Claims Attachments for HIPAA

WEDI National Conference
May 19, 2004
La Jolla, California
Claims Attachments for HIPAA

Presented by:

Maria Ward, PricewaterhouseCoopers, Co-Chair
HL7 Attachments SIG

Wes Rishel, Gartner, Immediate Past Chair, HL7

Don Bechtel, Siemens, CoChair WEDI SNIP,
Chair AFEHCT
Claims Attachments for HIPAA

- High Level Overview
- The standard recommendation:
  - X12 277/275
  - HL7 Clinical Document Architecture (CDA)
- (Don’s Talk)
- Issues
High Level Overview

- Maintains principles of original approach & continues to support prior industry recommendations:

  **WEDI Attachment Workgroup Report, 1994 Recommendations:**
  - Standardize attachment data elements
  - Coordinate affected entities to develop guidelines
  - Work with Medicaid to standardize/eliminate attachments
  - Develop 274/275 as primary vehicle
  - Create standard way to link data across transaction sets
“Go forward” Plan was based on results from Proof of Concept (POC) Team

- 5 Medicare contractors funded by HCFA to develop Electronic Request for Information
- 1997 began considering options for Claims Attachments as response to request - April 1997 approached HL7
- August 1997 POC Team joined HL7 and helped to form ASIG
- ASIG solicited industry input before moving forward
Industry outreach recommendations

- Determine most frequently used Attachments
- Consider Attachments where HL7 messages already exist / in development
- Need to “Standardize” the questions payers ask - industry consensus required
- Form “Attachment workgroups” by soliciting help from all sectors of industry (e.g. payers, providers, National Associations)
- Use LOINC codes
Organizations and Documents

ASC X12 & Subcommittee
X12N

X12 Trans. Sets
277, 275

X12N Impl. Guides
277, 275

Health Level Seven

HL7 CDA

HL7 Additional Information Message Impl. Guide

LOINC Consortium

LOINC Codes

HL7 Attachment Impl. Specs

*LOINC codes may be omitted in some attachments.

© Copyright 2004, Health Level Seven
Unsolicited Attachment

Provider

Deliver a service

Submits a claim with Supporting Documentation

X12N 837 + X12N 275
Additional Information

Payer

Sufficient to Pay?

Yes
Pay the claim

No
Deny the claim

© Copyright 2004, Health Level-Seven
Request for Additional Information (Solicited)

Provider:
- Deliver a service
- Provider submits a claim
- Assemble supporting documentation
  - X12N 277 Request for Additional information
  - X12N 275 Additional Information

Payer:
- Need more info to pay?
  - Yes:
    - Request additional documentation
  - No:
    - Pay the claim
- Sufficient to Pay?
  - Yes:
    - Pay the claim
  - No:
    - Deny the claim
Applicability

Claim Attachment Transaction usage requirements – same as previous transactions

✓ Provider has choice to:
  • Request 277 from payer
  • Respond to request via 275/HL7

✓ Payer has responsibility to:
  • Create 277 when provider elects to receive it
  • Receive & process a 275 / HL7 when providers elect to receive it

**Assumptions based on requirements of previous HIPAA transactions. The NPRM will confirm or deny.**
Attachment types ultimately selected for development and HIPAA recommendation:

1. Ambulance
2. Emergency Department
3. Rehabilitative Services
4. Lab Results
5. Medications
6. Clinical Notes
Brief Description: Role of X12N Transactions
Overview…X12N Transactions

- X12N 277 – Health Care Claim Request For Additional Information Implementation Guide (IG)
- X12N 275 – Additional Information To Support A Health Care Claim or Encounter
- Original versions submitted to HHS were 004020
- Enough time elapsed to allow for developing new version – 004050
- Expected to submit to HHS April 2004

© Copyright 2004, Health Level-Seven
X12 N 277 – Health Care Claim Request For Additional Information Implementation Guide (IG)

- Based on same standard 277 transaction set as claim status response
- Used by Payer to request additional information about a claim
- Claim control number in 277 links back to the claim for re-association
- Uses LOINC codes - specificity of request
X12N 275 – Additional Information to Support a Health Care Claim or Encounter (IG)

- When claim & attachment sent together: attachment Control number (TRN) ties back to 837 (PWK)
- When attachment in response to 277: payer’s control number is in the TRN. Ties back to payer’s control number from the 277
- BIN segment holds HL7 claims attachment information
- BIN segment recommended maximum size = 64 MB
Technical Recommendation...HL7
Background

◆ “Big” issues--policy
  - payers who want flexibility on what can be asked
  - providers who want no requirement for attachments
  - providers sending “the entire chart”

◆ Issues manageable through technology/standards
  - predictable content
  - structured vs. unstructured vs. document image
  - coding system for attachment questions
    • versus nothing (i.e., unstructured)
    • versus X12-enumerated codes (i.e., limited and simple)
  - syntax
Revised Approach

- Original approach based on HL7 Messaging, “EDI-like”
- New Approach (described here):
  - Based on XML
  - Low impact option for providers
  - Low impact for payers
  - Suitable for EDI and Web-based approaches
Structured Data: Must We Sell the Future to Gain the Present?

Present (near future)
- limited ability of providers to provide structured data
- limited ability of payers to use structured data
- ROI available by saving People, Paper, and Postage

Future
- increasing levels of autoadjudication
- better medical management
- more extensive collection of quality data
- requires structured data

There is a way to have both!

© Copyright 2004, Health Level-Seven
“Legacy” Syntaxes
- HL7 v2 and X12
- Only dealt with through mappers
- Awkward for dealing with text
- Will be used for many years
- Not the best choice for new endeavors

XML
- Was “the future” in 1998
- Ubiquitous low-cost tooling plus part of most mapping products
- XSL = auto-rendering
- equally at home with structured data and text
- Currently the syntax of choice for new endeavors, especially Web-based endeavors
Henry Levin, the 7th is a 67 year old male referred for further asthma management. Onset of asthma in his teens. He was hospitalized twice last year, and already twice this year. He has not been weaned off steroids for the past several months.
The CDA Standard

- ANS HL7 CDA R1.0-2000 includes:
  - Description of the CDA framework
  - Header
- CDA Body – Level One
  - ongoing work for levels two and three
  - would be nice, but not necessary for attachments
HL7 Clinical Document Architecture (CDA)

- CDA is an XML document specification set
- Objective: standardization of clinical documents for exchange using XML
- XML markup is application independent
  - HIPAA guiding principles
- Markup is metadata added to data (discrete elements, narrative text, images)
- Markup provides information persistence and processability across applications

© Copyright 2004, Health Level-Seven
“Human-Decision” vs. “Computer-Decision” Variants

Human-Decision Variant
- Matches the most prevalent workflow: a person reviewing the information to make a decision
- “Low-impact” on health plans (easy to display using common tools)
- “Low-impact” on providers (supports low-cost document preparation and “fax-like” use of existing paper or document images)

Computer-Decision Variant
- Permits computer-assisted adjudication or autoadjudication
- Includes specifications for breaking data down into computer-accessible elements
- Includes LOINC codes to identify the questions
- Includes answer codes suitable to the question
- Processable in “Human-Decision” mode by health plans that have not adopted a computer-decision approach.
- Can be applied selectively, one attachment at a time.
What is LOINC?

- Logical Observation Identifier Names and Codes
- Universal names and ID codes for identifying
  - laboratory and clinical test results
  - other information meaningful in claims attachments
- Freeware -- sponsored by National Library of Medicine
- Specified for clinical interfaces by Federal Consolidated Health Informatics (CHI) committee
- Owned by
  - Regenstrief Institute
  - Logical Observation Identifier Names and Codes (LOINC) Consortium

© Copyright 2004, Health Level-Seven
LOINC: Identifies Information

- **Identification:**
  - What follows is the diagnosis (LOINC 27754-1)

- **Content:**
  - The diagnosis is “diabetes” (ICD-9-CM 250.00)

- **LOINC codes identify information in:**
  - 277 (Questions)
  - 275 (Answers)
  - CDA (Document type)
  - Computer Decision Variant (Captions = Answers)

© Copyright 2004, Health Level-Seven
Why LOINC?

- POC pilot in 1996 revealed that Claim Status Reason Codes were not effective in requesting information from providers
- Using LOINC lets us be very specific when needed
- LOINC already had many codes needed for Claims Attachments
- LOINC consortium was very accommodating regarding special code requests
LOINC and RELMA

- Universal Identifiers for Lab and other Clinical Observations
- Maintained by Regenstrief Institute & LOINC Committee
- For FREE Code Set and User Guide go to: www.regenstrief.org/loinc
- Relma Utility Program helps to navigate LOINC database FREE at www.loinc.org/relma
- Used to Identify Question in the 277 and the Answer in the 275
CDA: Semi- or fully-structured HIPAA Claims Attachments

Provider

Scanned Paper or Document Imaging

Transcription

Specific XML forms

Level 3 CPR

Payer

Image + XML

Semistructured

Structured and coded

Autoadjudicate

© Copyright 2004, Health Level-Seven, Source: Gartner Research
What Happens to Computer-Decision Structure?

- Providers "may" code the details with LOINC codes if they "can", but initially have no incentive to do so
- Payers "can" ignore the LOINC detailed codes -- indeed they will do so automatically if they use the viewing stylesheet
- Payers that choose to auto-adjudicate claims in a process that includes attachments will announce to providers that those that choose to add use structure and detailed LOINC codes will have their claims adjudicated faster
  - no need for a new standard at that time
  - the move to the higher level is incentive-based
Provider Readiness

- **Highest IT Ability:**
  - Next-generation patient accounting, integrated with next-generation computer-based patient record
  - Structured clinical data available on-line and tightly integrated with revenue cycle

- **Intermediate:**
  - Some medical record data on-line, often in image format, much data only in chart
  - Separate but competent patient accounting

- **Better practices**
  - Clinical data only in chart
  - Modern billing system with integrated HIPAA EDI

- **Too many practices**
  - Clinical data only in chart
  - Billing system integrated through print images or using DDE billing

© Copyright 2004, Health Level-Seven
Low Impact Provider Approaches

- **Highest IT Ability:**
  - Create computer decision variant

- **Intermediate and better practices:**
  - Patient accounting or 3rd-party vendor (e.g., integration broker)

- **“Too many practices”**
  - “DDE” Web-based support
    - payer
    - clearinghouse (has standard output)
  - Attachment-specific solutions
    - low cost of development
    - Microsoft InfoPath, Adobe Accelio
    - Still requires EDI or clearinghouse for submission
Low-Impact Payer Approaches

- **Lowest development cost**
  - Print attachments and handle the paper as today
  - *not* lowest operational cost, although less expensive than receiving paper

- **Document management system in place**
  - Integrate mapper with document management system, creating human-readable images in the DMS
  - Pass key to DMS entry to claim suspense system

- **No document management system**
  - Get a document management system, or
  - Save incoming attachments on Web server and pass the URL to the claim suspense system + self-develop records management functions
A Vendor Perspective
On Implementing
Claim Attachments

Presenter: Don Bechtel
Siemens Medical Solutions Health Services
Healthcare Data Exchange
A footnote to this presentation.

This is not a SIEMENS Presentation, rather it is an industry perspective as seen by many vendors.

This may appear negative, but it is intended to build awareness about the potential implementation issues we must resolve.

I believe the vendor community does believe this transaction is needed and that it will help improve the healthcare system efficiency.
Type of Vendors

- Large Hospital Information Systems (HIS)
- Medium HIS
- Small HIS
- Departmental Systems
  - Laboratory
  - Radiology
  - Pharmacy
  - Clinical Care
  - Longitudinal Care Records/Respoistory
  - Medical Records – HIM – EHR
  - Others

© Copyright 2004, Health Level-Seven
Type of Vendors Cont’d

- ASP System for Hospital Systems
- Large Group PMS
- Small Provider PMS
- ASP Systems for Small Providers
- Billing Services
- Clearinghouses which may provide some of the above (HIPAA vs Non-HIPAA)
- The industry will need a variety of solutions
## Vendor/Market Type

<table>
<thead>
<tr>
<th>Applications/Departmental Systems</th>
<th>Large HIS</th>
<th>Medium HIS</th>
<th>Small HIS</th>
<th>Lg Grp PMS</th>
<th>ASP Sm PMS</th>
<th>Sm PMS</th>
<th>Billing Svc’s</th>
<th>Clearinghouses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Billing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records (EHR)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Imaging</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longitudinal Care Rec’s</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scanners</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paper Records</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**X = Likely**  **X = Less likely**
## Integrated Solutions

<table>
<thead>
<tr>
<th>Applications/Departmental Systems</th>
<th>Large HIS</th>
<th>Medium HIS</th>
<th>Small HIS</th>
<th>Lg Grp PMS</th>
<th>ASP Sm PMS</th>
<th>Sm PMS</th>
<th>Billing Svc's</th>
<th>Clearinghouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Billing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clinical Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records (EHR)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Imaging</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longitudinal Care Rec’s</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scanners</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paper Records</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**X = Likely**  
**X = Less likely**
Large to Med. HIS Vendors

- Will look to provide work flow integration
- May include Small Practices and Clinics when owned by hospital
- But, data will be in many places
  - In many different states
- Semi-Manual solutions may work, but will be disruptive
  - This could be a good first step
  - But, what will the impact be to the vendors?
    - Is this what our customers expect?
    - Will the vendors be criticized for not doing more?
    - Should these solutions be left for smaller niche vendors?
    - In the vendor community who will/should take the lead?
Small HIS to Small PMS

- Semi Manual solutions may be the best solution
- Will cost some practices additional money to implement
  - Purchase scanners and store data
  - Will have to purchase some kind of software to interface scanned documents into the HL7 CDA Message and X12 275 envelope transactions
Large HIS vendors will have many integration issues:
- Cost to develop may be much higher
- Cost for solutions or products will be higher than semi-manual solutions
- Time to market will be longer
- Most large HIS environments have multiple vendors supplying departmental systems
  - Will introduce integration issues/APIs
  - Data flow and data content issues to construct complete messages
- Vendors need to ask, “What does customer want?”
  - What will the customer be able to do on their own?
Where is the data?

When a request is made for additional data, where will the data be found?
- Is it with Medical Records?
- Longitudinal Repositories?
- Still in the Departmental Systems?
- A combination of the above?
- Which system should be queried?
  - Where should the query be initiated from and by whom?
- Will a user interface be needed to make these decisions?
In some cases the recipient of the 277 may not be the entity with the data?

- Billing Dept, Billing Services or Clearinghouses
- How will these requests be forwarded to the provider?
- Will the provider environments be fragmented?
  - How will the Billing Service or Clearinghouse know where to send?
  - Will the provider need to receive all requests then determine where to send requests?
    - More systems to develop.
    - What approach should the vendor take or assume?
What format is the data in?

- Depending on where the data resides, formats could be different.
  - Should the data formats be converted?
  - Will payers have specifications requiring only certain acceptable formats?
  - If images are used (Scanned or documented images), will the data be too inclusive?
    - Will we have minimum necessary issues?
Code Sets Concerns

- LOINC is the right code set for requesting and sending information
  - But, is this widely implemented in the vendor systems today?
  - Will we need to translate between LOINC and other code sets and will these translations work?
  - What about other coding structures, will payers again require codes within the data that may need to be translated or added?
    - Are these problems reduced or increased with CDA?
  - Impact and timing of ICD-10 and/or SNOMED direction
Financial & clinical systems must interface

Applications will need to define APIs

Will the industry be able to provide these fast enough for vendors/users to integrate?

Will we need to test –
  – A proof of concept within the enterprise?

Will we need to have standards for these APIs or will each vendor invent their own?
If a Clearinghouse is providing EDI services – will they get the 277?

What will they do with the 277?
- Opportunity to provide ASP services
  - But data collection will be disconnected and manual
- Opportunity to integrate with Claim Workstations
- Opportunity to integrate with provider based applications
  - Data collection may be more integrated
  - But will depend on the capabilities of the provider
  - Time and cost will still be an issue
Billing Services

- May have the same issues as the Clearinghouse
  - If claim status goes to the Billing Service
  - Will the 277 go here too?
  - How will this be forwarded to the provider?
  - What will the provider do?
Impact of EHR

◆ For more highly integrated solutions:
  - EHR will allow better collection of discrete data
  - More highly integrated systems may need this in place
  - Adoption of EHR will be key to success
  - Imaging of Medical Records will help but data may not be as discrete
AFEHCT offered a number of recommendations for implementation

Including multiple pilot projects to explore some of the issues that will be encountered

- Highly integrated solutions
- Limited integration
- Semi-Manual solutions in large environments
- Clearinghouse and Billing Service issues
Recommendations

- We need vendor and industry consensus on how to proceed with interoperable solutions
  - AFEHCT & WEDI should work to build this consensus
- Consider following AHIMA timelines for “true HER”
  - 2008-2010
Issues & Industry Approaches to Addressing Them
Issues

◆ Other issues: Payer

  - Unsolicited Attachments:
    • Privacy concerns: if provider sends unsolicited attachment (& payer doesn’t need) or sends more information than needed
    • Workflow concerns: maintaining & storing data
  - File size limitations
  - Can translators handle the combined standard?
    • Some on record as supporting X12/HL7 combined standard
    • Several already demonstrated in various demos
  - Desire for pilot testing
Other issues: Provider

- Electronic Claims Standard but no Attachment Standard
  - HIPAA brought providers a standard way to submit electronic claims but some have a significant percentage that require attachments. These claims must still be submitted on paper
- Desire for standard attachment content requirements
- Can translators handle the combined standard?
  - Some on record as supporting X12/HL7 combined standard
  - Several already demonstrated in various demos
- Need for pilot testing
Many industry organizations working together to determine and address other issues:

**HL7, X12, WEDI, AFEHCT, HIMSS**

- Vendor awareness and education project
- Possibility of coordinating pilot project(s) – too soon to know if this can be accomplished without government funding
- Goal would be to have diverse group of payers, providers, vendors engaged
- HL7-IHE Demo HIMSS ‘04 -- debriefing report at:
Working to resolve issues

HL7 and WEDI SNIP Collaboration

- National educational effort through webcast series
  - Initial webcast April 13, 2004
    - FAQ available on WEDI website
  - Subsequent webcast June 15, 2004

- National effort to conduct survey of industry stakeholders
  - Validation of initial attachment types
  - Additional attachment needs
  - Other
Timeline...\textit{dates subject to change}

- August 1996: HIPAA Enacted
- January 2000
- September 2003: Finalize Ballot
- December 2001: Amended HL7 Specification
- January 2003: Proposed New Approach
- May 2003: ASIG Decision to Go Ahead
- September 2003
- Spring/Summer 2004
- December 2001
- January 2000
- August 1996
- Early/Mid 2007: Compliance
- Fall 2004(?): NPRM?
- Increased Industry Awareness
- Finalize Ballot
- Proposed New Approach
- Amended HL7 Specification
- Initial HL7 Attachments Specification
- HIPAA Enacted
- Pilots and Voluntary Adoption?
Other attachments currently under development in HL7:

- In varying stages of development
  - Home Health – Claims
  - Home Health – Pre Certification
  - Periodontal Charts
  - Medicaid:
    - Consent Forms
    - Children’s Preventative Health Services
    - Other

2003 ASIG White Paper discussing the CDA for Attachments
Resources

WWW.WEDI.ORG

WWW.HL7.ORG
General information and link to ASIG

WWW.X12.org
General information and link to X12N/ TG2/ WG9 & WG5
Resources

- HHS - Administrative Simplification page
  - [http://aspe.hhs.gov/admnsimp](http://aspe.hhs.gov/admnsimp)

- Washington Publishing Company (HIPAA Implementation Guides) – includes all materials related to Claims Attachments
  - [http://www.wpc-edi.com](http://www.wpc-edi.com)

© Copyright 2004, Health Level-Seven
Contacts

- Maria Ward
  Maria.t.ward@us.pwc.com
- Wes Rishel
  Wes.rishel@gartner.com
- Don Bechtel
  donald.bechtel@siemens.com