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Gentlemen:

Thank you for providing the opportunity for the American Health Information Management Association (AHIMA) to comment to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards and Security as you review the proposed Accredited Standards Committee (ASC) X12 Version 5010 and the National Council for Prescription Drug Programs (NCPDP) Version D.0. AHIMA is disappointed that it has taken so long for this review to occur, however we are pleased to see that you are now pursuing this issue with the goal of reporting to the Secretary of Health and Human Services (HHS) shortly.

AHIMA has been advocating for upgrading the HIPAA transactions to the ASC X12 version 5010 and the NCPDP version D.0. We urge the NCVHS to recommend these upgrades to the HHS Secretary for adoption and implementation as soon as possible.

AHIMA also believes that the NCVHS should recommend to the Secretary a streamlining change to the HIPAA standards updating process, which is currently required of the Standard Development Organizations (SDO), the Designated Standards Maintenance Organization (DSMO), as well as the NCVHS and the Centers for Medicare and Medicaid Services' (CMS) Office of Electronic Standards and Security (OESS). The subcommittee should not be burdened with the task it now faces with reviewing an upgrade to transaction versions that are essentially 10 years old. No other industry works with such outdated standards. The more that our healthcare standards are held back by the current processes, the greater the associated problems with implementation and the ability to meet the information and data requirements that are currently being proposed by the healthcare industry, the Secretary, Congress, and employers.

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AHIMA is a nonprofit professional association of over 51,000 health information managers (HIM) who work in a variety of functions throughout the healthcare industry. HIM professionals are involved in functions and processes that provide or use healthcare information or data that is transferred via the HIPAA standard transactions. AHIMA and its members have advocated for the full adoption and uniform use of the HIPAA transactions, and were among those who promoted the administrative simplification cause that became part of the HIPAA law in 1996. While we do not believe that uniformity and administrative simplification have been achieved to the desired level, we continue to support the concepts behind HIPAA.

AHIMA has reviewed the questions proposed by the subcommittee and we feel that only some of the questions can be addressed by our organization. You will find our responses below. The other questions can only be appropriately answered by professionals who deal directly with the implementation of the transaction standards.

1. What is the business benefit to you in terms of moving to the next version of each transaction?

The business benefits of moving to the proposed version of the HIPAA transactions include:

- The capability for the US healthcare community to upgrade its current 30-year old classification standard ICD-9-CM:
  - The current versions of HIPAA transactions can accommodate the upgrades to ICD-9-CM, namely ICD-10-CM for morbidity diagnoses classification and the ICD-10-PCS for inpatient facility procedures and technology, however these versions cannot accommodate the descriptors needed to identify the classification field. The descriptor is needed to allow multiple classifications to be used in the transactions and therefore accommodate longitudinal information needs. The upgrade of ICD-9-CM is needed for many reasons, but most crucial include:
    - The elimination of workarounds to supply data that can be accommodated in the ICD-10 classifications but cannot be supported by ICD-9-CM, such as minimum data sets and data to determine severity of the patient for quality measurement as well as to determine levels of care rendered by physicians. These workarounds are essentially paper based and are very inefficient and expensive.
    - The ability to describe 21st century diagnoses and technology and procedures. Supplying information and detail not available in ICD-9-CM is forcing providers to submit paper-based supporting details that would be addressed by a more contemporary classification system.
    - The ability to accommodate international descriptions of pandemic and other similar disease occurrences. The US has the ability to report mortality data, but we cannot report morbidity information due to the limitations of ICD-9-CM.
    - The ability to allow the US full participation in the development of the next ICD version recently initiated by the World Health Organization (WHO) ICD-11.
    - Inclusion of ICD-10-CM and PCS requirements in software and electronic health records (EHR) as they are purchased by providers and IT professionals. Purchasers of such systems would not have to encounter a very expensive retro-fit in the future.

- The capacity of acute inpatient facilities to report “present on admissions” data required by Congress and CMS, but cannot be accommodated under the existing 4010 version.

- The ability to take advantage of improvements to the 4010 standard that have been unavailable, whereas most other software used in healthcare have had version upgrades on a regular basis, making them much easier and less costly.

1.a Are there transactions that although are currently implemented, have limited or no utilization?

AHIMA is part of a coalition that is co-lead with the Medical Group Management Association (MGMA) and the American Academy of Family Physicians (AAFP). The coalition is seeking to achieve the promise of administrative simplification. This coalition has identified the need to uniformly utilize the X12 270 and 271 eligibility transactions and are promoting the Committee on Operating Rules for Information Exchange's (CORE®) approach to these transaction functions. It is unclear to us how version 5010 will improve the use of the 270 and 271 transactions, but we believe that an improved version of the transactions will improve and increase the use of these functions, which will in turn increase the return on investment with the other HIPAA transactions.

1.b Are there transactions that you have implemented with a lot of work arounds in order to continue to meet advancing business needs?

HIM professionals consistently report the need to supply post-claims data in a variety of formats and throughout the claims cycle. This is done to accommodate limited and/or missing coded data that cannot be provided on the X12 – 837 due to its limitations. The ability to provide more detailed information that eliminates various needs for additional reporting cannot be addressed until the 4010 is upgraded. This problem also applies to pre-admission reporting (eligibility) functions and some functions such as reporting minimum data sets that potentially could be accommodated with HIPAA transactions if the additional detail could be placed on the claim or within other HIPAA transactions.

2. Industry Implementation Plan:

a. Who should develop it?
b. Should it be part of the regulation?
c. Who should enforce the progress?
d. Are there incentives or penalties to assure meeting intermediate dates?

- In past testimony, the groups involved in the SDO recommendation indicated the need for a two-year period to implement the version upgrades. Since it is the SDO membership that is deeply involved with vendors and the information technology professionals that have to engage in the upgrade, we believe they should be the ones to make such a recommendation.

- AHIMA believes that the implementation plan should not be part of the recommendation. Vendors and health IT professionals should have the flexibility to implement the upgrades with guidance from the SDOs. The value of electronic data interchange (EDI) is the ability to more efficiently update versions.

- Incentives will only be available if lack of implementation prohibits one trading partner from exchanging necessary data with another trading partner. Currently, under HIPAA, health plans would have to be capable of receiving the transactions in a version 5010 or D.0 by the "implementation by" date.

3. What are the issues for Distinct Entities?
   a. Guidance from CMS
   b. Budget cycle
   c. Developing accurate cost estimates

- Upgrading to 5010 and D.0 are technical implementations. HIPAA would require that CMS (as a health plan) indicate its status with trading partners and subcontractors. If CMS decides to issue regulations beyond HIPAA then it would fall outside the focus of this particular hearing.

- CMS /OESS can provide some interpretation of the rule, but it does not appear that CMS has the capacity to provide technical guidance to the entire industry. This would be the purview of vendors and IT professionals.

- Quick resolution and recommendations to the Secretary, as well as quick movement for any necessary federal requirements and industry education would permit the industry to budget accordingly. The NCVHS should recommend streamlining the process for standards version upgrades to permit the industry in the future to budget for upgrades and keep the cost of such upgrades down. As the NCVHS considers ASC X12 version 5010, the industry is currently working on version 5040.

- We are concerned with cost estimates and the ability to accurately project them as the industry has not experienced a change of this magnitude before. It would be beneficial to the subcommittee if the ASC X12 could provide estimates from other member industries that have gone through such an upgrade. As noted, however, the significant delay in upgrading version 4010 will make costs disproportionately high. If the process for future changes can be modified to allow for less time between changes, we would presume the cost of version changes would be reduced significantly. As we have noted often to the NCVHS, the longer version upgrades are delayed the higher the cost of conversion.

5. Overlap with other potential HIPAA changes
   a. Claims attachments
   b. ICD-10
   c. Medicare change
   d. Other initiatives

- The questions presented by the Subcommittee have identified "claims attachments" – AHIMA presumes they are referencing the ASC X12 proposal for the HIPAA "claims attachment" – as a potential overlap. We must call your attention to AHIMA's 2004 testimony recommending that the adoption and implementation of the HIPAA claims attachment be delayed. We believe:
  - The need for the claims attachment will be significantly reduced once the ICD-9-CM is upgraded to ICD-10-CM and ICD-10-PCS and its ability to describe 21st century medicine and technology as well as patient severity.
  - The data used in the claims attachment must be integrated with the data and standards included in the standard (HL7) EHR, and data, standards, and use cases identified. The claims attachment is another form of secondary data submission and as such should be going through the same discussion as other secondary data by the AHRQ, NCVHS, and AHIC.
  - The options under the claims attachment no longer fit the approaches taken by the Secretary and AHIC with regard to providing incentives for adoption of EHRs.

- Discussions that have occurred regarding ICD-10, beginning with the NCVHS hearings held in 2002 suggest that both the HIPAA transaction versions and the ICD-9-CM upgrade could be implemented within a three-year period. It is envisioned that work on the 5010 implementation would overlap with ICD-10 implementation in the second year of the 2-year 5010 implementation. Vendors have also suggested that the two implementations are not necessarily supported by the same personnel. The standards for both 5010 and ICD-10 are known and planning for such a conversion should already be underway.

- Changes to Medicare are common and some of the currently debated Medicare changes are occurring because of the failure to have the 5010 version and ICD-10 classifications in place. We expect the same to occur with quality measurement since ICD-9-CM cannot provide the detail to review quality measures with other knowledge concerning the patient, disease, and procedures/technology used. Each delay in implementation of 5010 and D.0 means more overlapping activity to support the necessary work-arounds.

6. What were the "mistakes" during the initial HIPAA implementation that we must avoid?

- The initial HIPAA implementation was made without much healthcare industry knowledge of EDI standards and occurred during a different era of healthcare information technology. The technology and knowledge of EDI has improved significantly since then.

- The implementation of the 8 HIPAA standards was the initial implementation, and was completed out of sequence from the ASC X12 recommendations. AHIMA recommends that the subcommittee seek input (via the ASC X12) from other industries who have updated EDI standards regarding their lessons learned and best practices through the implementation experience.

11. Are there other specific policy issue that should also be in the proposed rule?

If standards are to be successful, then questions such as the example given on "non-medical codes" should be directed to the SDO, and not after the standard has been approved. There are processes to adjust some of the code sets in the ASC X12 standards. If they cannot be accommodated in 5010 or D.0, then they should be submitted to the SDO for inclusion in the next version. This is one more reason why the version process must be modified to permit more consistent and frequent upgrading.

AHIMA applauds the Standards and Security subcommittee on the questions they have raised and in taking time to address this issue so the industry can make the long-awaited upgrade in the HIPAA transactions. We hope the experience of the last several years will permit policymakers to recognize the need to have processes that allow for the timely upgrading of the standards in order to keep our information systems in sync with changes and government mandates within the healthcare industry. We support any effort that can be made to streamline and modernize the process.

Now is the time to move forward with the proposed adoption of the ASC X12 5010 and the NCPDP D.0 versions. These versions are crucial to the ability of the healthcare industry to move forward and meet the President's electronic health record challenge. **AHIMA urges the subcommittee and the NCVHS to recommend that the Secretary adopt and implement these versions as quickly as possible so that implementation occurs no later than January 1, 2010. We commit to assisting the industry and the NCVHS in this process in any way possible.**

Again, AHIMA thanks you for this opportunity to provide input into the subcommittee's discussion. If we can answer any additional questions or concerns, please contact me at 202-659-9440 or dan.rode@ahima.org, or in my absence, contact Allison Viola, AHIMA's director of federal relations at 202-659-9440 or allison.viola@ahima.org.

Sincerely,

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