



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*

January 10, 2006

Office of the Secretary  
Department of Health and Human Services  
Attention: CMS-0050-P  
Room 445-G, Hubert Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Re: HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule, 45 CFR Part 162, CMS-0050-P, (September 23, 2005)**

To Whom It May Concern:

The American College of Physicians (ACP), representing over 119,000 doctors of internal medicine and medical students, appreciates the opportunity to submit comments on the proposed rule: *HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule*, published in the Federal Register dated September 23, 2005. This proposed rule would establish new standards for electronically requesting and sending additional health care information to support submitted health care claims data. In addition, we recognize the importance of this rule as it helps to simplify and expedite the health care claims adjudication process when additional documentation is requested to support the original claim.

We appreciate this opportunity to provide comments about the adoption of this rule as it will allow our members to reap the rewards from the standardization of the claims adjudication process. In this proposal we recognize the Centers for Medicare & Medicaid Services' (CMS) attempt to increase the adoption of information technology, however those who use the technology the least but stand to benefit the most, will face significant obstacles in attempting to comply with this proposal without some modification and additional consideration. Further, the College recognizes the potential to facilitate the auto-adjudication of claims for those who possess Electronic Medical Records (EMRs) will significantly reduce their administrative costs but the process of electronic claims attachments may present an onerous burden on providers with small offices (a significant number of our members) and therefore defeat the intention of accelerating the adoption of health care information technology and the development of the national electronic health information system.

## **SUMMARY OF RECOMMENDATIONS**

- We propose a pilot or the publication of the results of any previous pilots to fully evaluate the implications to health care providers, health plans, and clearinghouses as they attempt to comply at the *practical* level.
- We further recommend that when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.
- We propose as part of the rule that CMS consider establishing an expedited procedure for the adoption of other claims types for industry use.
- We also recommend that large imaged or scanned documents be imbedded in the X12 transaction as compressed or zipped file format. This will ultimately reduce the size of the file that will be stored on servers and computers, and in addition, facilitate the reduction of upload, transmission, and download times of the files
- In addition, we request the exemption of computerized faxes used in response to a request for additional information, as a form of electronic transmission.
- We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.
- We propose that health plans be specific about documentation needed for prior authorization of visits, procedures, and medications and if physicians requested and received prior authorization they should send the pre-specified documentation in the original claim. Prior authorization should be sufficient to adjudicate a claim and physicians should not be required to send additional information to adjudicate the claim further.
- We request (as a practical consideration) that physicians who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision.
- We recommend that there should be a standard field/code that will allow the physician to indicate that he does not have the documentation and/appeal the request.

## **GENERAL COMMENTS**

We believe the standardization of the electronic claims attachment process will speed up the adjudication of claims. This will be beneficial to health plans, clearinghouses, and healthcare providers. We are concerned however, that certain aspects of this proposal will be burdensome for many providers and will act as a deterrent to its use and ultimately the adoption of EMRs.

It is our contention that those who will reap the greatest benefit from this rule are those who have invested or plan to invest in EMRs and benefit from auto-adjudication. For these physicians the implementation of this rule will result in significant administrative savings and expedited reimbursement. However, for a significant number of our members, who do not have EMRs and choose to comply, there are aspects of this proposal that will pose significant challenges.

The ACP offers the following comments on the proposed rule:

## **SPECIFIC COMMENTS & RECOMMENDATIONS**

### EFFECTIVE DATES (p. 55994)

Though we recognize the need to standardize the claims attachment process and although this rule proposes to take effect in two years for large health plans and three years for smaller ones, we think that prior to full implementation there should be some attempt to pilot the application of this proposal to ensure that all aspects of this process effectively interact and to clarify the necessary processes for providers --- both those in large and small practices, and those using and not using EMRs --- to implement realistically these claim attachment procedures. It would also be helpful if CMS would include in the final rule the results of any pilots that have been previously conducted. Further, when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.

#### *Recommendations:*

- We propose a pilot or the publication of the results of any previous pilots to fully evaluate the implications to health care providers, health plans, and clearinghouses as they attempt to comply at the *practical* level.
- We further recommend that when and if physician compliance is required, it may be prudent to implement the rule in a graduated manner i.e. larger practices implement prior to smaller practices.

### ELECTRONIC CLAIMS ATTACHMENT TYPES (p. 55996)

We agree that covered entities need to gain experience with implementing and using an initial proposed set of claims attachment types for the initial rollout of this rule. In addition, we agree that there is a subset of information that will be common to most claims attachments. We propose that CMS should identify a standardized methodology to facilitate the adoption of other claims attachment types at a later date. We think that leaving the adoption of other types to ad hoc voluntary agreements between covered entities will negate the benefits of adopting standardized claims types and the standardization of the electronic claims attachment process. We think that there should be an expedited methodology to facilitate the development and adoption of new claims types; for example HL7 or an

appointed group of industry and provider representatives who would vet, approve, and disseminate new claims types for universal adoption.

*Recommendation:*

- We propose as part of the rule that CMS consider establishing an expedited procedure for the adoption of other claims types for industry use.

FORMAT OPTIONS (p 55997)

The *human decision variant* allows the health care provider to send electronic claims attachments to the payer as imaged or scanned documents or as narrative text for human review. You propose that this will be a benefit to small practices that do not have EMRs. We think that for many of our members this method will predominate and while this will encourage some to use the standard there are still significant hurdles to overcome: the size of files, the bandwidth for transmission, and the size/storage capacity servers etc.

For example, if large sections of the medical record need to be scanned or imaged, there will be a substantial burden on the provider to have available additional server and computer storage capacity. In addition, the upload and transmission of these large data files can be slow and inefficient if the practice does not have sufficient bandwidth. One solution to these problems is to reduce the size of the files by compressing them. The benefits of compressed or zipped files include faster upload and transmission, less storage space on servers and desktops. For this reason, the X12 transaction should facilitate the use of compressed files.

We also request that to the extent that providers transmit claims attachments using computerized faxes that these faxes should be exempted from the electronic claims attachment rule. This will be consistent and in keeping with other rules (e.g. e-prescribing rule) that have exempted computerized faxes as electronics formats.

*Recommendations:*

- We also recommend that large imaged or scanned documents be imbedded in the X12 transaction as compressed or zipped file format. This will ultimately reduce the size of the file that will be stored on servers and computers, and in addition, facilitate the reduction of upload, transmission, and download times of the files
- In addition, we request the exemption of computerized faxes used in response to a request for additional information, as a form of electronic transmission.

SOLICITED vs. UNSOLICITED ATTACHMENTS (p. 55999)

The College is in agreement with the proposal to require health plans to submit only one electronic request for additional claims information. We also agree that this requisition should contain all the questions that are minimally necessary or the health plan to adjudicate the claim. In addition, we agree that there should be an attempt to limit “unsolicited” claims attachments. However, there are certain, specific, service claims for

which health plans routinely request additional information. Nonetheless, the plans will not accept “unsolicited” claims attachments submitted with the original claims. This causes an unnecessary delay in the billing process. We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.

As a special circumstance we request that those instances where the provider requested and obtained prior authorization for a procedure, visit, or medication from a health plan that on submission of that claim, the health plan should not be permitted to ask for additional information to adjudicate the claim. In this instance, the physician will be required to attach all the necessary documentation used for the approval with the original claim.

We also agree that it is important for providers to comply with the minimum necessary standard, however it maybe impossible or impractical for medical practices to comply as shown in the following practical example:

A physician refers a patient to an orthopedist for a back problem. In theory, the physician should send the patient with a referral (if required) and the minimum necessary information for effective continuity of care. Then the patient follows up with his physician for review of his hypertension, diabetes mellitus, obstructive lung disease, and back pain. All information pertinent to the visit is recorded in the note for that day. The medical note represents a summary of all the issues related to the visit in this instance all four diagnoses. For this visit and all others the medical note represents a single integrated note, which touches on multiple issues. The managed care company sends an electronic claims attachment request, which specifies, "...please send all notes pertaining to back pain."

What is considered the minimum necessary information to comply with this request - the entire note, or just the parts of the note that are relevant to back pain? We seek further clarification considering the practical considerations and implications. For the average physician it is not often possible or practical to separate from the medical note that information only specific for back pain. If the physician complies using *Provider Scenario 1* (see page 56007 of proposed rule) all the notes, results etc that contain back pain would have to be copied, and checked for compliance with the minimum necessary provision and all information not pertinent to the request would then have to be blacked out. The final document(s) would then have to be scanned, and finally uploaded into the system as an image or Portable Document File (PDF) to be sent electronically to the health plan. In this scenario compliance with the “minimum necessary” provision would require that physicians hire additional medical records staff to function as chart redactors. If the ultimate aim is to encourage physicians to adopt electronic transmission of claims and claims attachment, we think this will represent a significant obstacle to adoption. As a possible solution, we request that physicians who respond electronically to the request for additional information with scanned or imaged documents be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision

In *Provider Scenario 4* (page 56008), the provider uses an EMR to respond electronically to the request for additional information. To an extent EMRs may make it relatively easy for physicians to separate visit notes by diagnosis, but they may not be able redact notes according to the minimum necessary standard. In other words, it may not be possible to take that note and only extract information pertinent to back pain. Again, we request that

physicians with EMRs who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision

*Recommendations:*

- We recommend that plans be required to be more transparent about situations that routinely require additional documentation and that this documentation should be accepted as part of the initial claim.
- We propose that health plans be specific about documentation needed for prior authorization of visits, procedures, and medications and if physicians requested and received prior authorization they should send the pre-specified documentation in the original claim. Prior authorization should be sufficient to adjudicate a claim and physicians should not be required to send additional information to adjudicate the claim further.
- We request (as a practical consideration) that physicians who respond electronically to the request for additional information be afforded a well defined, practical safe harbor regarding the “minimum necessary” provision.

PROVIDER vs. PLAN PERSPECTIVE (p. 56001)

There are instances where the health plan will request additional documentation to adjudicate a claim; however, there is no provision in the proposed rule to allow the physician to indicate that he does not have the required documentation and to appeal the request.

*Recommendation:*

- We recommend that there should be a standard field/code that will allow the physician to indicate that he does not have the documentation and/appeal the request.

ATTACHMENT CONTENT AND STRUCTURE (p. 56001)

To reduce the size of files facilitate the incorporation of compressed data files (see *FORMAT OPTIONS* above)

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS (p. 56013)

There should be an expedited process to facilitate modifications and new attachments especially if they conform to previous standards. There should be a clear roadmap to guide the modification of existing types and the introduction of new claims attachment types. If they go through a SDO such as HL7 and are consistent with previous standards then their adoption as standards should be expedited. Also see *ELECTRONIC CLAIMS ATTACHMENT TYPES* above.

## CONCLUSION

The College applauds any attempt to encourage healthcare providers, clearinghouses, and health plans to adopt health technology and ultimately build the healthcare information technology infrastructure. The electronic claims attachment proposal is one element that will help our members to implement technology in their clinical practice. However as outlined about there are many considerations that we think CMS should take into account.

Again, the ACP greatly appreciates this opportunity to comment on the proposed standards. Please do not hesitate to contact Dr. Mureen Allen., Senior Associate, at (202) 261-4539 or [mallen@acponline.org](mailto:mallen@acponline.org) if you have any questions regarding these submitted comments.

Sincerely,

A handwritten signature in black ink that reads "Joseph W. Stubbs". The signature is written in a cursive, flowing style.

Joseph W. Stubbs, MD, FACP  
Chair, Medical Service Committee