NMEH Claims Attachment Testimony to the National Committee on Vital Health Statistics

March 3, 2004

Introduction

Thank you, my name is Penny Sanchez with Electronic Data Systems (EDS), the current Fiscal Intermediary for California Medicaid. I am also a co-chair of Health Level Seven's (HL7) Attachment Special Interest Group. Today, I am here representing the National Medicaid EDI HIPAA Workgroup, more commonly referred to as NMEH. The NMEH is divided into sub workgroups, one of which is the claims attachments workgroup. I am a co-chair of this sub workgroup along with Linda Louise Bush of Pennsylvania Medicaid. We would like to thank you for the opportunity to share our perceptions of the impending proposal for electronic claim attachments and some of our concerns and questions.

NMEH Background

To give you a little background, the NMEH was formed under the sponsorship of the Systems Technical Advisory Group of the National Association of State Medicaid Directors (NASMD) in November of 1999. It began with only 10 states participating and within six months grew to include representatives from all 50 states, the District of Columbia, and other U.S. territories. NMEH members are very active in all the HIPAA related Standards Development Organizations (X12, HL7 and NCPDP) as well as industry organizations such as WEDI SNIP and AFEHCT. NMEH members serve on the National Uniform Billing Committee (NUBC) and the National Uniform Claim Committee (NUCC) as representatives of the NASMD. Our goal is to identify HIPAA related issues common to Medicaid organizations, define resolutions to these issues, represent Medicaid as a collective group in national and state forums and to share ideas and common processes. We seek to develop processes needed to support our provider community who serve an at-risk beneficiary population. At the same time we must maintain the integrity and policies of the Medicaid program.

Medicaid Usage for Attachments

In addition to the use of supporting information to appropriately adjudicate claims according to policy and to meet specific state and/or federal requirements, Medicaid agencies see the potential to use the electronic attachment transaction for business purposes not covered by HIPAA such as:

- To adequately assess prior authorization requests
- To assess the effectiveness of special state or federal programs and to validate that program standards are met
- To support case management clinical data collection needs
- To perform post payment reviews
- To mitigate fraud and abuse within the Medicaid program.

One of the major gaps for Medicaid agencies in implementing the initial Transactions and Code Sets rule was the absence of a standard way to electronically receive the required supporting documentation needed for claims and prior authorization. The current process to receive additional information is very manual and labor-intensive, since most Medicaid agencies continue to receive attachments via paper or fax. This is both inefficient and costly for the provider and the Medicaid agency. We see the move towards electronic standard attachments as a definite improvement on efficiency in processing both claims and prior authorization requests. Although prior authorization attachments will not fall under the proposed rule, we mention it here because several Medicaid agencies such as California, Minnesota, North Carolina, Oklahoma, and Indiana may voluntarily implement electronic attachments in support of prior authorization or pre-certification requests. In addition, the national Medicaid Information Technology Architecture framework (MITA), which is currently under development by CMS, will strongly encourage states to adopt common national IT standards to facilitate interoperability, improve data exchanges between trading partners, and make better use of the internet and emerging technologies. MITA's mission is to establish a national framework of enabling technologies and processes that are specifically designed to support improved program performance for today's patient-centric, Medicaid enterprise. A critically important piece of that strategy is the development of standard claims and prior approval attachments that can be uniformly utilized and understood by everyone. We eagerly anticipate the release of a claims attachment NPRM and eventual final rule, and urge the department to release this as soon as possible so that the gap between the electronic claim and the remaining supporting documentation is closed.

NMEH Position on Current Proposal

Members of the NMEH actively participate in the workgroups at X12 and HL7 that have been developing the solution for claims and prior authorization attachments.

The NMEH fully supports definition of a standard to electronically transmit claims attachment data. By defining standard content for attachments, both providers and payers know what data content is required at the time of the encounter allowing providers to capture the appropriate data. The NMEH supports the current claims attachment approach defined by X12 and HL7. We are particularly pleased with HL7's recent decision to move away from the fully codified HL7 traditional messaging structure to the more flexible XML based HL7 Clinical Document Architecture (CDA). Since the CDA offers different levels of implementation, we see it as a definitive benefit for both providers and health plans, including Medicaid agencies. Many Medicaid agencies felt that the initial approach using only structured codified data would have posed challenges for both providers and Medicaid agencies. The fully codified model poses several operational and business challenges such as:

- Cost to implement this model is expensive and analysis needs to be performed to ensure the appropriate return on investment can be achieved
- Some provider organizations maintain their clinical and attachment data in imaged medical record systems and discreet codified data is not easily available to their administrative systems

The CDAs capability to capture either imaged documents, text data, or fully structured codified data allows both the provider and the Medicaid agency the flexibility to determine which method best meets their business model. We see this flexibility in the CDA as a means to greater participation in electronic attachments. Most Medicaid agencies anticipate the initial implementation phase for claims attachments will be limited to imaged documents and text data due to state budget limitations and system staff resource availability. As states are able to complete cost benefit analysis on various attachments types, they may choose to integrate into their processing systems fully codified capabilities in order to realize the full benefit of the structured content - the auto adjudication of claims. As with many of the Transaction and Code Set standards, Medicaid agencies need to work through the issues in operationalizing the claims attachments solution and integrating it into their current infrastructure.

The models defined by X12 and HL7 allow providers to send attachments in an unsolicited manner if the health plan or Medicaid agency has instructed the provider that the additional information will always be needed at the time the claim is transmitted. Health Plans or Medicaid agencies can also request the information in a solicited manner using the X12 277 Request for Additional Information with the appropriate LOINC value. We agree that both of these methods should be available but are concerned that the unsolicited model may result in the receipt of attachments not necessary for processing the claim. This will likely result in the need for both the Medicaid agencies and the providers to be mindful of the minimum necessary provision under the HIPAA Privacy regulation. Medicaid agenices and health plans need to be cognizant of this provision when requesting additional information under the solicited model and providers need to ensure that the data provided under both the solicited and unsolicited model adheres to the minimum necessary principle.

Concerns/Issues

The NMEH has identified the following concerns/questions:

Are we ready for XML? Some Medicaid agencies have already begun development of Web Portals and other applications using XML while others have expressed concern about the ability to forge into a new application language and technology where they have no familiarity. Most of these concerns seem to be centered around whether Medicaid agencies will have the knowledgebase, systems staff and funding necessary to support XML based applications and to make the appropriate business changes.

Can we constrain file sizes? It is our expectation that many of the attachments we receive will be imaged documents. Image files can be quite large even when captured in a compressed format. In order to maximize our efficiency in receiving batch transmissions, we believe that health plans including Medicaid agencies should be able to define file size limitations for each transmission. This allows these covered entities the ability to better handle capacity planning within their own network.

The adoption of new attachment types: The NMEH sees value in the six (6) attachment types already developed and published by HL7s Attachment Special Interest Group and expects that these attachment types will cover many of their attachment business needs.

In addition, the NMEH has been working hard over the last several years to define data content of attachment types that meet specific Medicaid needs beyond those of the six attachments already published by HL7. We have been actively participating with the HL7 Attachments Special Interest group to perform the requisite industry outreach and draft the data requirements into HL7 Additional Information Specifications. These attachment types include: Children's Preventive Health Services, Periodontal Charting, Durable Medical Equipment, and Consent Forms which cover the federally required abortion, hysterectomy and sterilizations consents. HL7 has also defined data content for Home Health attachments which several Medicaid agencies plan to use. Medicaid has identified several other types of important attachments that still require content definition. A few of these are: Non-emergency transportation, proof of timeliness, third party liability, eligibility, vision and X-rays.

The changing face of medicine requires that we adapt quickly and efficiently. In the past, many Medicaid agencies have used quickly adopted local codes to accommodate changes in policy or to accommodate new medical technologies. Under HIPAA, use of local codes is not an option and one alternative to capture this additional information may be through the use of attachments. The NMEH recognizes that the legislative rule making process takes a considerable amount of time. We encourage the Department to develop a process to adopt future attachment types for use under HIPAA in a more timely manner or to look at alternatives other than the time-intensive rule-making process to adopt additional attachment types while still allowing for the appropriate level of scrutiny and public comment on the attachment content. In the interim, Medicaid agencies may choose to use the published attachment specifications voluntarily.

Consent attachments: One of the more onerous attachment types for both providers and Medicaid agencies is the federal requirement for physical consent documents for abortion, hysterectomy, and sterilization. These requirements are defined in 42 subparts E and F (441.200-259) and 42 subparts B and C (50.201-210, 301-310) of the Code of Federal Regulations. Medicaid agencies must obtain a physical paper copy of the consent form in order to receive federal matching funds. This documentation contains several signatures validating that specific federal requirements are met. The NMEH has worked hard to define these exact requirements in an electronic attachment format so that an HL7 Additional Information Specification standard can be published. This attachment type would allow Medicaid agencies to capture the federal mandated validation requirements electronically. However, we continue to find barriers to completing this attachment definition. According to the Medicaid Division at CMS, the "wet" signature of the entities defined on the consent form must be obtained in their appropriate context before the claim can be processed and federal matching funds received. In the past, this has required Medicaid agencies to obtain paper copies of these forms. In 2003, we submitted a white paper which is attached to this testomony to CMS proposing several options to improve the efficiency of this process. The preferred options were as follows:

1. Allow the providers to retain the documentation in their office. Providers would identify on the 837 transaction or paper claim form that the document is retained in the physician's office and may be obtained on request. Medicaid agencies would perform post-payment reviews to ensure that federal

mandates are met. This method would decrease up front costs for adjudication and increase post payment review costs.

2. Allow a scanned image of the paper documentation to be submitted with the electronic attachment.
3. Allow structured codified data with an indicator for "signature on file" at physician's office.

We also explored several other alternatives such as Digital Signatures using Public Key Infrastructure, Point of Service swipe cards, SMART card technology, and biometrics. None of these methods were recommended due to cost and implementation difficulty. Unofficially, CMS has stated that they would allow an image of the entire consent form showing the "wet" signatures with the electronic attachment; however, we are still waiting for a formal response on this issue. The need to send in this data in paper format is both a burden for the provider and Medicaid payer. The NMEH continues to develop this electronic attachment in hopes that it may be able to use it voluntarily or as a HIPAA standard in the future.

Medicaid Involvement in Attachments Pilots: Medicaid payers are an integral part of the health care industry. We believe that pilots should be conducted as new transactions types are adopted under HIPAA; however, the release of an NPRM or Final Rule should not be contingent on completion of pilots. Most states are not in a position to participate in pilots at this time; however, a couple of states have expressed some level of interest in participating in pilot projects for attachments. While one state has expressed they would be willing to participate in a pilot with or without funding, others are concerned with the level of effort and costs associated with such an endeavor. Some questions they have are: Is enhanced funding available? What technical support is available during the pilot project? Who would coordinate trading partners and vendor support?

In closing, the NMEH believes that the implementation of a standard electronic claim attachment would improve efficiency for the provider process as well as efficiency for the Medicaid agencies claims adjudication process. It is our hope that as the industry moves towards more technical sophistication, the ability to use the CDA to its full potential will be realized so that claims can be auto adjudicated providing lower processing costs for providers and payers and allowing faster payment for providers.

I thank you for this opportunity to share the views of the National Medicaid EDI HIPAA workgroup and we look forward to seeing a future NPRM for claims attachments. I would be pleased at this time to answer any questions you may have.