

**HL7 January Working Group Meeting
January 8 – 12, 2006
Phoenix, Arizona
Report Submitted by
Bob Davis**

Executive Summary

At this HL7 meeting the focus of the AHRQ representative, Bob Davis, was three fold:

Primary was to attend the Attachment Special Interest Group (ASIG). This work group is responsible for development for the clinical component of the claims attachment. **The significance of this for public health data systems is the potential precedents to be established with a standard that integrates clinical and administrative data in federal statute and regulations.**

In addition, HL7 management was consulted to support an initiative to harmonize the demographic information common to the ANSI ASC X12 and HL7 standards. ANSI ASC X12 management will also be asked to support this initiative at the next trimester meeting in Seattle from February 5 – 9, 2006. **The significance of this for public health data systems is the potential to make data more comparable across the country.**

The Public Health Emergency Response Special Interest Group (PHERSIG) is developing a new data type to describe spatial data in all three dimensions to support the varied needs of public health for graphic representations of data.

Though Bob Davis is not directly involved in the development of the functional model for the electronic health record (EHR), anyone having questions about the EHR functional model should direct them to Bob Davis, who would be able to re-direct them colleagues at HL7 that can provide the pertinent information.

General HL7 News

Below is the schedule of future HL7 working group meetings:

- May 7-12, 2006 - San Antonio, Texas
- September 10-15, 2006 - Boca Raton, Florida
- January 7-12, 2007 - San Diego, California
- May, 2007 - Berlin, Germany
- September 16-21, 2007 - Atlanta, Georgia

In the past few years HL7 and ANSI ASC X12 have agreed through a new Memorandum of Understanding to collaborate more closely on issues of joint

concern. As a result liaisons have been approved by the respective organizations. They are:

- Bob Davis is the ANSI ASC X12 liaison to HL7 (rdavis@nahdo.org)
- Maria Ward is the HL7 liaison to ANSI ASC X12 (Mward60610.aol.com)

The significance of this is that both ANSI ASC X12 and HL7 see the benefit in enhancing the communication between the two organizations to establish integrated health care data standards. Any questions about the relationship between the two organizations should be directed to either of the liaisons mentioned above.

Attachment Special Interest Group (ASIG) working session highlights

- There is a Data Standards Maintenance Request (DSMO) to add an external code list from the LOINC data base to reference attachment types to the ANSI ASC X12 standards. The advantage of this would be that additional attachment types could be implemented without additional changes to the X12 standards.

Public Health Note: *In general, it is preferable to have the standards refer to external code lists. This usually makes the standards more adaptable to changes the industry business needs. For instance, if in the future an attachment type is developed to accommodate the clinical data needs for pay for performance initiatives the implementation would not have to be slowed because of necessary maintenance to the X12 standard.*

- When the claims attachment development work first began, there was a work group formed to develop criteria for when a data element belonged in the claim and when it belonged in an attachment. Since it has been such a long time since that discussion last concluded, the ASIG agreed to re-constitute a work group with appropriate X12 work groups to re-address that same issue. **One of my basic tenants in the standards world has been that the quality of the data received by public health information systems is improved if existing health care provider infrastructures are used. Consequently, any decisions about what belongs in a claim versus in an attachment will impact public health information systems too.**
- One of the significant issues discussed at the ASIG meetings during the week was what release of the Clinical Document Architecture (CDA) standard should be named in the final rule. There was general agreement that there should be a migration from CDA Release 1 to CDA Release 2. The issue was how such a migration should occur without causing significant change to the claims attachment standard, which would necessitate a new Notice for Proposed Rule Making (NPRM). There was agreement that no change would be considered if another NPRM would be necessary as a result. Key in doing this would be maintaining the value tables in the Additional Information Specifications (AIS)

booklets. The other issue was how to get the necessary resources to do the work necessary for this migration. The Structured Documents Technical Committee, which is responsible for development and maintenance of CDA releases, met jointly with the ASIG to help characterize the issues. Below are highlights of that discussion. **Note: the significance to public health information systems is the resulting decision. I believe no matter what HL7 decides, public health systems will be able to adopt that solution with the same amount of effort. The highlighted discussion below is included for anyone interested in one of the critical technical considerations for electronic claims attachments.**

- All CDA releases are comprised of a Header and a Body. The contents of those parts change from release 1 and 2. Adopting a full functioned CDA release 2 standard would require modeling attachment types with the HL7 Reference Information Model (RIM). One alternative would be to make only a minimum number of the changes to the header and the body for the attachment necessary to replicate the question and answer format currently being used. The current release 1 standard fully supports human readable and computer decision variants. There was agreement any release 2 migration would need to maintain this dual function.
- Migration to Release 2 would eliminate use of local markups resulting in a more standard standard. One of the advantages of this would be that CDA release 2 provides more functionality to parse provider references using existing constructs in the standard. Currently the attachment control number, which is essential to the claims attachment proposed solution, is defined in that local markup and a namespace would need to be defined in the CDA release 2 as part of the migration process.
- There were questions about the when it would be appropriate to use SNOMED codes in the attachment standards, since the SNOMED codes would in some cases describe the clinical component of the answer. The group agreed to develop a map from the SNOMED clinical codes to LOINC for the express purpose of claims attachments. This would be done under the auspices of the ASIG. The purpose of this would be to address the overlaps between the clinical LOINC and SNOMED codes as they apply to the attachments. This hopefully would clear up an ambiguities between when SNOMED or LOINC codes are used.
- The issue of resources exist whether the claims attachment standard is migrated to CDA release 2 or not. If no conversion is made, then the industry will need to expend resources dual training staff for both CDA release 1 and release 2. The resources necessary to migrate to CDA release 2 are more internal to the ASIG and the Structured Documents Technical Committee. Several volunteers from both the ASIG and Structured Documents agreed to participate in a mentor teacher model to begin the necessary technical changes for the migration. This effort will require coordination with other groups developing CDA release 2 documents.

- The Workgroup for Electronic Data Interchange (WEDI) has formed a sub work group for claims attachments under the transactions work group to address claims attachments implementation issues.
- WEDI wants to be a centralized site for piloting of the X12 transactions including the claims attachments.
 - There was a questions raised about how potential pilot sites are educated on the role that WEDI wants to play in this process.
 - There are questions about the extent of what WEDI's role would and should be in this process especially if the funding is coming from outside of WEDI.
 - There is a new WEDI "membership light" that would allow access WEDI materials. There was a related question where this membership category would also allow participation in listserv discussions.
- There was a report from the Department of Health and Human Resources representative to the ASIG. It should be noted that the Office of HIPAA Standards has changed to the Office of E-health Standards and Services. Below are the highlights of the report.
 - Comment period ends at close of business on Monday, January 23, 2006.
 - Many organizations have already submitted comments. Included in that list are: AHA, College of American Pathologist, Delta Dental, Medicaid, Memorial Sloan Kettering Hospital, NUCC, NUBC, NCPDP, and ADA. (Note this list is not all inclusive)
 - There have been questions to CMS on how to do more education and outreach with HIPAA standards.
 - Comments have already been received on the following (note this list is not all inclusive):
 - The impact of the three year compliance dates impact the development of the Electronic Health Record (EHR).
 - The lack of pilots and testing of the proposed claims attachment standard.
 - There were comments about the medical policy about when to use the proposed attachment types.
 - There were comments recommending migrating to CDA release 2.
 - There were comments recommending migrating to the 5010 versions of the ANSI ASC X12 implementation guides.
 - There was a comment about using SNOMED codes in place of LOINC codes.
 - There were questions related to privacy and minimum necessary provisions of the privacy rule. It is important to note, however, the DHHS representative reported that there have not been many privacy complaints with the existing transactions. **Public Health folks should take note of that statement.**
 - There were concerns about the cost of implementing systems to do electronic claims attachments.

- There were comments both for and against allowing unsolicited claims attachments. **I believe Public Health Systems using this process for reporting additional clinical data would use an unsolicited model.**
 - A letter was submitted to DHHS by the AHA making a case that ICD-10 implementation would negate the need for attachments. The letter did not provide details on how that would work. **This is an opportunity for Public Health folks to take a leadership role in educating the industry on what to expect and what not to expect from the implementation of ICD-10-CM and ICD-10-PCS.**
 - The Department of Health and Human Services is hoping to publish a final rule for claims attachments by the end of this year.
 - Below are other issues unrelated to the claims attachment reported by the DHHS representative:
 - As part of Health Information Technology initiatives the federal government wants to use HIPAA eligibility transaction to create medical clipboard to solve the problem of having to fill in the same information at many different care settings. They are looking for federal accelerators to move the process forward.
 - There is considerable interest in obtaining patient medication history. The Department is considering using Medicare Part D data for this purpose.
 - There is interest in integrating claims data into a Personal Health Record by the Department. **This could be an opportunity to share experiences from the states with the federal government. Ideas are welcome on how to get states involved in this initiative.**
- It should be noted that in other business the ASIG is currently developing attachment types for E-prescribing and home health services.

Public Health Note: *The take away from this is that it is hard work to develop, implement and maintain standard solutions to business problems in the health care industry. The standards organizations, which are essentially volunteer organizations, should be commended for their persistence and dedication in breaking ground with a solution to integrate clinical and administrative health data. I believe it is in our best interest to apply these standard solutions solving our local data integration problems.*

Vocabulary Technical Committee

- The proposed claims attachment process integrates ANSI ASC X12 and HL7 standards. This potentially can create a problems when common terminology between the two organizations is different. The need to harmonize common vocabularies is obvious. The Vocabulary Technical Committee at HL7 agreed to

address this issue on upcoming conference calls and at the next working group meeting in San Antonio. It will also be necessary to get appropriate work groups at ANSI ASC X12 to participate in this initiative. Pending management “buy in” from both HL7 and X12, the proposed starting point for such a harmonization effort would be patient demographic data. Stay tuned for more on this initiative. **This is a place where Public Health could and should play a leadership role. Volunteers appreciated.**

Public Health Emergency Response Special Interest Group (PHERSIG)

- Based on previous discussions a proposed data type for spatial data was presented to the group for discussion. This data type needed to support the following use cases that have been presented to the group at previous working group meetings.
 - Global Positioning System devices
 - Geocoding algorithms based on a reference database of locations
 - Direct digitations of existing maps
 - New geodetic Cartesian coordinates, such as an area grid
 - Land based reference transmitters – LORAN-C
- The group decided to restrict the spatial data discussion solely to point data. Concerns about line, aerial data or remote sensing data would be discussed at a later date. The primary concern was not to build functionality usually residing in a GIS into the HL7 message.
- This proposed data type will be balloted by HL7 in the next ballot.

Public Health Note: *Users of spatial data for public health systems should closely examine the spatial data proposal, especially during the HL7 ballot process. It is important that the standards “do no harm” as well as supporting the full range of public health spatial data needs. The only way that can happen is to participate in the standards development process.*