This document contains the questions asked and the answers for the WEDI Audiocast on Claims Attachment that was conducted 13 April 2004.

1. **Is there a format for the Attachment Control Number (ACN) in the PWK segment?** Can a provider assign any alpha-numeric ID or can a Payer set a format for this field? (I.e. combined field = Rendering provider ID followed by the recipient number followed by the procedure code followed by the service date)

The ACN will be defined by the provider. It is intended to be unique among all control numbers within the claim. For example, it will not be identical to the patient account number or medical record number. Furthermore if there are two attachments associated with a claim, each will have a unique ACN. In this case, the PWK segment of the 837 would be repeated twice, each time with a unique ACN. Likewise, the LX loop (containing the BIN segment) of the 275 would also be repeated twice, with each LX loop identifying a different attachment with a unique number in the TRN.

The provider may assign any alpha-numeric ID of length between 2 and 80 characters as described in the X12N Implementation Guide.

2. **Do attachments as transmitted today (i.e. scanned images over the Internet) meet federal guidelines?**

We are not aware of current federal guidelines in this regard. With respect to the proposal described in the Audiocast, scanned images are permitted when accompanied by an XML document, as described in the HL7 implementation materials and when sent in accordance with HIPAA security measures.

The proposal can be implemented so that a provider would upload scanned images over the Internet with suitable security and key in data to identify the relevant claim and attachment. The Web server can than create a compliant CDA document and 275 transaction.

Although this is ultimately a matter of policy to be determined by DHHS, the Standards Development Organizations (SDOs) believe that the direct data entry (DDE) exception for the previous HIPAA transactions would support a transaction conducted in this manner between a payer and a provider. It clearly can be supported between a provider and a clearinghouse or a provider and its business associate.

3. **Is LOINC also used to describe the answer of the question?** Handout says it is used for both, but Wes mentioned in his presentation that "... LOINC is used to describe the request/questions BUT NOT the answer".
LOINC codes are used both in the 277 and the 275 to describe the questions and their answers.

LOINC codes describe information that is being asked or answered. If the answer is itself coded, the coding system for the coded answer itself will be different. For example, the LOINC code 27754-1 can be used in a requesting 277 or a replying 275 to indicate that a diagnosis for the patient is being requested, and that the diagnosis code is being sent back in response. While the original LOINC request code is sent back with the 275 response, the actual response itself, in other words the diagnosis code itself, will be coded in ICD-9-CM, for example if the diagnosis is diabetes, the response will have the code: 250.00. An example of how this request and response will actually appear will be provided in each attachment specification booklet.

4. If the recommended standard is X12 + HL7, where does XML come in? Is XML part of the recommended solution?

The short answer is yes, XML is a required part of the recommended solution. HL7 has multiple standards. This recommended approach is based on the HL7 Clinical Document Architecture (CDA) which is itself based on XML.

XML is a standard that describes a syntax for organizing information within documents. It is published by the World Wide Web Consortium (W3c.org). A hallmark characteristic of XML is the use of "tags" to enclose information. Tags are pairs of markers like <section> and </section> that might enclose the information in a section.

The HL7 Clinical Document Architecture (CDA), like many other standards these days, uses the XML syntax. The CDA standards documents describes how to use XML to encode clinical documents. For example, it names XML tags for the header of a document such as <patient></patient> and <provider></provider> and for the body of the document such as <section></section> and <caption></caption>. It further defines the nesting of these tags, e.g., the caption must appear within a section:

   <section>
     <caption>the caption goes here</caption>
     The section content goes here
   </section>

The HL7 Attachments specification then builds on the CDA. It specifies which of the available CDA tags must be in the header. For a specific attachment it defines what must be the content of the sections in the body.

More information is available in HL7 Additional Information Specification Implementation Guide.

5. In slide #8, it was noted that LOINC codes may be omitted in some attachments. In what case would the LOINC codes be omitted?
In transactions complying with the Human Decision Variant, LOINC codes may be omitted for captions in the body (e.g., those that identify the questions and answers). In this variant, the only LOINC code that is required is in the header, to identify the type of document being sent.

For example, consider two different instances of an ambulance attachment, one coded using the human decision variant, and one coded using the computer decision variant. Both examples would contain the following element in the header:

```
<document_type_cd V="18682-5" DN="AMBULANCE SERVICE CLAIMS ATTACHMENT "/>
```

This gives the LOINC code that identifies the ambulance attachment. They would differ, however, in how information was represented in the body. The human decision variant would have the require information content, labeled in a human-readable form. For example, the name of the destination site would be represented like this:

```
<paragraph>
  <caption>EMS transport destination site name</caption>
  <content>Alfred E. Newman Neurological Institute</content>
</paragraph>
```

An attachment coded using the computer decision variant would have the same information. However, this variant would also include a LOINC code identifying the content of the answer, as shown underlined below.

```
<paragraph>
  <caption cd V="18582-7" S="2.16.840.1.113883.6.1"/><EMS transport destination site name</caption>
  <content>Alfred E. Newman Neurological Institute</content>
</paragraph>
```

6. Will the NPRM regulate the use of unsolicited 275? If not, will the NPRM prohibit the payer to specify the conditions on when the unsolicited 275 is allowable?

Only the DHHS can answer questions on policies related to the use of the 275 in the NPRM. The SDOs have prepared specifications to support the unsolicited 275, however that policy may permit or restrict it.

7. On slide #17, BIN segment max size=64 MB. Is this the max size of all BIN segments in the 275 transactions or 64MB per BIN segment?

The X12N Implementation Guide supports 64MB per BIN segment. Organizations may wish to comment on this when responding to the NPRM.

8. During the X12 recommendation presentation, it was discussed that the payer could send a 277 to request the 275 info (using the payer control
number as the method to link these), and it was mentioned that the provider could send the 275 in the same envelope with the 837 (using the provider assigned number - passed in the PWK segment of the 837). What about cases where the provider has attachments that he wants to send that apply to multiple claims - some/all of which haven’t even been billed yet because the dates of service haven’t occurred yet? Currently we allow providers to send attachments either on paper or through DDE that we link with claims which they send later through paper, DDE or electronic batch, using a key (provider, recipient ID, etc.) to match them up. From what I heard, this is not an option under the recommendations presented.

Under the current Implementation Guide an attachment used to support multiple claims (for the same patient) would be sent multiple times. This provides the payer with the ability to know easily when it can retire the attachment record. The requirement to send the attachment multiple times electronically is not as burdensome on the provider or payer than it would be to send a paper attachment multiple times.

In addition, the X12N 275 Implementation Guide requires that the 275 with the attachment data be sent within the same Interchange or file as the original claim. The guide does not allow the unsolicited 275 to be sent independently. This allows the payer to determine whether to suspend the claim or continue processing. If claims had to be suspended because a subsequent 275 might be coming, this would delay claims processing and create difficulty paying promptly.

Organizations may want to consider commenting on these issues in the NPRM.

All responses to questions in this document were provided by the presenters for the April 13, 2004 WEDI audio cast for claims attachments.