Attachments Frequently Asked Questions

Version 1.2

February 2008

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We publish this document for informational use only. We periodically make changes to the information, and will incorporate these changes in new editions of this publication. The HL7 Attachments Special Interest Group (ASIG) may make improvements and/or changes to this publication at any time.

In particular, the content of this document is not intended to contradict the standards, implementation guides, or other criteria related to the HIPAA Transactions and Claims Attachments standards. The Centers for Medicare and Medicaid Services (CMS) also maintains a FAQ website, see: http://questions.cms.hhs.gov/ On that web page, you may search for relevant questions by entering ***Claims Attachments*** into the **Search Term** box, and select **Exact search** in the **Search By** box.

We welcome your constructive feedback regarding all of the content in this document.

Introduction

This is a compilation of questions gathered during various presentations in a variety of industry forums since 2003, with responses from several of the X12N and HL7 subject matter experts. We expect to continue this process, and will update this FAQ document from time to time.

The original publication represented an attempt to answer 35 questions in anticipation of the potential requirements to be published in the HIPAA Claims Attachments Notice of Public Rule Making (NPRM). Responses were prepared by the members of the HL7 Attachments Special Interest Group (ASIG) and the X12N Work Group 9, based upon the HL7 and X12N standards proposed to the Secretary of the Department of Health and Human Services (DHHS).

By the time of the NPRM (September, 2005), new versions of the standards were under development that reflected solutions to identified problems and improved messaging. Some of these were addressed in comments to the NPRM, which led to recommendations to the Secretary to name later versions in the final rule. As these standards have evolved so have the original answers. This version represents the efforts of the ASIG, and X12N WG9 members, to reflect the advances in the standards and changes to any of the context within the standards or proposed attachments.

How to submit questions

We welcome your questions and feedback. A special HL7 email address has been set up for this purpose, and you may also send your questions to the chairs of the ASIG – see: http://www.hl7.org/ASIG#faq, or mailto:ASIGfaq@HL7.org.

Revision History

Revision	Date	Description
0	9-22-2005	Initial publication of 35 questions and answers, gathered through various public presentations circa 2003-2005. Teams within the HL7 ASIG and X12N WG9 formulated the answers. An additional 10 questions were on file but unanswered. **Note:** All questions and answers at this point are prior to the proposed rule (NPRM) publication, and are based upon HL7 and X12N specifications published in May/June 2004.
1	1-24-2008	Second publication (draft version 1.1, for X12 review); introduces a new cover page and additional preface information, updates many of the 35 original answers, and adds 10 new questions and answers to reflect current information (e.g., what was in the NPRM, current usage of CDA Release 2 and X12 v5010, etc.).
2	2-08-2008	Second publication (final); changed version to 1.2

Questions and Answers

HIPAA Claims Attachments Questions

Q1: If the recommendation for electronic claims attachments is to use an HL7 standard within the X12N 275 transaction, where does XML come in?

eXtensible Markup Language (XML) syntax is the basis on which the Health Level Seven (HL7) Clinical Document Architecture (CDA) Standard is built.

The HL7 Attachments Recommendation uses the HL7 CDA Standard. The attachment itself is carried inside the Binary Data (BIN) Segment of the X12N 275 Transaction Set.

Q2: Is it true that LOINC codes may be omitted in some attachments? If so, in what case would the LOINC codes be omitted?

In transactions complying with the Human Decision Variant (HDV), Logical Observation Identifiers Names and Codes (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.

Q3: The X12N 275 implementation guide defines a recommended maximum of 64 megabytes (MB) for the BIN segment. Is this the maximum size of all BIN segments in the 275 transactions or is it 64 MB per BIN segment?

The X12N 275 Implementation Guide recommends 64 megabytes (MB) per BIN Segment. This BIN Segment can be repeated by repeating Loop 2000A in the transaction set.

Q4: The current recommendation supports the payer sending a 277 to request the 275 information (using the payer control number as the method to link these), and the provider sending the 275 in the same envelope with the 837 (using the provider assigned number - passed in the PWK Segment of the 837). Is it possible to use one attachment to satisfy multiple claims, some of which may occur in the future?

No, each claim must have a uniquely identified attachment. Therefore the same attachment would be resent with each claim.

Q5: What is the state of vendor readiness for HL7/ X12/ XML?

HL7 is working with other industry organizations to determine vendor readiness. There is ongoing collaboration with the Workgroup for Electronic Data Interchange (WEDI) to provide the healthcare industry with an educational program for electronic claims attachments.

Ultimately each covered entity needs to work with their vendors to assess the implementation approach that is best for them.

Q6: Will acknowledgements be required?

Only the Department of Health and Human Services (HHS) can answer this with any authority. HL7 and ANSI Accredited Standards Committee (ASC) X12 are currently working together to address the need for acknowledgements. Although the use of acknowledgements is not required under current Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, the use of acknowledgements is a widely accepted good business practice. We recommend using the 824 Transaction Set to acknowledge the BIN content and as a matter of principle, acknowledgements are always appropriate.

Q7: Why would a provider want to do this?

Assuming the question is about electronic attachments (vs. attachments at all) the response is similar to that for the other HIPAA transactions. Reduction of paper, introduction of standards (content and syntax) increased efficiency, ability to submit electronic attachment with claim, etc.; all lead to a return on investment (ROI) and decrease in the provider's Days Receivable Outstanding (DRO).

Q8: Will Medicare support the human decision variant or the computer decision variant?

Only The Centers for Medicare and Medicaid Services (CMS) can answer that. To date we've heard no discussion one way or the other.

Q9: Will the industry be required to implement all five attachment types at the same time, or will they be "phased in"?

We expect that trading partners will implement specific attachment types based upon their business needs. The HIPAA Claims Attachments Final Rule may provide guidance on the issue of phasing in the attachment types during implementation.

Once the work is done to support one attachment, the others should be able to follow suit fairly easily so the need for phasing in doesn't seem overwhelming.

Q10: What does a payer do with an unsolicited attachment they don't want or need?

Payers have suggested that this model of sending attachments may present workflow challenges. How a payer deals with this scenario is up to them, unless otherwise directed by HHS in the regulation.

Q11: Has there been an assessment of financial cost savings?

In order to assess financial data, a pilot project was conducted and the results published. See the Empire Medicare Services Electronic Claims Attachments Pilot at this page: http://www.empiremedicare.com/HUG/ECAPfiles/ecapindex.htm Note that the scope of this pilot was limited (using only "solicited" attachments). Quantifying cost savings for the entire Health Care industry would require additional pilot projects.

Q12: What is the percentage of claims that require attachments?

The percentage of claims that require attachments varies from payer to payer and is based on business needs and requirements.

Although the respondents were limited, an industry survey conducted in 2005 provides insight into usage of claims attachments by the health care industry.

See the summary and final report on the WEDI website, here: http://www.wedi.org/snip/public/articles/dis_viewArticle.cfm?ID=352

Q13: Would it be valuable for WEDI SNIP to write a white paper on the "best practices" from an IT perspective for attachments?

We believe that a paper written to focus on information technology (IT) best practices would be beneficial. We also believe that the business process must be addressed, either as part of this paper or separately.

Q14: What constitutes "compliance"? If the HDV is sent versus the CDV, or vice versa, are they both compliant?

Compliance was discussed in the Notice of Proposed Rulemaking (NPRM). The NPRM referenced a white paper entitled ''HIPAA and Claims Attachments: Preparing for Regulation'' which was written and published in August 2003 by the HL7 Attachments Special Interest Group (ASIG). It can be found at: http://www.hl7.org under the ASIG documents. This paper was extensively quoted in the NPRM, along with diagrams. The first sentence of the quoted text is: Providers and payers have the latitude to choose a path that suits their own balance of low/high impact vs. low/high business. We speculate that the Final Rule will address compliance and provide more specific information.

Q15: The 275 requires the transmission of structured or image data in HL7 format. Was there ever any consideration to just send a pointer/URL to an attachment held in a repository? This would address bandwidth and size issues.

As long as claims are in batch, providers will likely want to respond in batch. Regarding bandwidth issues, if a Uniform Resource Locator (URL) is sent, the payer still needs to download the document from the repository for viewing. The bandwidth usage will occur in either situation.

Q16: Can you attach multiple pages to a single BIN?

Yes, for human-decision variant (HDV) attachments, the non-XML body of the CDA document may contain multiple-page content, perhaps as a series of scanned document images in TIFF or PDF format. This combination of the CDA header and the non-XML file would be packaged together within a single BIN Segment using the Multipurpose Internet Mail Extensions (MIME) Standard.

Q17: Is there a way to send a 275 unsolicited in a separate GS and at a separate time?

When it is known at the time of billing that the additional information is required by the payer to adjudicate the claim, the provider may submit an unsolicited 275. If done at the same time as the 837, the 275 may be sent within the same interchange (ISA/IEA) as the initial 837.This situation requires separate GS/GE Functional Groups for the 837 and the 275. It may also be sent in a separate interchange.

Q18: For certain services (e.g. surgeries, emergency), providers customarily send the claim immediately and will not want to wait for the additional supporting data to send the claim.

The solicited model will support this business workflow. The provider can send the claim, and the payer, if additional information is needed, will send the provider an X12 277 to request the information.

Q19: With the introduction of yet another acknowledgement, will there be any white papers or instructions on how/when the various acknowledgements should be used? Can you provide a business model for usage?

While the description of the 102 transaction set was included in the appendix of earlier versions of the X12 275 implementation guide, the 824 is now being recommended by X12N and has support from HL7. The decision to move to the 824 was based on the Empire pilot.

It is the intention of X12N and HL7 to produce a “guidance paper” on how to utilize the 824 transaction set for acknowledgements to the 275/HL7 CDA.

Note that, while X12 and HL7 continue to work towards a solution for acknowledgements, such transactions are not currently mandated under HIPAA.

Q20: What happens to the internal audit trail with the business use of attachments?

All systems function differently. The Standards Development Organizations (SDO’s) cannot address how systems will support internal audit trails. This is a business issue for each organization, perhaps in conjunction with their business associates, to identify and resolve.

Q21: Is there a maximum number of 837's that can be sent in an ISA/IEA unsolicited attachment transmission?

The 837 implementation guide puts limitations on the number of claims allowed in an 837 (5000) and the X12N Work Groups working on attachments have no jurisdiction over the claim limitations.

While the 837 supports up to 5000 claims, each 275 will support multiple attachments for a single claim.

Q22: Which version of the 277 is used in this recommendation (4010 vs. 4050)?

Currently, the 277 as paired with the 276 as claim status request/response is the 4010 version. This is a different business use of the 277 transaction set and is a separate Implementation Guide – it is the "Request for Additional Information" implementation guide that is part of the claims attachment recommendation. Version 4050 was submitted by the SDO's to HHS for consideration in the NPRM process. NPRM comments indicated that the version named in the Final Rule should be 5010, and work was completed to publish the 5010 version. The Final Rule has not yet been published.

Q23: How do you envision an Internet-based Human Decision Variant (HDV) implementation would work for non-Medicare claims, since CMS currently has restrictions on Internet usage for health information?

The specifications neither require nor prohibit Internet usage. Wide ranges of secure Internet-based methods of information transfer are available to address this kind of implementation. For example, some batch-oriented implementations may choose secure file transports of (X12-277) queries and (X12-275 with CDA) responses. Others may work at the transaction level, in a more "real time" fashion. We expect that those skilled in the art will devise many methods of interaction, for both Medicare and non-Medicare claims and attachments, including solutions offered by clearinghouses.

Q24: Who pays for the cost of sending electronic claims attachments?

As an SDO, this issue is not within our realm of responsibility. We believe it to be a HIPAA policy issue.

Q25: (deleted)

This question/answer was deleted in the February 2008 publication as it no longer applies. In our next publication, we will insert a new question/answer in this spot.

Q26: What if comments come in about the standard specifications that necessitate changes to the documents, for example HL7?

HL7 ASIG reviewed the NPRM comments and determined that many comments merited changes to the Additional Information Specification (AIS) documents. These changes were successfully re-balloted and are being presented for inclusion in the Final Rule.

Q27: Must all attachment requests be codified?

Assuming the question is related to electronic attachment requests as prepared according to the X12 277 Implementation Guide, yes; all requests are codified with LOINC codes.

Q28: If the attachment requests are codified, the list will probably never be complete. Someone is bound to need something not yet codified.

For the five attachment types expected to be named in the Final Rule, all data content is defined in the AIS. If a payer has a need for additional data that isn't currently included in the AIS they can request an attachment through the Designated Standards Maintenance Organizations (DSMO) process and it will be considered for a future version of the applicable attachment type.

Q29: When the payer gets a non-standard response, what are the choices? Ask again, or ask differently? What is the value of a standard in this case?

Assuming the question refers to a non-standard electronic response, the response would not be in compliance with the HIPAA regulation and the payer should address this situation as they deem appropriate.

Non-compliance issues can be addressed to the Office of E-Health Standards and Services (OESS) at HHS.

Q30: When are unsolicited attachments sent? What is the impact of HIPAA privacy here? Are they exempt by the minimum necessary exemption for X12 administrative transactions?

Per the NPRM, the provider may send unsolicited attachments, if there is a prior agreement in place between the provider and payer. HL7 cannot address privacy issues. We expect HHS will again address unsolicited attachments and privacy in the Final Rule.

Q31: How is the attachment handled by the payer? Is the goal of the standard attachment being processed electronically by the payer without human intervention attainable? Are payers willing and ready to take the attachment automation step? Large payers are very different from small payers. Are vendors and clearinghouses ready to provide these automation tools?

All systems function differently. The Standards Development Organizations (SDO's) cannot address how payers will process electronic attachments. The recommendation intentionally supports an approach that works for both a lower and a more sophisticated level of technology. Payers may begin with the Human Decision Variant (HDV) at the lower level and progress to the Computer Decision Variant (CDV) over time. The CDV approach will support auto-adjudication of some attachment types.

Q32: Can we constrain file sizes?

Trading partners may constrain the overall size of a file containing the transaction sets, for example, to keep the number of transactions to a manageable number, which is optimal for both the sender and receiver of the files. The size of a single transaction may vary considerably, depending upon the size of a single attachment. X12N recommends that the BIN02 element (which contains the attachment) be limited to 64 megabytes (MB). For the Computer Decision Variant (CDV), the attachment size is very small. For the scanned-document images in the Human Decision Variant (HDV), 64MB is a reasonable limit (even with variations in the number of pages in a scanned document, the document scanning density, and several other factors). We are very interested in hearing real-world statistics in this area of "size".

Q33: How quickly can we adopt new attachment types?

Adopting new attachment types under HIPAA is a process that is governed by HHS. New attachment types created and approved by HL7 can be used among willing trading partners prior to regulatory actions under HIPAA.

Q34: Will the migration to the ICD-10 coding system reduce the need for claims attachment information?

Payers have historically required attachment data to justify payment of the claim. Even with the International Classification of Diseases, 10th edition (ICD-10) coding system, it would be a payer's business decision whether or not to require attachments and this may vary from payer to payer. At this time, it is premature to assess the impact of ICD-10 on any continued need for attachments.

Q35: Will the final rule regulate the use of unsolicited 275? If not, will the final rule prohibit the payer from specifying the conditions on when the unsolicited 275 is allowable?

The Standards Development Organizations (SDOs) have prepared specifications to support the unsolicited 275. This was done based on industry input. Per the NPRM, the provider may send unsolicited attachments, if there is a prior agreement in place between the provider and payer. We expect HHS will again address unsolicited attachments in the Final Rule.

Q36: Is there a format for the Attachment Control Number (ACN) in the PWK segment of the 837? May a provider assign any alpha-numeric ID or can a Payer set a format for this field? (e.g. combined field = Rendering provider ID followed by the recipient number followed by the procedure code followed by the service date)

There is no prescribed format, except as follows. There is always an identical Attachment Control Number (ACN) in the <inFullfilmentOf> CDA header element of the attachment document, and in the TRN Segment of the 275 transaction which envelops that attachment. Since the purpose of the ACN is to facilitate the association of an individual attachment with a specific claim, there must be some degree of "uniqueness" in assigning the ACN that meets the workflow requirements of both the Payer and Provider. In the solicited model, the Payer requests the attachment and supplies a Payer Claim Control Number in the TRN Segment of the 277 request; the Provider would then use that same Payer Claim Control Number when returning the attachment. In the unsolicited model, the Provider assigns an ACN according to its own scheme and places the ACN into the PWK Segment of the 837 in addition to the TRN Segment of the 275. There is no restriction regarding whether the ACN itself contains any intelligence such as the provider ID, procedure, or date.

Q37: What is the reasoning to allow multiple patient requests in the 277 Standard and only one patient response in the 275 Standard? Can you send multiple attachments in the 275?

The 275 Standard is specific to a single patient, whereas the 277 Standard may refer to multiple patients and claims. The 275 Standard is based upon various business criteria, for example the potential size of the attachment in the BIN Segment and the ability to match the attachment to the original claim or request. Multiple attachments may be sent in the same 275 as long as the attachments are all related to the same claim for the same patient.

Q38: Do attachments as transmitted today (i.e. scanned images over the Internet) meet federal guidelines?

We assume that whatever method is being referenced in the question, that it complies with existing HIPAA standards for Security and Privacy. Since the Claims Attachments final rule has not yet been published, we are unsure what it will say regarding any existing methods of handling electronic attachments, including any guidance as it relates to clearinghouses that may already process scanned images. While there are many ways to implement the X12-HL7 proposal within the boundary of the implementation guides, there are certain mandatory structures, which must be present for consistency across the wide range of proposed and future attachments. For example, every attachment is an XML document that complies with the HL7 CDA Standard, and some of these attachment implementations may contain scanned images when using the human decision variant (HDV).

Q39: Is LOINC also used to answer a question?

Well, yes and no. The answer itself is not a LOINC code. LOINC codes are used both in the 277 (request) and the 275 (response) to describe the information that is being asked or answered; but the answer itself is not a LOINC code. If the answer is a coded value, some other coding system would be used. For example, the LOINC code 27754-1 can be used to indicate that a diagnosis is being sent, while the actual diagnosis will be coded using ICD-9-CM.

In some cases, the answer to a single question is composed of multiple sub-parts, and additional LOINC codes are used to represent each sub-part. For example, in the Ambulance Attachment, the 277 request (codified with LOINC 15510-1) is for *"Information about the number of miles traveled during this ambulance service, type of miles, the rationale for excess/additional miles, the relevant times, and if the ambulance was loaded with a patient(s) or not."*

The answer to that single question is composed of as many as four answer parts; i.e., a "patient on board" indicator, a number of miles, a code indicating why there were excess miles, and the time the ambulance arrived on scene. Four different LOINC codes are used to distinguish these separate parts of the answer, but the actual values for the answers are: true/false, a number of miles (or nautical miles), a coded value indicating why the trip was longer, and a timestamp for the arrival time, respectively.

Q40: Where can the XSL style sheets be obtained?

The eXtensible Stylesheet Language (XSL) stylesheets and example files are available on the HL7 website, Attachments (ASIG) page, as part of the download package for this recommendation. Stylesheets are non-normative, and intended to be tailored for site-specific needs by implementers. The XML Schema Definition (XSD) schemas are available as part of the download package for the CDA Release 2.0 Standard in the HL7 Bookstore.

Q41: What if the provider needs to send the entire chart because that's what the payer requested? Can this be accommodated? Or will the payer have to request what they need "piece by piece".

It is possible to send the entire chart as part of the clinical notes attachment. See the Clinical Reports Attachment AIS for details. Note, as the Claims Attachments NPRM reminds us, the Privacy Rule's "minimum necessary" standards apply; Providers and Payers should consult the final rules for both Privacy and Attachments (when available), focusing on the term "medical record".

Q42: (deleted)

This question, which had not yet been answered, was deleted in the February 2008 publication because we could not interpret what the question was asking. We'll put a new question in this spot the next time we publish this FAQ document.

Q43: Are we ready for XML?

XML has matured very rapidly since it was introduced in 1998. It is supported by all modern mapping tools and is widely used today in many applications in healthcare and financial services.

Q44: Is the clearinghouse required to do the translation of the attachment standard?

Just as it performs translations for the other HIPAA standard transactions, a clearinghouse might also perform translations when needed for the Claims Attachments Standard. The NPRM speaks to this in multiple places; for instance, see pages 56001 and 56012.

Q45: Pilot projects – could there be funding available?

Not as far as we know. In the past, the Centers for Medicare and Medicaid Services (CMS), and its predecessor organization, the Health Care Finance Administration (HCFA) each funded pilot projects. However, the agency does not currently have funds available for additional pilot tests of electronic claims attachments.

Q46: I cannot find the Emergency Department Specification that was referenced in the NPRM; where is it?

NPRM responses indicated that the Emergency Department requirements can be met with the Clinical Reports specification and the Lab Results Specification, so the Emergency Department Specification was deleted from the suite of attachments.

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