

A NATIONAL STANDARD FOR HEALTH CARE CLAIM ATTACHMENTS – GAINING MOMENTUM

Due to a provision in the Patient Protection and Affordable Care Act (ACA), activity around electronic health care claims attachments is gaining momentum. ACA directed the Secretary of Health and Human Services (HHS) to adopt national standards, including Operating Rules for health care claim attachments no later than January 1, 2014 with a compliance date of no later than January 1, 2016. Health care claims attachments are supplemental documents that provide additional clinical or administrative data to the claims processor that cannot be accommodated within the claims format.

The goal of a standard for Health care Attachments is to make the process of submitting and adjudicating healthcare claims more efficient by providing structured, standardized electronic data to payers. By doing so, a receiver will have the data necessary to increase the rate of automated adjudication, and may thus reduce the administrative overhead necessary to process their transactions (i.e. claims, prior authorizations, etc).

The Health Insurance Portability and Accountability Act (HIPAA) required HHS to adopt a standard for claims attachments, but a Notice of Proposed Rule Making (NPRM) published in 2005 was withdrawn in 2010 due to technology and business need changes. That NPRM proposed the X12N 277 (Health Care Claim Request for Additional Information) transaction be used to request the additional information and the X12N 275 (Additional Information to Support a Health Care Claim or Encounter) transaction be used to respond to the request. It also proposed that Health Level 7 (HL7) develop specifications for the content and format of communicating the actual clinical information (Clinical Document Architecture – CDA).

The TMA Information Management Division actively participates in the Insurance Subcommittee of Accredited Standards Committee (ASC X12) which is working to finalize versions 6020 of the X12N 277 – Health Care Claim Request For Additional Information Implementation Guide (IG) and the X12N 275 – Additional Information to Support a Health Care Claim or Encounter (IG).

The 6020 Versions have been recommended by ASC X12 for adoption for use in the claims attachments standard.

MHS representatives from TMA and the Services also participate in the HL7 Structured Documents Work Group which creates the Clinical Document Architecture previously proposed by HHS as part of the standard for claims attachments in the 2005 NPRM. This work group continues to ballot implementation guide and attachment specifications built upon HL7 version 2.x messaging and upon the HL7 Clinical Document Architecture (CDA) standards.

"The claims attachment standard and operating rules are likely to impact TRICARE Purchased Care operations, and may impact Direct Care (MTF) third party billing operations".

Some of the most common claims attachments requested of providers by the TRICARE Managed Care Support Contractors in Purchased Care operations include:

- Ambulance Trip Reports for Advanced Life Support
- Operative Reports and Notes
- Discharge Summary
- TRICARE Hospice Care
- Physician Orders for Therapy Claims
- Certified Medical Necessity
- Office Records (Physicals)

On the Direct Care side, the Air Force reported that they are most commonly requested to provide the following types of claims attachments:

- Medical Records
- Medicare Explanation of Benefits (EOBs)
- Primary Other Health Information (OHI)/ Coordination of Benefits (COB) or auto carrier information (non-Medicare)
- Operative Reports and Notes
- Accident details or injury reports
- Certified Medical Necessity
- Informed Consent
- High Dollar Claim

To keep abreast of updates regarding the Health Care Claims Attachments standard, watch the HIPAA site for more information.

Please send any comments and questions to HIPAAATCSIMail@tma.osd.mil

HIPAA ELECTRONIC TRANSACTIONS, CODE SETS & IDENTIFIERS

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