NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
Subcommittee on Standards
Hearing on Electronic Attachments Standards and Operating Rules
Hubert H. Humphrey Building
200 Independence Ave, SW, Room 705A
Washington, DC 20201
Wednesday, February 27, 2013

Presented by
George Arges

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Members of the National Committee on Vital and Health Statistic's Subcommittee on Standards, I am George Arges, Senior Director of the Health Data Management Group, at the American Hospital Association. The American Hospital Association (AHA) on behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual member thanks you for the opportunity to present our views on the Electronic Attachment Standard and Operating Rules.

Attachment Standard and Operating Rules

Over the past several years the major capital investment for our hospital members has been information technology and in particular the adoption of electronic health record (EHR) systems. Another of these initiatives is the investment needed to transition to ICD-10. This effort seeks to adopt a more robust clinical code set to improve the understanding of disease and illness. Both of these efforts are at the top of our member's information technology initiatives and require a considerable resource commitment.

Today's hearings are about the electronic attachment standard and operating rules. The attachment standards are of concern to hospitals because there is a lack of a well-defined business model that can be applied to the attachment standard. It is our view that use of the transaction standard should be rare and only used when billing information is insufficient to convey an understanding of the information reported on the claim. It should never be used as a mechanism that seeks to build a database of tests or lab results or for the receiver of this information to conduct data research. If the attachment is needed for certain types of rare situations or occurrences, its use should require reporting guidelines on use and handling of this information.

Much of the data contained on the claim comes from information contained in the EHR. The same can be said of the attachment standard, in that the information being requested often looks to the EHR to obtain the additional information and therefore becomes a secondary use of the EHR. If more specific and detailed information is being requested via the attachment request, it must only occur because there is some uncertainty about the information reported on the claim in relationship to the reported diagnosis codes. Our current ICD-9 diagnosis coding system often lacks the specificity needed to help users fully understand the information reported on the claim. Once the transition to ICD-10 is complete,

we envision less of a need to request additional information via the attachment since the specificity of ICD-10 will provide the detail users need to understand the information reported on the claim.

Our first recommendation is that the NCVHS oversee development of specific guidelines that describe the appropriate application of the attachment transaction standard and the associated purpose for requesting additional information; the guideline should provide a very narrow well-defined application or purpose. This is necessary to prevent misuse of the data contained in the attachment standard.

We would also recommend that protections on access be applied to the attachment transaction standard. This is especially important if the attachment standard carries an image of the EHR page which may contain more information than requested. The protections should include Digital Rights Management (DRM) that restricts the ability to view or open the attachment document to only authorized individuals or specifically designated email recipients. Additionally, the DRM should establish a reasonable period of time for the receiver to review the attachment data and then make a decision about the claim. After this period has expired, the attachment document cannot be reopened. The DRM should also limit the ability to print the attachment document.

This is especially important because the design of the attachment standard allows a portion of the hospital medical record document to be scanned and placed digitally within the attachment standard. Since there are a number of entities handling the transmission of the document, it becomes important to provide DRM protections, to limit access and review to only those authorized representatives, as well as to limit any printing or long-term storage of that document. Such actions would be in keeping with the minimum necessary provisions of HIPAA privacy to electronic records.

Establishing DRM processes will require providers and health plans to utilize a common DRM system application. It would also require someone to manage this process, register those requesting authorization to review the attachment and log them into the DRM system. The DRM system maintainer would receive the attachment from the provider they would apply the DRM (number of days to view the document, no printing) and would then route this request to the pre-registered health plan. The DRM system maintainer would be able to track whether the attachment was opened by the authorized receiver as well as how often they opened the document during the specified period. In addition, the DRM system maintainer can issue an annual report on the frequency of use of attachments by health plans.

Without these safeguards we would be increasingly concerned about HIPAA privacy violations. It is our hope that as our nation moves toward the use of ICD-10 clinical coding and its greater specificity, the need for additional attachment information will be eliminated. I also want to remind users of the HIPAA transaction standards that there are processes in place to embellish and add new information to the claim if needed to establish greater accountability around the billed charges.

I know that the National Uniform Billing Committee (NUBC) stands ready to entertain any new coding requests that are needed for inclusion to the UB-04 data set if it further eliminates the use of attachments. In the past when the NUBC looked at revising the UB-92 data set, we surveyed users to

determine which attachment information was provided as distinct documents. Based on this information we embarked on revisions to the UB-92. As a result, theUB-04 data set was created with a number of new codes and new data elements designed to eliminate the need for many of these attachments. However, it is imperative that users of the 837 institutional claim that incorporates the UB-04 data set, have programmed their systems with the necessary edit logic to understand all of the UB-04 codes and their meaning. **Any requests for attachment information that is already codified on the claim (837i) should be prohibited.**

Operating Rules

The AHA is supportive of operating rules, but in the case of attachments, I would urge that a model framework that includes guidelines and DRM management be established first. This is particularly important since operating rules generally seek to adopt the "best practices" associated with a particular transaction. In this case, the attachment as a HIPAA standard has not been in use for a significant period of time, does not have the protections that I mentioned earlier, and most importantly, we do not yet have operating rules for the claim standards. **The AHA recommends that operating rules for the claim standards be issued first to demonstrate adherence and functional capability of users to handle the full array of codified information on the claim.** Additionally, with the implementation of the ICD-10 coding system we may see a significant decline in the need for more information since greater specificity about the disease, illness, or procedure are part of the new clinical coding system.

I want to thank the NCHVS for the opportunity to share our comments and concerns about the attachment and corresponding operating rules. Should you have any additional questions I would be happy to answer them. I can be reached by email at garges@aha.org or my telephone at 312-422-3398.