…covered entities may use or share only the minimum amount of protected information needed for a particular purpose," the AMA believes that an entire medical record should never be requested using the electronic attachment approach and format. A report or specific question regarding a report, however, would be acceptable. Furthermore, the AMA thinks that DHHS should monitor the types, and frequency, of requests for information issued by health plans via the electronic attachment regulation.

Similarly, the AMA feels strongly that the term "one request" should be defined and clarified by regulation. The AMA is concerned that under the current proposed rule, health plans could dispense to participating physicians, via website or other means, information regarding necessary electronic attachments, which would not be considered the "one request," subjecting physicians to the possibility of a second request upon claim submission. The AMA believes that where health plans have well-documented, well-established policies regarding documentation requirements, these policies should constitute, "one request," and health plans should be restricted to "one response" to the attachment information originally submitted by the physician; rather than an additional request unrelated to the submitted documentation.

B. EFFECTIVE DATES (pp. 55994)

Under the proposed rule, covered entities, other than small health plans that have 36 months, must comply with the standards for electronic health care claims attachments 24 months from the effective date of the final rule. The AMA believes that these time frames are longer than necessary and would advocate a shorter implementation period, so long as the approved electronic attachment mediums remain as proposed.

C. OVERVIEW OF KEY INFORMATION OF ELECTRONIC HEALTH CARE CLAIMS ATTACHMENTS

6. FORMAT OPTIONS (pp. 55998)

Listed in Table 1 – Human vs. Computer Variants for Electronic Attachments, are three options available to physicians for the transfer of medical information. The options include, scanned images of pages from the medical record, natural language text with captions that match specified questions, and natural language text with captions identified by LOINC® codes and supplemented by coded information. The AMA judges that all of the aforementioned options should remain available to physicians. Solo and small physician group practices may need to rely on the faxed and/or scanned image option indefinitely due to the unavailability, for financial, staffing, or geographic reasons, of sophisticated information technology. The AMA is also concerned with the suggestion that small physician practices will adopt electronic medical records (EMR) in the near future. Decreasing reimbursements and increasing administrative costs are preventing physicians from acquiring the capital needed to invest in EMR technology, notwithstanding the establishment of pay-for-performance incentives by payers. Such flexibility, accompanying standardization, will ensure a smooth transition to the use of electronic attachments.

D. ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT BUSINESS USE (pp. 55998)

The proposed rule states that post-adjudication processes are not part of the electronic attachment requirements process. The AMA agrees with this approach. The AMA also believes that health plans should be prohibited from requesting additional information tied to post-adjudication processes when physicians have submitted additional documentation for the claim in an electronic attachment format. Any request and subsequent provision of information that meets the minimum necessary requirement should prevent a health plan from post-adjudication requests for additional information. Likewise submission of such information should limit a health plan’s ability to deny or retract payment based on deficient documentation.

2. SOLICITED vs. UNSOLICITED ATTACHMENTS (pp. 55999)

Pursuant to HIPAA, "[a] health plan may not reject a transaction because it contains data that the health plan does not need." The AMA believes that this prohibition should apply with equal force to electronic claims transactions. Furthermore, the AMA believes that what has been defined as "unsolicited requests" should be acceptable when a health plan routinely requests additional information for certain claims and/or when a health plan disseminates information regarding required documentation. When physicians know what documentation is required they often submit the necessary documentation in advance of a request. Such efforts should be encouraged rather than penalized, as they will facilitate the exchange of claim information and expedite the adjudication and payment process. In fact, the AMA believes that health plans should be required to request, in advance, that additional documentation (electronic attachments) accompany certain types of claims and should provide this information initially or whenever a change is made regarding required documentation.
The AMA further believes that requests for additional documentation should be required in only certain limited circumstances and should be narrowly tailored. The AMA is concerned that health plans, under the proposed rule, will fail to be judicious in their requests for additional documentation, causing enormous burdens on physicians. Payers should recognize and respond to all claims and should be permitted to ask for additional information only when such information is deemed necessary based upon the physician's response to the first request. Failure to prohibit payers from continually and repeatedly requesting additional information from a physician for a single claim will undoubtedly result in significant delays in claims adjudication and payment, as well as untoward administrative hassles. Health plans should be permitted one request for information and then a second request if, and only if, the second request is based upon information garnered from the response to the first request. However, the AMA cautions that even this proscription could lead to situations in which an initial request and response generates dozens of follow-up requests and responses. Thus, the AMA feels that there needs to be a definitive point at which no additional information can be requested and/or has to be provided.

Finally, the AMA is concerned by the provision that indicates physicians can send only one attachment per request. In situations where some, but not all, of the information requested is available, physicians should be permitted to submit the accessible information initially in order to commence the adjudication process. Such a procedure has the potential to lesson any unnecessary delays associated with the request for additional information.

3. COORDINATION OF BENEFITS (pp. 55999)

The AMA believes that as suggested above with regard to primary health plans, secondary health plans should be required to inform physicians on its physician Web site or through other means of information dissemination, what its documentation requirements are for certain claims. The AMA does not believe that the primary health plan should receive the secondary health plan's requested information either directly from the physician or indirectly from the

secondary health plan. Requested information and the responses to these requests should remain separate when a coordination of benefits issue ensues. The AMA believes that even if the primary health plan and the secondary health plan request the same information be sent via electronic attachment, the physician needs to directly provide each of the plans the requested information in a separate claims transaction.

4. IMPACT OF PRIVACY RULE (pp. 55999)

The AMA strongly believes that physicians own all claims data, transactional data and de-identified data created, established, and maintained by the physician practice, regardless of how and/or where such data is stored. The AMA deems physician ownership of health data to transcend claims data, and to include any data derived from a physician's medical records,

electronic health records, or practice management system. It is the physician, acting as the trusted steward of protected health information, who is required to maintain and safeguard patient health information that is submitted as part of an electronic attachment response to a health plan request for additional documentation. For this reason, the AMA strongly advocates that this rule include prohibitions against using the additional information submitted as a result of electronic attachments, for any purposes other than adjudication and payment. Such prohibitions would protect against third parties establishing and maintaining medical records and/or databases.

Moreover, the AMA thinks that CMS should provide guidance regarding when, and how much, information needs to be blacked out on electronic attachments. While the AMA is cognizant that certain information should not be submitted as part of an electronic attachment, it cautions that blacking out or otherwise trying to extract certain information can often create additional barriers to electronic transactions and further burden physicians.

In addition**,** under section 1178(a)(2)(B) of the Social Security Act and section 264(c)(2) of HIPAA, provisions of state privacy laws that are contrary to and more stringent than the corresponding federal standard, requirement, or implementation specification are not preempted. The effect of these provisions is to let the law that is most protective of privacy control. To the extent that these conflicts are implicated by implementation of the electronic attachment rule, the AMA would appreciate clarification from CMS on this issue.

The AMA also feels that included in the proposed rule should be a requirement that covered entities turn on their electronic audit trails in their practice management, EMR systems, etc., in order to allow for tracking of individuals access to the clinical record and PHI information. Typically, a vendor can easily comply with this request, as it is usually built into the software application.

Finally, as part of the Impact of Privacy Rule section, the rule states that "[f]or health care physicians who choose to submit attachment information in the form of scanned documents, efforts will need to be made to ensure that those documents do not contain more than the minimum necessary information." The AMA believes that CMS should clarify that "more

than the minimum necessary information," should not include information that was previously transmitted by the physician.

5. CONNECTION TO SIGNATURES (pp.56000)

The AMA requests that any consideration of how to handle electronic signatures include guidelines and definitions that would ensure that the appropriate person in physician practice has the authority to submit responses to the health plan inquiries. This added security will help physicians monitor information submitted to the health plan. Assistance with monitoring information submitted is of particular importance as physicians will ultimately be liable for any misinformation, violations of minimum necessary requirements, unsolicited requests, and/or other adverse events that can result from submission of an electronic attachment.

G. PROPOSED STANDARDS

1. CODE SET (pp. 56004)

The AMA believes that standard implementation guidelines for code sets are essential for uniform national application of the code sets. If standard guidelines for medical code sets are adopted, many attachments would be eliminated. If health plans and physicians are permitted to implement and interpret medical data code sets as they see fit, the purpose of Administrative Simplification will not be achieved. An important part of Administrative Simplification and reduced regulatory hassle includes the simplification of instructions for the coding of health care services. The overwhelming amount of paperwork to which physicians are subject could be significantly reduced if coding is standardized and electronic transactions are facilitated. Thus, the AMA believes that the CPT guidelines and instructions should be specified as a national standard for implementing CPT codes.

The AMA believes that it is difficult for the industry to submit thoroughly comprehensive comments on the attachment standard, given the number of issues for which the Notice of Proposed Rulemaking (NPRM) is soliciting guidance and assessment. As such, the AMA is of the opinion that HHS should issue an interim final rule (or its equivalent), that includes the comments submitted in response to the NPRM's solicitations. Issuing an interim final rule that includes the submitted comments, and affording a comment period, would provide the industry with an opportunity to react to a more specific set of recommendations

We are pleased that CMS is moving forward with the adoption of standards for certain attachments to electronic health care claims and we support CMS in this effort. We appreciate the opportunity to provide our views on the implementation of the electronic attachment rule and look forward to working further with CMS on this important matter. Should you have any

questions regarding these comments, please contact Carolyn Ratner, Washington Counsel, by phone, 202-789-8510, or by email, Carolyn.Ratner@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA