HL7 Claims Attachments – Frequently Asked Questions

The electronic version of this document, including subsequent revisions, is available on the HL7 Attachments Special Interest Group (ASIG) web page at www.HL7.org/ASIG. Last updated: September 22, 2005

Introduction

This is a compilation of questions gathered during various presentations in a variety of industry forums during 2003-2005, 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.

How to submit questions

We welcome your questions and feedback. A special HL7 listserve will be set up for this purpose very soon, and you may also send your questions to the Attachments Special Interest Group (ASIG) committee chairs – see: www.hl7.org/ASIG.

Revision History

Date	Purpose
9-22-2005	Initial publication, 35 answers (of 45 questions we have on file), based upon various public presentations circa 2003-2005, and addressed by teams within the HL7 Attachments committee (ASIG) and X12N WG9. **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. –mike cassidy

Questions and Answers

Q1: If the recommended standard is X12 and HL7, where does XML come in? Is XML part of the recommended solution?

The XML standard is the basis on which the HL7 Clinical Document Architecture (CDA) standard is built. The HL7 Attachments Recommendation is built upon the HL7 CDA standard.

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), 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 X12 275 implementation guide maximum size for the BIN segment is defined as 64 MB. Is this the maximum size of all BIN segments in the 275 transactions or is it 64 MB per BIN segment?

The X12N Implementation Guide supports 64 MB per BIN segment. This BIN segment can be repeated by repeating Loop 2000A.

You may wish to comment on this when responding to the NPRM.

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).

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.

The current recommendation does not support this scenario because it was never presented to the Standards Development Organizations as a business need.

You may want to consider commenting on this in the NPRM if you feel it is a necessary process that must be accommodated in the standards.

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

HL7 is working with other industry organizations to target the vendor community in order to provide education and seek input as to vendor readiness.

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

Q6: Will acknowledgements be required?

Only HHS can answer this with any authority. HL7 and X12 are currently working together to address the need for acknowledgements.

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 provider DRO (Days Receivable Outstanding).

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 6 attachment types included in the recommendation be "phased in"?

It isn't the recommendation of the SDO's to phase in the 6 attachments. 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. We believe the ability to permit or restrict this will be addressed in the NPRM.

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.

You may wish to comment on this when responding to the NPRM.

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

This is another reason why pilots are needed. Until we can actually see how this will impact covered entities, it's difficult to assess the savings.

Empire Medicare Services and both Medicare Part A and Part B providers recently completed a pilot project. While the scope of this particular pilot was limited (using only "solicited" attachments), other pilots are in the discussion or early development stages. The more pilots we have, the better we will be able to assess the costs and benefits. The results of the Empire pilot will be published shortly.

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.

An industry survey was completed earlier in 2005. The summary of the survey indicates a limited number of respondents, so the results do not necessarily represent the universe of providers and payers exchanging claims attachments; however, it does provide some idea of volume for certain covered entitites.

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 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?

We believe this will be addressed in the NPRM.

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. As far as bandwidth issues, if a URL is sent, the payer still has to deal with download of the document from the repository for viewing. The bandwidth usage will happen with the EDI or the download function.

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

For imaged documents, this would be one file with the multiple pages within a single BIN.

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

Currently, the way the recommendation is written, the 837 and the corresponding attachment must be sent in separate functional groups within the same interchange envelope. The purpose was to eliminate the need for payers to have to "pend" claims waiting for the corresponding attachment.

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. 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 is included in the appendix of the currently available 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.

You may wish to comment on this when responding to the NPRM.

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

All systems function differently. The Standards Development Organizations 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 puts limitations on the number of claims allowed in an 837 (5000) and the X12 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)?

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. The SDO's have submitted version 4050 of this implementation guide to HHS for consideration in the NPRM process.

Q23: Looking at the start up with the Human Decision Variant (HDV) side where the Internet is involved, do you envision that would work for the non-Medicare side of medical claims, as Medicare currently doesn't allow this exchange over the Internet for security reasons?

We should proceed even if Medicare still has policy restrictions on Internet use.

Q24: Question about "who pays" for the cost of sending electronic claims attachments?

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

Q25: When the NPRM comes out, should people comment on the NPRM only or also comment on the IG's?

Read the NPRM, the Implementation Guides, the AIS booklets, the LOINC code set, the HL7 CDA IG, etc. Read ***all*** of the referenced documents and comment on all of them, as appropriate.

It is imperative that all areas affected by this transaction be included in the documentation review and comment. For example, an entity may wish to include individuals from areas such as IT, legal, clinical, other business operational areas, medical review etc.

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

HL7 will review comments and determine the ability to respond in an expedited manner. We have a process in place in HL7 to re-ballot in an expedited fashion if we need to.

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 six attachment types expected to be named in the NPRM, 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 either:

- Comment during the NPRM process, indicating that the additional data needs to be added to the AIS, or
- After the *final* rule is published, submit the data request 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 HIPAA Standards (OHS) 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?

Unsolicited attachments are sent at the discretion of the provider.

HL7 cannot address privacy issues. We believe HHS will address this in the NPRM.

You may wish to comment on this when responding to the NPRM.

Q31: How is the attachment handled by the payer? Is the ideal of the standard attachment 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 CH's ready to provide these automation tools?

All systems function differently. The 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?

Refer to the implementation specifications for file size requirements. See other Frequently Asked Questions for more specific information regarding specific transaction size limitations.

Q33: How quickly can we adopt new attachment types?

Adopting new attachment types under HIPAA is a process that is governed by HHS. We believe HHS will address this in the NPRM.

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?

One response to this might be that payers have historically required attachment data to justify payment of the claim. Even with the 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. However, all things considered, it may be premature to comment on this question at this time.

Q35: Will the Notice of Proposed Rule Making (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?

The Standards Development Organizations (SDOs) have prepared specifications to support the unsolicited 275. This was done based on industry input. We believe the ability to permit or restrict this will be addressed in the NPRM.

You may wish to comment on this when responding to the NPRM.

More Questions – in progress

Note: Responses to the following questions are still under consideration. We will get to these as quickly as possible – including fixing typos in the questions themselves ☹.

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)

Q37: What is the reasoning to allow multiple requests in the 277 and only one attachment in the 275?

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

Q39: Is LOINC also used to describe the answer of the question?

Q40: Where can the XSL style sheets be obtained?

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"

Q42: Slide regarding sending email notification re: 277 – issue with clients that would worry about timely filing notifications regarding ERISA and ??? – is e-mail an acceptable method of communication?

Q43: Are we ready for XML?

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

Q45: Pilot projects – could there be funding available?

Q46: (This space available - your question here? ☺)

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