WEDI Strategic National Implementation Process (SNIP)
Attachment Collaboration Project (ACP) Workgroup

ACP White Paper

Partnering for Electronic Delivery of Information in Healthcare

Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions

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I. PURPOSE

The purpose of this White Paper is to provide supplemental information to be used to transition from a manual process to an electronic process and to provide a single resource document for implementers to use to help them get started in their implementation planning.

The development of standards for electronic attachments spans multiple standards development organizations. Over the past several years, ASC X12N and HL7 have worked together to ensure that their standards are compatible to meet the needs of the industry. Since the use of multiple standards in a single transaction is new to the industry, ASC X12N, HL7 and WEDI collaborated on a project to provide an overview on how these standards work together with business processes.

II. SCOPE

This document is focused on the business and operational processes of exchanging additional information (Attachments) using the HL7 standards for clinical information and the ASC X12 transaction sets for requesting and transporting the clinical information. The detailed technical requirements are not covered in this document as the standards development organizations have provided the technical guidance in the standards implementation documents.

This White Paper will provide the following:

- An overview of Attachments
- Resources needed to have a successful implementation of Attachments
- A review of some of the current processes for requesting and responding to additional information to help understand the challenges
- Examples of implementation approaches in the industry
- A review of Electronic Attachment Business flows for Claims,
- Prior Authorizations[1] and Notification
- Provide business use cases and examples
- A guidance on how to embed additional information within an ASC X12N transaction in the BDS segment.

Commented [BL1]: Will need to have an RFI completed by X12N before this can be added to the document. Either put this in a appendix or a separate paper (not preferred as this requires an additional document for industry to use until 7030 is implemented).

[1] The term “prior authorization” as defined in the ASC X12N Health Care Services Review – Request for a Review and Response.

III. OVERVIEW

A. Why Is Additional Information Exchanged?

In the course of doing business, payers may need additional information from a provider to determine if the service being billed or requested is consistent with medical policies. These policies may require additional information to complete the adjudication or authorization process and may be different for each payer or may vary based on State mandates. The medical policies may include:

- the patient's insurance benefits
- the general medical policies
- the level of service being performed
- the specific condition/diagnosis to include past history and/or treatment that has already been completed, but was not effective

B. What Additional Information is Exchanged?

Based on feedback from the health care industry, the following documentation was most commonly exchanged and has been supported as structured documents in the HL7 implementation guide for attachments.

- Consultation Note
- Discharge Summary
- History and Physical
- Operative Note
- Procedure Note
- Progress Note

In addition to the list above the HL7 implementation guide also supports the following structured document:

- Continuity of Care Document (CCD)
- Diagnostic Imaging Report (DIR)
- Care Plan
- Referral Note
- Transfer Summary
- Patient Generated Document

Other clinical information not listed above may also be exchanged using C-CDA R2.1 by taking advantage of the "Unstructured Document", as described in Section 1.1.24 of the C-CDA R2.1: Volume 1 Introductory Material.

Commented [BL2]: Bob D will add additional language to expand to include other HL7 documents.

Following are some common payer requests sent to a provider requesting additional information based on a claim or prior authorization that is received. Each of these examples can be automated through the use of standard electronic attachments solutions, as described in the identified sections of this white paper

Claim Examples:

A request might ask for an Operative Note or Procedure Note for unlisted procedures or a CPT having:

- Modifier 22 (increased procedure),
- Modifier 52 (reduced services); or
- Modifier 62 (2 surgeons).

A request may also ask for Progress Notes or Consultation Notes for high level Evaluation and Management Codes.

For detailed examples see Section IX.

Prior Authorization Example:

The request might ask for Progress Notes for a request for additional occupational therapy or Admission Summary Report when requesting permission for an unscheduled admission.

For detailed examples see Section IX.

IV. CURRENT MANUAL PROCESS FOR ATTACHMENTS

This section provides an overview of some of the current processes for exchanging additional information between payers and providers. Before implementing standard electronic attachments, it is important to understand your current business flows in order to determine how to proceed with your implementation approach.

A. How is Additional Information Exchanged Today?

During the claims adjudication process or during utilization review the payer may determine that additional information is required, resulting in sending a request to the provider. The payer may also communicate a list of procedures and/or services that would require additional information for the claim and/or prior authorization allowing the provider to submit without waiting for a request. The process may be automated based on predefined rules or the request for information is systematically generated and sent to the provider.

The attachment information may be submitted using multiple methods based on payer specificity. Examples of methods used today are:

- **Paper** – the payer sends a letter to the provider and the provider may return a copy of the letter with the information requested by mail, fax, or uploaded to an electronic web portal.
- **Verbally** – the payer calls the provider and asks the questions and the provider communicates the information while on the call.
- **Website** - the payer contacts the provider and points to a URL for a document that would require completion by the provider.
- **Secured email** – the payer and provider may have established a workflow to allow for the request and response to be handled through a secured email exchange.
- **Fax** – the payer faxes a form to the provider for completion and fax back. (The payer must have the provider fax number on file or obtain it prior to using this method).

Internet –trading partners may use Secure FTP or other secured protocols

B. How is Additional Information Requested?

Today, most payers send hard copy letters to request additional information to support a claim or prior authorization submitted by the provider. These letters are typically mailed to the address on file for the provider or the payer may call the provider to request additional information for claims or prior authorizations. The request may be an automated process by some entities.

The payer may also communicate a list of procedures and/or services that would require additional information for the claim and/or prior authorization allowing the provider to submit without waiting for a request.

C. How is a Request Processed by the Provider?

When a request for additional information has been received by a provider it may be handled in different ways depending on the type and/or size of provider.

In the case of a small physician practice, the mail typically goes to one location and the routing of documentation may not be an issue. However, larger practices and institutional facilities may receive the information into a central billing office or mailroom. The information is then routed to the appropriate provider or department within the provider's organization to determine how to respond to the request or if it is necessary to forward on to another department. This manual routing to multiple hops may result in the information getting lost.

For smaller practices, the front office staff and/or clinical staff may gather the information requested from their medical records. Depending on whether the medical records are electronic or paper based, the information is copied or printed and sent to the payer. For privacy reasons, some information must be redacted prior to sending to the payer.

For larger hospital-based practices and facilities, the central billing office normally gathers the information. They work closely with the compliance area to ensure the information shared meets their internal requirements. The requested documents are pulled from the clinical systems, photocopied, and sent to the payer.

The provider returns the additional information along with a copy of the request letter by the due date specified in the request or they risk denial or delay of payment. When a tracking or reference number is included in the request, the provider should include it in the additional information being returned.

In the case of a pre-authorization the request for additional information can be handled in the pre-authorization unit which is usually staffed with clinical coordinators, or handled by the physician.

D. How is Response Processed by the Payer?

Today, the information requested may be received in a central mail room or go to a central fax machine. This requires a process for determining where to deliver the documentation within the payer organization. Often times the documents are misrouted and may be lost in the delivery, delaying the adjudication or review. Documents that are imaged or scanned may trigger an internal workflow, or may be sent to the appropriate department, or accessed through the payer's imaging system.

For claims, when the information requested is received, the claim processor will review the documentation and either forward to the medical review department for review or process the claim based on appropriate policies and benefits.

For Prior Authorizations, Internal Utilization Management (UM) workflows are unique, however, most have standard turn-around times to complete the review that would prompt a proactive search by the UM staff to look for specific documents received and housed in the imaging system under a specific member, or under a specific attachment control number if more sophisticated searches are available.

Most Utilization Management Organizations (UMOs) have established criteria to determine medical appropriateness for specific procedures to include scheduled or unscheduled admissions. Workflow will vary by UMOs as to how information is accepted and distributed, but in most cases the workload is distributed by service geographical locations, plan sponsor, or the type of the services being requested.

E. Where is Attachment Data Stored Today?

1. Payers

When a document response is received by the payer the document is usually imaged or scanned and stored in an image database. If information is received as an image, the image itself is stored. Third party document management systems may provide a link to an already stored document.

2. Providers

Providers store documents in various systems – (i.e., hospital and/or ambulatory Electronic Health Records (EHR), radiology, or laboratory systems). If information is in separate systems that are not connected it may require the provider to retrieve information from more than one location. Some large enterprises have document management systems that house scanned documents from multiple systems.

V. TODAY'S CHALLENGES

Based on the current processes there are many challenges that both payers and providers have to overcome. This section provides some of the more significant challenges that should be addressed as the industry moves toward standard electronic attachments.

A. Identifying Proper Address and Routing

Payers typically send the request for additional information to the provider address on file – this may not be the address for the department or individual who will be responding to the request. This can cause a delay in getting the response in a timely manner. Because of the discrepancies often found in the provider file addresses letters are often returned or sit in dead letter file at the post office.

Providers may have challenges routing the request within the facility/organization. The letters may be lost and not make it to the appropriate staff person resulting in denials and appeals.

B. Matching the attachment to the claim

When the attachment is received through fax, mail and other methods, the payer may have challenges matching it to the claim or prior authorization. This causes delay in finalizing the claim or reacting to the prior authorization. It may also result in denial due to lack of additional information.

C. Cost of Mailing

Because the majority of the requests go out in a hard copy, the payer incurs the cost of mailing letters. Again, because of the address challenges, the cost may be incurred more than once. The provider incurs the cost of mailing the information back to the payer. If the answer is not sufficient the first time, there may be multiple requests and responses.

D. Timeliness

Requesting, receiving and processing additional information through the postal services can often take weeks. This can negatively impact the provider's revenue cycle. Because of the manual workflows around the mailing and routing of the requests, information may not be received in time to prevent denials. If denied this may force the provider into an appeals process and/or cause the payer to reprocess the request. A delay may also affect the clinical care based on the amount of processing time for prior authorization.

E. Insufficient or Wrong Information

The provider may struggle with what the payer is requesting and to what degree. The provider may need to contact the payer to get clarification or the provider may send what they think is being requested – too much or too little. This may add to the turn-around time or cause the payer to accept and store unnecessary information. It may also cause the provider to send more than minimally necessary.

VI. BENEFITS OF STANDARD ELECTRONIC ATTACHMENTS

The current workflow for Attachment has significant challenges that can be addressed as the industry moves to the exchange of standard electronic attachments.

A. Benefits for Payers

- Savings on printing and postage associated with the paper
- Efficiency in receiving the response opening and delivering (Mail room costs)
- Savings in customer service due to fewer phone calls requesting and responding to the need for additional information
- Savings for imaging (staffing and imaging costs)
- Automating some processes when data is received in a structured format
- Savings on the cost of appeals as information flows in a more efficient manner
- Faster turn-around time as information is received electronically
- Faster decision making as information received should be more accurate due to the specific LOINC requests

B. Benefits for Provider

- Savings on printing and mailing of the clinical information and postage
- Savings on staff time for pulling the information
- Efficiency in receiving request opening and delivering (Mail room costs)
- Maintaining an audit trail of who has viewed personal health information and where it has been sent
- Providing more accurate information due to the specific LOINC requests
- Savings on the cost of appeals as information flows in a more efficient manner
- Ability to automate some processes when request is in a structured format

Commented [BL3]: Add section C for ROI pointing to an appendix. Sherry Wilson will drive the section with others to provide input.

VII. GETTING STARTED WITH STANDARD ELECTRONIC ATTACHMENTS

This section addresses some of the critical skills and resources needed for making the transition from the current processes outlined in Section IV to the electronic process for Attachments.

A. Recommended Skill Sets for Implementation

Before implementing standard electronic attachments, it is important to understand the skill sets and staffing requirements that may or may not be needed as part of the project team. The information provided is a recommendation only and may or may not apply to every organization.

1. **Knowledge Base:**

- Internal Business Processes and Workflows
- Technical and Business understanding of the standards
    - ASC X12N Technical Reports and standards
    - HL7 CDA Clinical Document Architecture
    - Basic XML knowledge
    - LOINC
    - Base64 Encoding
    - Mime Packaging
    - Transport Methods

2. **Staff Resources from the following areas (list is not be all inclusive):**

Provider

- Operations for Practice Management & other support systems (e.g., invoice, supply, utilization review)
- EHR vendor
- Practice Management vendor and/or clearinghouse
- IT (programmers, business analysts and quality assurance)
- Office Manager
- Medical Records Department and/or Billing staff
- Policy
- Security and Privacy
- Training
- Legal and Contracting (Business Association Agreements)
- Compliance
- Technical Writers
- Contractors, Consultants

Payer

- EDI department and/or clearinghouse
- Operations
- Claims
- Medical Review (utilization)
- Imaging Systems (data warehouse)
- Appeals
- IT (programmers, business analysts and quality assurance)
- Policy
- Security and Privacy
- Training
- Legal and Contracting staff (Business Associate Agreement)
- Compliance
- Technical Writers
- Contractors, Consultants

Clearinghouses/Intermediaries and Health Information Exchanges

- EDI department
- Operations
- Imaging Systems (data warehouse)
- IT (programmers, business analysts and quality assurance)
- Security and Privacy
- Training
- Legal and Contracting staff (Business Associate Agreements)
- Compliance
- Technical Writers
- Contractors, Consultants

B. Reference Material

Before getting started the following documents should be included in your resource materials. The version that should be used of the HL7 documents ASC X12N Technical Reports 3 published for the purposes of exchanging Attachments should be the version named in regulation or agreed upon by trading partners in the absence of regulations.

HL7 Reference Materials

The following list of reference materials are essential to implementing attachments and are located on the *HL7 website.*

- Quick Start Guide for CDA R2
- HL7 Consolidated Clinical Document Architecture Release 2 (C-CDA R2)
- HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 – US Realm (DSTU)
- HL7 Companion Guide for C-CDA R2
- HL7 Clinical Documents for Payers Set 1 (CDP1)
- HL7 Digital Signatures and Delegation of Rights Release 1

Logical Observation Identifiers Names and Codes (LOINC) *LOINC*

ASC X12N Reference Materials

The following list of ASC X12N Technical Report Type 3 reference materials are essential to implementing attachments and associated transactions are located in the *ASC X12 Store:*

- ASC X12N 277 Health Care Claim Request for Additional Information
- ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter
- ASC X12N 278 Health Care Services Review – Request for Review and Response
- ASC X12N 275 Additional Information to Support a Health Care Services Review
- ASC X12N 837 Health Care Claim: Professional (837-P)
- ASC X12N 837 Health Care Claim: Institutional (837-I)
- ASC X12N 837 Health Care Claim: Dental (837-D)
- ASC X12N Acknowledgment Package (TA1, 999, 824)

Additional Resources

- Internet Engineering Task Force (IETF) RFC 2557 (mime) and RFC 4648 (Base64)
- XML for Dummies *XML for Dummies 4th Edition*
- XML in 10 Minutes *XML in 10 minutes*

C. Approach to Implementation

During your implementation you will be faced with many decisions. In this section there are some key points to think about along with some options from other implementers for your consideration. It is not the intent of this paper to provide all of the decision points or options but to provide you with some things to consider.

1. What versions of the standard attachment transactions should be used?

This White Paper is version agnostic when discussing the implementation of standard attachments. This allows this document to provide guidance regardless of the version.

The examples in Section IX have been created using implementation specification version 6020 for the ASC X12N 277 and ASC X12N 275; all other examples are created using the current 5010 HIPAA version of the ASC X12N transactions. The HL7 C-CDA examples are created using the v2. These versions have been recommended to NCVHS by both organizations for adoption under HIPAA.

At the time of publication, ASC X12N recommended implementation specification for version 006020 at the NCVHS hearings in February 2016.

2. Things to Think About

Commented [MD4]: Need more detail – Laurie B and Mary Lynn can you fill this in?

5/3/16 wg call- Bob D recommends an appendix be added to reflect how someone would infest the 275 with the attachment. Bob will work on the next couple of weeks and provide recommendation back to the group.

1.Include how to reassociate a request with a response (solicited)
2.How to associate an attachment with a claim/auth etc (unsolicited).

Payer

- How to determine that an attachment is needed to create the 277 for solicited. What and how to communicate rules for unsolicited.
- What kind of file should they map the ASC X12N 275 input to?
- How can the 275/HL7 data be viewed by the operational areas?
- How to view structured data as human readable data? For structured and unstructured.
- Should you use stylesheets? How and when to use stylesheets.
- What type of editing will be done on the incoming files?
- How to interpret null flavors (there are some null flavors that can be used in the C-CDA templates)

- Will you use a client server application or an imaging system?
- Will you use a documentation management system?
- Understand your internal loop back to the final adjudication or authorization process.

Provider

- What does your vendor support?
- Where is your clinical data stored? How will you access it?
- When you receive the request, what kind of file will the 277 get mapped to?
- What is the flow?
- How do you map the EHR and clinical information?
- How and when to use null flavors.
- Where else will the information come from outside of the EHR?

VIII. OVERVIEW OF ATTACHMENTS

A. Solicited and Unsolicited Attachments

The HL7 Supplement Specification used for the clinical portion of the Attachment allows for the additional information as a response from the provider to a request from the payer (Solicited) or based on a set of pre-defined rules by the payer or in state mandates without a specific request (Unsolicited).

B. Structured and Unstructured Documents

The HL7 Supplemental Guide contains detailed information on structured and unstructured documents. The use of the C-CDA Templates provide the flexibility to allow for many different attachments as outlined in Section III.B.

A structured document has a header and a structured body. The structured body is made up of section level template(s). A structured body does not necessarily require all the data to be codified and may include narrative text. The C-CDA allows for flexibility in the use by the receiver. When the clinical information within the body is codified it allows the receiver to either use a style sheet to render the information in a human readable form or to use the codified information to automate decisions based on the content.

C-CDA also allows for unstructured documents in formats supported by HL7 Implementation Guide for CDA®, Release 2: Unstructured Documents. Implementers should refer to the C-CDA Implementation Guides for more information about unstructured documents. The current formats supported include:

- MSWORD
- PDF
- Plain Text
- RTF Text
- HTML Text
- GIF Image
- TIF Image
- JPEG Image
- PNG Image

C. Logical Observation Identifier Names and Codes in Attachments

LOINC Codes are used extensively in the exchange of Attachments. LOINC codes are used to identify the specific kind of information being communicated in both the request and response (both solicited and unsolicited.) The HL7 Supplement Specification provides a list of the codes associated with specific attachment types. In addition to the code, HL7 strongly recommends the inclusion of the published name associated with the code.

LOINC Modifier Codes are also used to set variables in the request for information. For example, the Modifier may specify a specific time period for reporting the information.

For more information about the use of LOINC refer to the HL7 Supplement Specification section on Use of LOINC in Attachments.

D. Requesting Electronic Attachments

When a payer/UMO determines the need for additional information for a claim or prior authorization, the implementation specifications for the standards listed below are used to facilitate the request:

- ASC X12N 277 Health Care Claim Request for Additional Information
- ASC X12N 278 Health Care Services Review – Request for Review and Response

The payer/UMO first determines the appropriate LOINC for the information required and includes that in the request. Set any applicable parameters around the information being requested (i.e., a time period) by using a LOINC Modifier. For more information about selection LOINC and LOINC Modifiers refer to the HL7 Supplement Specification.

A unique identifier (Unique Attachment Identifier) must be included to help with matching the response from the provider to the claim or prior authorization. The Electronic Flows for Attachments Section IX provides details on where and how the LOINC and Unique Attachment Identifier is used in the ASC X12N standards.

E. Transporting the Clinical Information for Attachments

Once the clinical information is pulled and ready to send to the payer/UMO, the provider must determine the method for transmitting. ASC X12 has developed standards to support the exchange of the clinical information for claims and prior authorizations. The ASC X12 275 is used as the 'envelope' for the clinical information. Details on the way to use the information to match the original transaction to the attachment is covered in Section IX of this document.

- ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter
- ASC X12N 275 Additional Information to Support a Health Care Services Review

In addition to the ASC X12N 275 there are a variety of transport options for exchanging any C-CDA document. For more detail on these options refer to Appendix E in the HL7 Attachment Supplement Specification.

IX. BUSINESS FLOWS, USE CASES AND EXAMPLES

A. Claims

1. Electronic Process Flows for Solicited Claims Attachments

When a provider submits a claim for payment (triggering event), a payer may determine that additional information is needed to complete the adjudication. The payer initiates a request for that additional information. The provider receives that request, and responds to the payer with the Attachment requested.

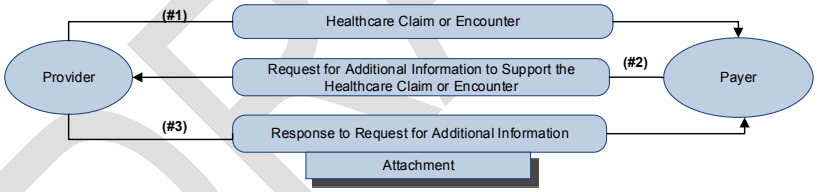
The diagram below depicts the business flow for a solicited claim attachment.

Arrow #1 The claim submitted by provider to a payer is the triggering event.

Arrow #2 The request for additional information by payer to provider using ASC X12N 277 Health Care Claim Request for Additional Information.

Arrow #3 The provider responses with an Attachment using ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter.

Figure 12: Example - Claims Attachment (Solicited)



2. Electronic Process Flows for Unsolicited Claims Attachments

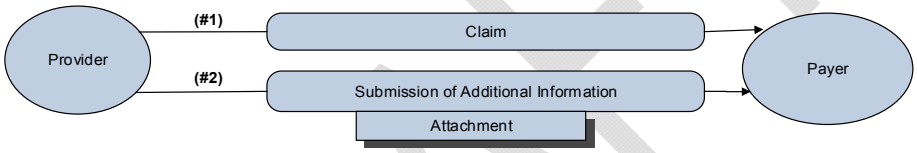
A provider submits a claim to a payer and knows in advance that additional information is needed to complete the adjudication, the provider may submit the Attachment without waiting for the request.

The diagram below depicts the business flow for an unsolicited claim Attachment.

Arrow #1 The claim submitted by provider to a payer.

Arrow #2 Provider submits additional information previously agreed to between payer and provider as an Attachment using ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter.

Figure 26: Example - Claims Attachment (Unsolicited)



3. Use Cases and Examples

Solicited Claim Level

The provider performs a surgery on the patient. There is not a HCPC's code for the procedure the provider performed therefore the provider submits the claim using a not otherwise specified procedure code (NOC code). The payer requires additional information to adjudicate the claim. The payer sends the X12 277 Healthcare Claim Request for Additional Information to the provider to request the operative notes for the surgery performed. The provider receives the ASC X12N 277 Health Care Claim Request for Additional Information ~~request for additional information~~. The provider gathers the appropriate information and returns using the ASC X12N 275 Additional Information to Support a Health Care claim or Encounter with HL7 C-CDA embedded in the BDS (binary) segment.

ASC X12N 277 Healthcare Claim Request for Additional Information	Comments
ST*277*0001*006020X313~ BHT*0085*48*AB12345*20160118*051055*RQ~ HL*1**20*1~ NM1*PR*2*ABC PAYER*****PI*PAYERID~ PER*IC**TE*8551234567~ HL*2*1*21*1~ NM1*41*2*XYZ CLEARINGHOUSE*****46*SUBMITTERID~ HL*3*2*19*1~ NM1*1P*2*HOLY HILL HOSPITAL*****XX*PROVIDERNPI~ HL*4*3*PT~ NM1*QC*1*SMITH*JOHN*Q***MI*PATIENTID~ TRN*1*0616299100010~ REF*X1*PT12345~ DTP*106*D8*20160218~ SVC*HC:28999*150~ STC*R3:11504-8::LOI*20160118~ REF*6R*LN12345~ DTP*472*D8*20160107~ SE*19*0001~	The version of the ASC X12 277 in this example is the 6020.

ASC X12 275 Additional Information to Support a Health Care Claim or Encounter	Comments
ST*275*1234***006020X314**~ BGN*11*456789*20160225~ NM1*PR*2*ABC PAYER*****PI*PAYERID~ NM1*41*2*XYZ CLEARINGHOUSE*****46*SUBMITTERID~ NM1*1P*2*HOLY HILL HOSPITAL*****XX*PROVIDERNPI~ NX1*1P~ N3*123 MAIN ST*1~ N4*FAIRFAX*VA*64108~ NM1*QC*1*SMITH*JOHN*Q***MI*PATIENTID~ REF*X1*PT12345~ LX*1~ TRN*2*0616299100010~ STC*R3:11504-8::LOI~ REF*6R*LN12345~ SVC*HC:28999*150~ DTP*472*D8*20160107~ DTP*368*D8*20160402~ CAT*AE*TX~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ SE*21*1234~	The version of the ASC X12 275 in this example is the 6020.

Unsolicited Claim Attachment

The provider performs a surgery on the patient which requires unusual circumstances. The provider knows that the payer requires the operative notes for these type of services. The provider submits the 837 (claim) with the HCPC's code of 58952 with the 22 modifier. The provider also submits Operative Report using the X12 275 transaction with the HL7 C-CDA embedded in the BDS (binary) segment at the same time he submits the claim.

ASC X12 275 Additional Information to Support a Health Care Claim or Encounter	Comments
ST*275*1234*006020X314~ BGN*02*456789*20160225~ NM1*PR*2*ABC PAYER*****PI*PAYERID~ NM1*41*2*XYZ CLEARINGHOUSE*****46*SUBMITTERID~ NM1*1P*2*HOLY HILL HOSPITAL*****XX*PROVIDERNPI~ NX1*1P~ N3*123 MAIN ST*1~ N4*FAIRFAX*VA*64108~ NM1*QC*1*SMITH*JOHN*Q***MI*PATIENTID~ REF*X1*PT12345~ LX*1~ TRN*1*0616299100010~ REF*6R*LN12345~ SVC*HC:28999*150~ DTP*472*D8*20160107~ DTP*368*D8*20160402~ CAT*AE*MB~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ SE*20*1234~	The version of the ASC X12 275 in this example is the 6020.

B. Prior Authorization and Notification Process Flows

1. Electronic Process Flows for Solicited Prior Authorization Attachments

When a provider submits a request for prior authorization, a payer may determine that additional information is needed to complete review. The payer initiates a request for that additional information. The provider receives that request, and responds to the payer with the Attachment requested. For the purposes of the scenario below it is assumed that the Prior Authorization Request (triggering event) would be submitted using the ASC X12N 278.

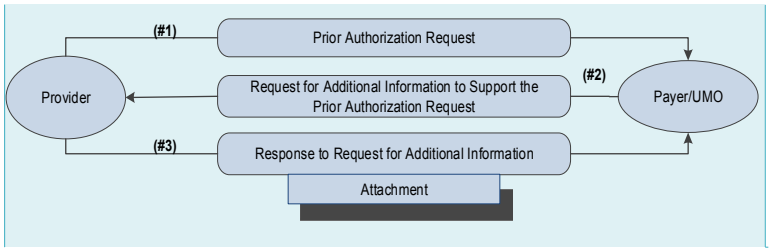
The diagram below depicts the business flow for solicited Prior Authorization Attachment.

Arrow #1 The Prior Authorization Request by a provider using the ASC X12N 278 Health Care Services Review - Request for Review and Response as~~is~~ the triggering event for requesting an attachment.

Arrow #2 A Request for Additional Information in support of a Prior Authorization requested by payer to the provider using ASC X12N 278 Health Care Services Review - Request for Review and Response.

Arrow #3 The provider's response with an Attachment using ASC X12N 275 Additional Information to Support a Health Care Services Review.

Prior Authorization (Solicited)



Commented [SW5]: Same comment regarding labeling as above

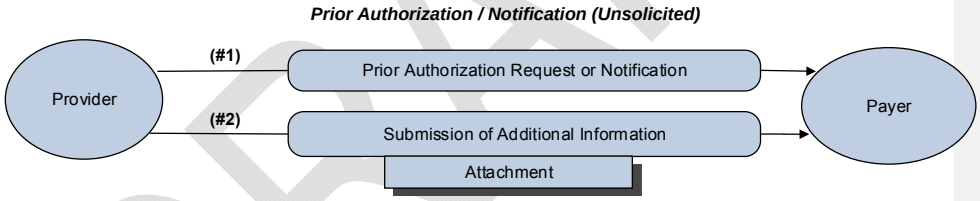
2. Electronic Process Flows for Prior Authorization and Notification Unsolicited Attachments

When a provider submits a request for prior authorization or notification to a payer and knows in advance that additional information is needed to complete the approval, the provider may submit the Attachment without waiting for the request.

The diagram below depicts the business flow for an unsolicited Prior Authorization or Notification Attachment.

Arrow #1 Prior Authorization Request or Notification from a provider to a payer using ASC X12N 278 Health Care Services Review - Request for Review and Response.

Arrow #2 Provider submits additional information previously agreed to between payer and provider as an Attachment using ASC X12N 275 Additional Information to Support a Health Care Services Review.



3. Prior Authorization and Notification Use Cases and Examples

Solicited Prior Authorization Event Level Use Case:
Patient goes to the emergency department as the result of feeling shortness of breath. Physician exams the patient and determines that he should be admitted for inpatient treatment. A request for prior authorization is sent to the payer for approval using the ASC X12N 278. The payer receives the request for authorization to admit the patient and determines that additional information is required before authorizing the admission. The payer sends ASC X12N 278 Request for Additional Information to the facility. If pending and requesting additional information the following response could be utilized as shown below. The provider pulls the requested information from the appropriate application (i.e., EHR, PMS, paper files) and creates an ASC X12N 275 Additional Information to Support a Health Care Services Review to send to the payer.

Solicited Event Level Example (triggered by a Request for Prior Authorization)

ASC X12 278 Request for Additional Information	Comments
ST*278*0001***005010X217~** BHT*0007*11*614571989898*20160118*05105949*AT~ HL*1**20*1~ NM1*X3*2*PAYER*****PI*PAYERID~ HL*2*1*21*1~ NM1*1P*2*REQUESTINGNAME*****XX*REQUESTINGNPI~ HL*3*2*22*1~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*MEMBERID~ DMG*D8*19310131*U~ HL*4*3*EV*1~ UM*AR*I**21:B**03~ **HCR*A4**0U~** REF*NT*5623558800000000~ DTP*435*D8*20160117~ HI*ABF:R0602*LOI:**LOINC-1~** PWK***77*EL***AC***5623558800000000~** MSG*ADDITIONAL INFORMATION THAT THE PAYER MAY WANT~ NM1*71*1*PROVIDER*ATTENDING****XX*ATTENDINGNPI~ NM1*AAJ*1*PROVIDER*ADMITTING****XX*ADMITTINGNP~ NM1*FA*2*FACILITY*****XX*FACILITYNPI~ HL*5*4*SS*0~	The version of the ASC X12 278 in this example is the 5010. The BHT06 (Transaction Type Code) should be reported as "AT"(Administrative Action) The 2000E HCR segment reports that the request has been Pended (HCR01=A4) and additional information is required (HCR03=0U) The HI segment at the Patient Event level can report LOINC code(s) for the additional information that is being requested at a diagnosis code level. A unique Attachment Control identifier (PWK06=5623558800000000) is assigned by the payer which should be reported in the ASC X12N 275 submission. In addition the PWK segment is reporting that a "Support Data for Verification" (PWK01=77) could be sent electronically (PWK02=EL) as this is the preferred method to receive this additional information.

UM*HS*I*1~ HCR*A4**0V~ DTP*472*D8*20160117~ SE*24*0001~	

Below are additional PWK options that could be utilized by the Payer when LOINC codes were not used:

Additional PWK Segment Options	Comments
PWK***15*BM***AC*5623558800000000~	The PWK segment is reporting that a "Justification for Admission" (PWK01=15) will be sent via mail (**PWK02=BM**) and the Attachment control number (**PWK06**) should be referenced along with the documentation when sending back to the Payer.
PWK***AS*FX***AC*5623558800000000*Use form at www.payer.com/prior_auth_forms/Form1234~	The PWK segment is reporting that an "Admission Summary" (PWK01=AS) can be found at the following URL "www.payer.com/prior_auth_forms/Form1234"and should be faxed to the Payer (**PWK02=FX**) after completion along the Attachment control number (**PWK06**).

ASC X12 275 Additional Information	Comments
ST*275*1234*006020X316~ BGN*11*456789*20160502*0632~ NM1*1P*1*REQUESTINGNAME****XX*REQUESTINGNPI*67*1P~ NM1*40*2*PAYER NAME*****PI*PAYERID*67*PR~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*MEMBERID~ LX*1~ TRN*2*5623558800000000~ STC*R4:LOINC-1::LOI~ HI*ABF:R0602~ DTP*368*D8*20160502~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ SE*14*1234~	The version of the ASC X12 275 in this example is the 6020. The BGN01=11 is reporting that this is a response to a request for additional information The provider that requested the original preauthorization The Payer or UMO that will be receiving the transaction The Attachment Control Number (PWK06) that was originally returned in the 278 response requesting additional information The response LOINC code for the information that was being requested The date the additional information was submitted

Solicited Prior Authorization Service Level Use Case

An Orthopedic Surgeon is submitting a preauthorization request to perform a total hip replacement for one of his patients. The services will require a limited inpatient stay to complete the services. A request for prior authorization is sent to the payer for approval using the ASC X12N 278 (Health Care Services Review — Request for Review and Response). The payer receives the request for the elective admission and determines that additional information is needed as to why the patient is being admitted on 03/17/2016, but the surgery is not scheduled until 03/18/2016. The payer also needs medical necessity for the total hip surgery. The payer sends a request for this additional information using the ASC X12N 278 (Health Care Services Review — Request for Review and Response). The provider receives the request for additional information from the Payer and submits the ASC X12N 275 Additional Information to Support a Health Care Services Review with the requested information.

Solicited Prior Authorization Event and Service Level Example (triggered by a Request for Prior Authorization)

ASC X12 278 Response and Request for Additional Information	Comments
ST*278*0001***005010X217~** BHT*0007*11*614571989898*20160502*05105949*AT~ HL*1**20*1~ NM1*X3*2*PAYER*****PI*PAYERID~ HL*2*1*21*1~ NM1*1P*2*REQUESTINGNAME*****XX*REQUESTINGNPI~ HL*3*2*22*1~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*MEMBERID~ DMG*D8*19310131*U~ HL*4*3*EV*1~ UM*AR*I**21:B**03~ **HCR*A4**0U~** REF*NT*5623558800000000~ DTP*435*D8*20160817~ HI*ABF:M160~ MSG*ADDITIONAL INFORMATION THAT THE PAYER MAY WANT TO GIVE BACK TO ASSIST WITH THE UM DECSION PROCESS~ NM1*71*1*PROVIDER*ATTENDING****XX* ATTENDINGNPI~ NM1*AAJ*1*PROVIDER*ADMITTING****XX* ADMITTINGNP~ NM1*FA*2*FACILITY*****XX* FACILITYNPI~ HL*5*4*SS*0~	The version of the ASC X12 278 in this example is the 5010. The BHT06 (Transaction Type Code) should be reported as "AT"(Administrative Action) The 2000E HCR segment reports that the request has been Pended (HCR01=A4) and additional information is required (HCR03=0U) .

UM*HS*I***2**~ HCR*A4**0U~ DTP*472*D8***20160817**~ **HI*LOI:LOINC-1~** PWK***77*EL*****AC***5623558800000000~** HL*6*5*SS*0 UM*HS*I HCR*A4**0U~ DTP*472*D8*20160818 **HI*LOI:LOINC-2*LOI:LOINC-3*LOI:LOINC-4~** SV1*HC**|27130** HSD*FL*1 PWK*77*EL***AC*5623558800000000~ SE*35*0001~	The HI segment at the Service level can report LOINC code(s) for the additional information that is being requested for that specific service only. This could be a LOINC code to report a justification for the day before surgery admission. A unique Attachment Control identifier (PWK06=5623558800000000) is assigned by the payer which should be reported in the ASC X12N 275 submission. In addition the PWK segment is reporting that a “Support Data for Verification” (PWK01=77) could be sent electronically (PWK02=EL) as this is the preferred method to receive this additional information These service level LOINC codes are being reported to obtain additional information related to the procedure code “27130’ for the total hip replacement surgery

ASC X12 275 Additional Information	Comments
ST*275*1234***006020X316**~ BGN*11*456789*20160502*0632~ NM1*1P*1***PROVIDER*REQUESTING****XX*REQUESTINGNPI***67*1P~ NM1*40*2***PAYER NAME*****PI*PAYERID***67*PR~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*MEMBERID~ LX*1~ TRN***2*5623558800000000**~ STC*R4: **LOINC-1**::LOI HI*ABF: M160**~** DTP*368*D8***20160502**~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ LX*2~ TRN***2*5623558800000000**~ STC*R4: **LOINC-2**::LOI SVC*HC:**27130*0**~ DTP*368*D8***20160502**~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ LX*3~ TRN***2*5623558800000000**~ STC*R4: **LOINC-3**::LOI~ SVC*HC:**27130*0**~ DTP*368*D8***20160502**~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ LX*4~ TRN***2*5623558800000000**~ STC*R4: **LOINC-4**::LOI SVC*HC:**27130*0**~ DTP*368*D8***20160502**~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ SE*14*1234~	The version of the ASC X12 275 in this example is the 6020. The provider that requested the original preauthorization The Payer or UMO that will be receiving the transaction The Attachment Control Number (PWK06) that was originally returned in the 278 response requesting additional information The first LOINC code for the information that was being requested about the day before surgery admission The date the additional information was submitted The Attachment Control Number (PWK06) that was originally returned in the 278 response The second LOINC code for the information that was being requested about procedure code 27130 The date the additional information was submitted The Attachment Control Number (PWK06) that was originally returned in the 278 response The third LOINC code for the information that was being requested about procedure code 27130 The date the additional information was submitted The Attachment Control Number (PWK06) that was originally returned in the 278 response The fourth LOINC code for the information that was being requested about procedure code 27130 The date the additional information was submitted

Notification Unsolicited Event Level

A provider wants to notify the Payer of an emergency inpatient admission. Based on previous encounters with a specific Payer, a review of the patient's medical records will be needed before the admission can be preauthorized. In this instance the provider will be sending both a Notification using the ASC X12N 278 (Health Care Services Review — Notification and Acknowledgment) and an ASC X12N 275 (Additional Information to Support a Health Care Services Review). The payer receives the notification for the emergency admission and determines that a "Treatment Plan" has already been sent electronically as reported in the PWK. This information will be captured to assist with the ongoing utilization review process. A 278 acknowledgment will be returned to indicate that the notification was received and processed.

ASC X12N 278 Notification	Comments
ST*278*000000001***005010X216~** BHT*0007*14*614571989898*20160717*051055*NO~ HL*1**20*1~ NM1*1P*1******XX*INFORMATIONSOURCENPI~ PER*IC*INFORMATION SOURCE CONTACT NAME*TE*5555556310~ HL*2*1*21*1~ NM1*PR*2******PI*PAYERID~ HL*3*2*22*1~ NM1*IL*1******MI*MEMBERID~ DMG*D8*19310131*U~ HL*4*3*EV*0~ **UM*AR*I*1*21:B**03~** **DTP*435*D8*20160717~** **HI*ABF:R079~** **HSD*DY*2~** CL1*3*30~ PWK***08*EL***AC***1234567~** NM1*71*1*PROVIDER*ATTENDING****XX*ATTENDINGNPI~ NM1*AAJ*1*PROVIDER*ADMITTING****XX*ADMITTINGNPI~ NM1*FA*2*FACILITY*****XX*FACILITYNPI~ SE*20*000000001~	The version of the ASC X12 278 in this example is the 5010. Initial emergency notification for an inpatient admission The admission date will be 20160717 The admitting diagnosis The request is for 2 days A unique Attachment Control identifier (PWK06=1234567) is assigned by the provider which will also be reported in the ASC X12N 275 submission. In addition the PWK segment is reporting that a "Plan of Treatment" (PWK01=08) was sent electronically (PWK02=EL) to assist with the Utilization Review process.

ASC X12 275 Additional Information	Comments
ST*275*1234*006020X316~ BGN*22*456789*20160502*0632~ NM1*1P*1***PROV*REQUESTING*****XX*REQUESTINGNPI***67*1P~ NM1*40*2***PAYER NAME*****PI*PAYERID***67*PR~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*MEMBERID~ LX*1~ TRN***1*1234567~** STC*R4: **LOINC-1**::LOI HI*ABF:R079**~** DTP*368*D8***20160502**~ CAT*AE*HL~ OOI*1*47*ATTACHMENT~ BDS*B64*3117*ADD HL7~ SE*14*1234~	The version of the ASC X12 275 in this example is the 6020. The provider that submitted the original Notification The Payer or UMO that will be receiving the transaction The Attachment Control Number (PWK06) that was originally submitted with the 278 Notification. The TRN01=1 reports that this is an unsolicited 275. The LOINC code for the information that was sent to support the Notification The date the additional information was submitted

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