May 17, 2012

The Honorable Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Reference: CMS-0040-P
7200 Security Blvd
Baltimore, MD 21244-1850

Dear Acting Administrator Tavenner:

On behalf of the Healthcare Billing and Management Association (HBMA), we are pleased to submit these comments on the proposed changes to the ICD-10 CM effective date, establishment of Health Plan IDs (HPIDs) and Other Entity IDs (OEIDs) (CMS Reference CMS-0040-P).

HBMA members process physician billing, non-physician billing, hospital billing and other claims integral to the U.S. healthcare delivery system. HBMA members frequently perform all of the physician's practice management functions, accounts receivable management, medical billing consulting, as well as assistance in the preparation and completion of provider enrollment forms and other administrative and practice management services.

HBMA members typically provide services to specialty physician groups and primary care practices and process Medicare, Medicaid, and private health insurance claims. A typical HBMA member processes approximately 350,000 – 400,000 claims per year; some do much more.

The financial machinery of America's healthcare system has evolved dramatically in the three decades since the transition from ICD-8 to ICD-9 CM. In 1977 the following everyday elements of today's billing and reimbursement systems did not exist:

- DRGs
- APCs
- RVUs
- NPIs
- Denial codes
- HIPAA
- Electronic claim submission
- Electronic remittance
- Electronic funds transfer
- Clearinghouses
- Evaluation and Management codes
- PECOS and structured provider enrollment

The gravity of undertaking a complete replacement of one of the most essential elements of the healthcare reimbursement mechanism cannot be overstated: if ICD-10 CM implementation is executed *flawlessly*, there will be little difference between "before" and "after;" if there are problems, the impact will range from painful to cataclysmic.

1540 South Coast Highway • Suite 203 • Laguna Beach, CA 92651
877-640-4262

As someone said recently, "There is no greater disruption to healthcare than changing the payment model." Changing the way we code medical claims is effectively changing the payment model because this directly affects provider payment.

It is easy to agree that everyone wants the ICD-10 CM transition to succeed. It is equally easy to find agreement that all parties express willingness to "do their part."

We MUST learn from the mistakes that were made in transitioning from 4010 to 5010, and undertake the transition from ICD-9 CM to ICD-10 CM in a way that demonstrates we learned those lessons.

Since the day the Secretary announced that she intended to seek a delay in the effective date for mandatory use of ICD-10 CM codes, we have heard reports about various entities immediately stopping work on ICD-10 CM implementation. Individuals who were hired to handle/oversee the transition for their organizations have been let go and resources set aside for the ICD-10 CM transition have been redirected to more immediate/pressing needs.

If CMS was concerned that we were behind schedule in January, then we are even further behind today. It is imperative that CMS reestablish a deadline and timetable for ICD-10 CM compliance as soon as possible.

Finally, if all we accomplish as a result of this NPRM is moving the date from October 1, 2013 to October 1, 2014 or some later date, then we will have failed to make the changes that will be necessary to ensure that the new date is final and the transition is successful. More importantly, we will merely be delaying the likelihood for payment disruptions and patient access to care problems from 2013 to 2014.

If CMS and HHS want to restore their credibility in the Administrative Simplification arena and ensure that we do not face a similar call for delay in 2013, then we must learn from our past mistakes in order to avoid repeating them.

ISSUE 1 – LEARN FROM THE 5010 EXPERIENCE

The 5010 Transition was subjected to what seemed to be an active and dedicated effort to plan and monitor the transition. There appeared to be an unprecedented level of education and efforts by stakeholders to share information and resources, with the goal of a successful transition. Despite this, there were serious problems with the 5010 transition and we have seen a de facto extension of the deadline until July 1, 2012.

In our view, central among the shortcomings in the 5010 transition was the lack of a standard definition of what it meant to be "5010 ready." In early 2010, billing companies were being told by practice management vendors, clearinghouses and health plans that they were "5010 ready." Similarly, HBMA was being told by its members that they, too, were "ready."

Technically, the entities that were saying they were "5010 ready" in early 2010 were not misrepresenting their status as far as that term could be applied at that point in time; however,

realistically, no one could have been 5010 ready in early 2010 because no one was in a position to test.

What we subsequently learned was that every entity in the claims processing chain had a different definition of what they meant by the term "ready."

We have also learned from the 5010 conversion that payor testing was severely limited. The first 12 weeks of 2012 underscore this point in that many payors only tested syntax prior to the implementation of 5010. In many cases the scope of testing did not adequately cover the true edits nor did the testing provide for end-to-end testing with remittances as part of the test.

In addition, we learned that:

1. Planning could have been more in-depth and more stakeholders more intimately involved;
2. Communication could have been more clear, more comprehensive and more broadly disseminated; and,
3. No time was planned for remediation and retesting before implementation.
4. Payors were permitted to implement on whatever schedule they wished. Some went well before 1/1/12, and it was a nightmare figuring out who did what and when. Some payors announced they were going live and then subsequently announced they were not going live.
5. There was a lack of transparency that made it virtually impossible to know the root cause of a problem. For example, the provider/billing company handed off the claim to a clearinghouse who in turn handed it off to another entity before it went to the Health Plan. The provider/billing company only knew they had no issue with step one in the chain so they could not determine why the claims were denied because they did not know about steps two and three.

Despite two 5010 enforcement delays there remain ongoing reports of insurers, vendors and clearinghouses that continue to struggle, causing financial harm to the providers who have rendered care and are not being paid for covered services. It has been more than 4 months since the effective date for 5010 compliance and many plans are still not 5010 compliant. Segments of the industry are still using "contingency" plans and some payors are still incorrectly adjudicating claims under the 4010 requirements and the use of companion guides remains pervasive with some payors. The provider community had hoped that the move to 5010 would have dramatically reduced the use of plan-specific companion guides but early reports indicate that this not the case.

We are concerned that unless the "lessons learned" from 5010 materially inform and affect the implementation of ICD-10 CM, the economic stability of America's healthcare reimbursement systems will be at risk and could be severely compromised, affecting provider viability and patients' access to care, a concern we know CMS shares.

Although HBMA supports this proposed delay, in principle, we strongly recommend significant changes in the required methodology and work towards readiness providers, vendors and health plans will need to demonstrate over the next 2½ years in order to avoid implementation problems.

Keep in mind that in relative terms, adoption and implementation of 5010 was simple compared to the much greater magnitude of ICD-10 CM.

Every vendor system that stores, uses, depends on, transmits, or receives an ICD code, for whatever purpose, must make some degree of modification to some component of the software to accommodate ICD-10 CM. In the process, each vendor is forced to make decisions and set rule(s) or policies regarding how they will treat ICD-10 CM codes and handle the transition from ICD-9 CM to ICD-10 CM. While some elements of the modifications or upgrades necessary to prepare for ICD-10 CM have been addressed by many vendors, payors and clearinghouses during the transition from ANSI 4010A1 to ANSI X12 5010A1, an enormous amount of work remains to be done.

The recent 5010 conversion and the updates to the Practice Management and Hospital Information Systems (PMS and HIS) expanded the fields processed in the X12 837P, X12 837I and X12 837D transactions. Therefore, the foundation for sending and receiving ICD-10 CM codes between providers and payors has been accomplished, but there are other areas of concern that can have an impact on business processes for providers and revenue cycle management companies that are just as important to the industry. These have not received as much attention by CMS or other parties as the 835/837 transactions.

For example, the proper handling of data interfaces may have as much potential impact as provider-to-clearinghouse/payor and payor-to-clearinghouse/provider exchange of claim (837) and remittance (835) data. If data cannot get to its intended location in the proper form and be received and interpreted in the proper form, then submission of claims, and certainly "clean" claims, can be interrupted. There is a huge network of data being exchanged every second of every day by data trading partners on behalf of their clients. Ultimately, this network of data being exchanged affects the ability of billing systems to generate claims to payors and vice versa.

Examples of the types of interfaces we mean are:

- Hospital/EHR systems
- PM/EHR systems
- PM/Lab systems
- EHR/Lab systems
- EHR/EHR systems
- PM/PM systems
- Lab/lab systems
- PM/Payor or clearinghouse systems
- PM/Coding systems

The underlying issue of these interfaces is that there are various approaches the "owners" of each type of system can take when setting policies for handling data interchanges that involve ICD codes. Some owners may choose to use the GEMS mapping system, others will build or buy non-GEMS translators and others may choose to extend maintenance and support of both ICD-9 CM and ICD-10 CM tables well beyond the final implementation date for ICD-10 CM. In fact, HIPAA-exempt insurers such as automobile, tort and workers compensation plans may continue to utilize ICD-9 CM for years to come.

In the latter cases, the editing and validation of codes may be based strictly on the Date of Service (DOS) or may be a combination of the DOS and a flag provided in interface files that denote

which code version is being used on each charge record, encounter, etc. (because it is important to know which version is being used). There are other potential policies and rules various system owners may set to help them deal with ICD-10 CM.

Because there are at least two entities involved in each interface, there must be ample time allowed for communication and necessary development/modification between every data trading instance to handle the specifics of each interface. In most cases, we anticipate that the originator of the data file will set the rules for how they are handling ICD codes contained in their data files, whether transmitted via HL7 or proprietary format in real-time or batch mode. The system receiving the data will, in most cases, have to conform to the rules/policies for ICD codes set by the originator. There will, of course, be exceptions.

These will be very time and resource consuming activities and failure to perform them properly can create chaos in the healthcare world. Providers AND billers could be rendered incapable of functioning if these are not considered and sufficient time provided for their development when the time frame for ICD-10 CM is finalized.

While the transport aspects of the ICD-10 CM processing has, for the most part, been achieved via 5010, many, if not all, Electronic Data Interchange/Clearinghouse vendors will need adequate time to incorporate updates to their data validation or edit systems. This includes code validation, date validation, medical necessity validation, correct coding initiatives and all published and promulgated payor rules based on diagnosis and procedure coding.

One of the lessons learned during the 5010 conversion was that adequate notification of the coding edits will be necessary to ensure successful testing between feeder systems (PMS and HIS) and the Electronic Data Interchange/Clearinghouse systems, as well as any contemplated testing between payors and providers.

Therefore, in the time remaining before full implementation of ICD-10 CM, we encourage CMS and the Secretary to establish firm, mandatory benchmarks that cannot be ignored to assess the status for **all** facets of the healthcare industry. These benchmarks would look at patient care, access, coding, billing, payment, operations, workforce, regulatory requirements and other initiatives on a concurrent time-line.

Finally, it is likely that some payor systems will not be able to process true ICD-10 CM codes at the point at which the ICD-10 CM goes into effect; some payors have acknowledged that they will use crosswalks to convert ICD-10 CM to ICD-9 CM for adjudication purposes and that some type of conversion will take place when providing electronic remittance transactions back to the providers.

This will result in providers needing information to determine if payments are in accordance with contracted agreements between providers and payors. These solutions will include systems offered by vendors as well as other manual processes employed by the providers.

HBMA understands and supports a one-year delay as a necessary step to ensure successful implementation and minimal disruption to the industry. However, we strongly recommend that the following be adopted in conjunction with the delay.

RECOMMENDATION 1:

CMS should adopt and enforce a uniform definition of ICD-10 CM "ready."

As you know, some vendors and health plans have already announced that they are ICD-10 CM "ready." Clearly, this cannot be true as there has been no external end-to-end testing or payment impact analysis for claims other than the years-old CMS–3M project for DRG to I-10 comparison. Because there is no definition of "ready," plans and vendors can currently make their assertions without consequence.

"ICD-10 CM ready" should mean, at a minimum, the complete end-to-end testing of 837 and 835 transactions in full production has been successfully accomplished. Any maps or crosswalks used by a health plan to adjudicate a 5010/ICD-10 CM compliant claim must be publicly available and the diagnosis code(s) used for claims adjudication are reported. HBMA would be happy to work with CMS and other stakeholders on the development of an official "ICD-10 CM ready" definition. HBMA also recommends that the definition of "ready" include all of the transaction types mentioned above (i.e., not just the ability to submit claims or process remittances containing ICD-10 CM codes).

Finally, any entity (billing company, software vendor, clearinghouse health plan, provider, etc.) that cannot document that they meet this definition of ready, should be prohibited from publicly asserting that they are ICD-10 CM "ready." Entities improperly asserting ICD-10 CM readiness should be subject to fines and penalties.

HBMA recommends Health Plan coverage policies be published by October 1, 2013. This would allow adequate time for: programming of claim edits that conform to ICD-10 CM specific policy changes; data analysis; education and training; and, other preparations for ICD-10 CM.

HBMA recommends that CMS create a national bulletin board where all health plans can enter their name and/or plan(s), date ready for testing, date ready for production, links to any ICD-9 CM/ICD-10 CM maps or crosswalks the plan may use during the transition and contact information for each, along with the site where any companion guides can be located and downloaded.

In addition, CMS could use this national bulletin board as a means of tracking and publicly reporting Health Plan readiness. Providers would know ahead of time which plans were on-schedule and those that were behind. Consumers would also be able to ascertain whether their plan was on schedule and make insurance purchasing decisions accordingly. Plans that are ready could realize a market advantage during "open seasons" whereas plans that are behind could experience a loss of market share because of the potential for disruption in claims payments.

Finally, CMS could take appropriate action to intervene if a plan does not comply with the various interim implementation compliance deadlines.

RECOMMENDATION 2:

HBMA recommends that the new date be adopted, subject to the identification of specific, verified readiness criteria for providers and insurers.

If these deadlines are not met by Health Plans due to blatant disregard for making the necessary changes, CMS has the authority to impose penalties for failure to be HIPAA compliant. CMS should announce its intention to exercise – and be prepared to exercise – the penalty imposing authority for failure to meet the various milestones. We presume providers have every incentive to be compliant, because failure would result in a rejection of claims and adversely affect cash flow. Plans, however, have little financial incentive to be compliant and some have suggested Plans have an incentive to be non-compliant. We leave that to CMS to decide.

In addition, as we have recommended in the past, HBMA strongly recommends that implementation deadlines be tiered as follows:

1. One date for all systems to complete data interchanges between systems other than payors.
2. One date for completion of testing with all payors
3. One date for production with all payors

Regardless of the ultimate date at which ICD-10 CM will go into effect, a full year of true end-to-end testing should be provided with clear dates for when payors must have a testing schedule established. In addition, the testing should provide for a full weeks' worth (or similarly relevant array and volume) of de-identified production claims processed in a test harness. This will ensure all possible test scenarios are accounted for.

Delaying the effective date for ICD-10 CM adoption and implementation without instituting industry-wide phased readiness requirements would be a waste of time and resources. Without specific benchmark requirements, the same problems and lack of readiness we saw with 5010, will again present themselves in 2014 as we close in on the ICD-10 CM implementation date.

RECOMMENDATION 3:

Affected stakeholders (all payors, health plans, clearinghouses, software vendors, etc., as applicable) will issue, by October 1, 2012, a public statement of commitment to comply with the following Readiness Criteria.

A. All insurers engaging in the exchange of electronic claim information from any submitter must publish new, revised and/or retired diagnosis-based coverage policies by October 1, 2013. Insurers that have never published such policies are not obliged to do so for ICD-10 CM.

B. It should be a requirement that the diagnosis(s) used as the primary driver for payment be identified in the X12 835 electronic remittance transaction.

C. All insurers must issue and maintain a public notice of the diagnosis code format(s) they will employ during live testing and in live production thereafter. The notice shall include whether the insurer is adjudicating claims utilizing:

- Natural ICD-10 CM;
- ICD-10 CM codes received from submitters that are then mapped, cross-walked or otherwise translated to ICD-9 CM or other non-ICD-10 CM codes for adjudication;
  - Identification of the commercial or proprietary products and/or methodologies employed, by product name or description;
- ICD-9 CM codes that the insurer will continue to require from providers and the reason(s) for non-transition (i.e. HIPAA exempt, inability to meet the implementation deadline, lack of funding, etc);

D. All submitters and all claim recipients must have tested by a date certain.

E. Certification or some form of validation of testing by April 30, 2014.

As mentioned previously, Health Plans not meeting the deadlines would be subject to penalties unless CMS concluded that the plan was unable to comply with the deadlines despite a good-faith effort to meet the deadline.

Providers who are non-compliant would not be subject to penalties; however, the plan would not be required to adjudicate the non-compliant claim thus creating a financial incentive for the provider to be compliant.

Failure to require all payors, providers and vendors to adhere to established timelines, testing schedules, complete and thorough end-to-end testing, transparency in transactions, and definitions could result in insurmountable problems.

RECOMMENDATION 4:

In justifying the proposed delay, CMS identified several other major changes that were occurring almost simultaneously with the ICD-10 CM implementation. Each of these changes will have some impact on provider staff and/or resources that will be diverted from ICD-10 CM implementation. Among the other changes are:

A. The place of service (POS) requirement now delayed until October 1, 2012, poses significant operational implementation compliance challenges (transmittal 2435);

B. PQRS incentive payments. Because of the incentive payment schedule, providers will be attempting to report adherence to the PQRS criteria using one set of codes while attempting to learn and transition to a new set of codes.

C. The industry is also in the process of complying with:

i. EHR adoption;
ii. Meaningful use certification;
iii. ePrescribing;
iv. ACA state Medicaid requirements;

v. HIPAA/HITECH audits; and
vi. Contractor audits

Because ICD-10 CM is the foundation for these and multiple other CMS initiatives, successful transition and implementation of ICD-10 CM has broad based implications.

HBMA recommends delaying implementation of any new initiatives (see HPID and OEID comments) that are dependent upon successful ICD-10 CM implementation or which would divert necessary resources from ICD-10 CM implementation. This will allow full attention to ICD-10 CM.

ISSUE 2 – USE OF ICD-10 CM BY ALL PAYORS

As you know, not all payors are required to transition to ICD-10 CM. For many providers, this means that the normal claims adjudication process will require use of both ICD-9 CM and ICD-10 CM codes until all payors of healthcare claims are HIPAA compliant. Therefore, rather than fully replacing ICD-9 CM with ICD-10 CM, the healthcare industry will need the capability (and capacity) to utilize both coding systems – ongoing.

It is also not uncommon for the claims adjudication process to take a year or more to complete while appeals, redeterminations, corrections, coordination of benefits, etc. occur. Some within the industry have indicated that claim payments could be disrupted for as many as five years. Obviously, this greatly complicates transition to ICD-10 CM.

Finally, numerous surveys and reports by various coding and billing organizations found that greater than 50 percent of physician documentation cannot be reported to the most specific codes currently available. HBMA also understands that many, perhaps most, diagnosis codes reported for outpatient physician professional services are not the most specific ICD-9 CM option as a direct result of the suboptimal documentation.

Similar to ICD-9 CM, the ICD-10 CM codes include unspecified reporting options. Part of the rationale for moving from ICD-9 CM to ICD-10 CM is the greater degree of diagnostic specificity and clinical granularity of ICD-10 CM. If there is no requirement to accurately document and report the most specific codes for each patient encounter, the improved data analytics and outcomes projected as a result of ICD-10 CM utilization will never materialize.

Requiring specific and detailed provider documentation will require significant and costly physician education and training. Unless and until physicians buy into the premise that how they currently document is suboptimal, and likely not reflective of the level of care they are actually providing, and that their current documentation does not provide the details to evaluate quality of care and outcomes, behavior will not change.

We believe the historic CMS ICD-10 CM education that states physician practice changes are not needed and the continued availability of “unspecified” codes have both contributed to the slow pace of change to ICD-10 CM.

Equally important, critical work to adequately prepare for the transition is compromised by lack of information regarding payor coverage policies. (See Recommendation 1) Given that CMS' NCDs, PQRS, CMS contractor LCDs, commercial payor coverage policies, pre-authorization requirements and myriad other coverage issues are contingent on diagnosis codes, the availability of this information must begin by October 1, 2013 and must be included in any effective end-to-end testing.

RECOMMENDATION 5:

HBMA strongly recommends that all providers, vendors, clearinghouses and health plans (including workers' compensation plans and automobile insurance plans) that process healthcare claims be required to comply with the HIPAA standard transactions. In other words, we call for the complete elimination of HIPAA exempt status.

We understand plans, such as workers' compensation and auto insurance, may have unique documentation requirements. However, the use of approved, current code sets should be mandatory. California, for example, has asked for codes dating back to 1999 and 2005. The sheer magnitude of exempt plans creates barriers to a smooth conversion to ICD-10 CM.

CMS should use the additional time to update their Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) to provide its best guidance to the physician community and make this information available to providers by October 1, 2013, if the software vendor, coding support products, claim editing products, billing edit products, repricing products and the clearinghouse industry segments are to have adequate time to accommodate the rewritten LCDs and NCDs. Furthermore, the additional time will be essential, to incorporate into physician and other provider documentation and coding training.

Although technically not part of this NPRM, HBMA strongly recommends that CMS provide guidance by October 1, 2013 as to how unspecified codes will be treated after the implementation of ICD-10 CM-CM. We also urge CMS to provide national provider education on how unspecified codes will be treated.

ISSUE 3 – NATIONAL HEALTH PLAN IDENTIFIER

In addition to seeking comment on the proposed delay in the implementation date for ICD-10, CMS is also proposing to adopt new Health Plan Identification Number (HPID) and Other Entity Identification Numbers (OEID).

The original HIPAA legislation enacted in 1996 called upon HHS to develop uniform national identifiers for both providers and health plans. The intent was to eliminate the necessity for providers to maintain multiple, plan-specific identifiers and to streamline the claims submission or information gathering process for the provider by having a single unique health plan identifier.

In 2004, CMS announced the adoption of the National Provider Identifier (NPI) as the single national identifier for providers. These have been in use for several years. Although there have

been problems with the adoption and use of NPIs, many, if not most, of the problems appear to have been resolved.

CMS now proposes the adoption of the HPID as the "standard for the unique identifier for health plans," and identifies two types of "plans" that require identification: "Controlling Health Plan" and "Subhealth Plan." The purpose behind having two terms is to differentiate between health plan entities that would be required to obtain an HPID, and those that would be eligible, but not required, to obtain an HPID.

CMS proposes to require all covered entities to use a HPID whenever a covered entity identifies a health plan in a HIPAA covered transaction.

In general, HBMA supports the adoption and use of Health Plan Identifiers; although it must be stated that we are skeptical that the savings CMS believes will accrue as a result of this initiative can be achieved. It appears that some of the assumptions made about the utility and value of HPIDs when HIPAA was enacted in 1996 were overstated.

The inability to achieve the presumed administrative savings and efficiencies originally assumed by adoption and use of an HPID is not sufficient reason to scrap the idea and there may be future uses for the ID numbers that will allow unnecessary costs to be avoided.

CMS believes health care providers can expect savings from HPID implementation:

(1) Decreased administrative time spent by providers interacting with health plans; and,

(2) Automation of processes for every transaction that moves from manual to electronic implementation.

There is no question that providers – and billing companies – are frustrated by the myriad of problems they encounter when attempting to get claims properly submitted and paid by health plans. HBMA members and their clients are frustrated by errors arising because a claim was routed to the wrong location, a claim was rejected due to incorrect health plan information being given to the provider by the patient; or the provider has difficulty verifying that a patient was truly enrolled in a particular plan and the benefits of the plan in which the patient was enrolled.

As we stated in testimony before the NCVHS in 2010:

> *"Patients should be able to provide the healthcare provider with their health plan's national identifier, which we believe to be important to this and other reforms, as well as the patient's personal plan identification number. With these two pieces of information, the provider should be able to easily verify enrollment in the health plan, the type of plan and the financial information…"*

In our testimony we also pointed out:

*"If a provider were able to have instantaneous verification of the patient's insurance eligibility – **including the specific financial obligation of the patient** – the provider would know that:*

1. *The patient truly is enrolled in the health plan;*
2. *The amount the provider must collect from the patient in terms of co-pay, deductible or both at the time care is provided; and,*
3. *The financial obligation (if any) of the insurer."*

Adoption and mandatory use of Health Plan Identifiers will move us substantially down the road toward achieving the administrative simplification goal but more will still be required before we realize the type of savings you envision. The HPID is important, but it MUST be linked to the beneficiary ID in order to ensure that the provider gets accurate and timely information.

CMS spends considerable time discussing the level (corporate, legal entity, product, benefit package, plan, etc.) at which the HPID should be assigned. We believe that the level at which the Plan is identified is not as important as the linkage between the Plan identifier and the beneficiary identification number that appears on the beneficiary's card.

The key for the provider is that he/she has all of the information necessary to get the type of information we mention above. Health plans have dozens and dozens of products with varying levels of coverage (including varying levels of co-pays and deductibles). It would be impractical to issue a Health Plan ID at this level.

The Plan ID is what can efficiently get the provider to the appropriate "doorway" or portal and allow the provider to enter that portal. But once inside the plan's system, it will be the beneficiary ID that will get the provider to the proper plan for that particular patient.

In and of itself, the Plan ID will not, nor can it, resolve the many frustrations providers experience when attempting to deal with health plans. But the ID, in conjunction with the beneficiary ID can accomplish this objective.

RECOMMENDATION 6:

HBMA supports the establishment of the Health Plan ID at the level of specificity proposed by CMS.

HBMA also encourages CMS to mandate that the Plan ID cards also contain the relevant beneficiary identification that will allow the provider to easily access the particular product in which that beneficiary is enrolled.

We are concerned, however, with the timing of this initiative. As noted above, adoption and implementation of the ICD-10 coding system will consume a tremendous amount of time, energy and resources for health plans, providers and their business associates. CMS proposes that for "large" health plans, use of the HPID would become mandatory on October 1, 2014 and for small plans, October 1, 2015.

As we stated earlier, we believe CMS should suspend or postpone other initiatives that will impact or affect the ability of health plans providers to direct the resources necessary to meet the October 1, 2014 ICD-10 CM deadline. For this reason, we are concerned that mandating adoption and use of the HPID concurrent with the adoption and implementation of ICD-10 CM could prove to be a problem for some health plans and providers.

ISSUE 4 – CMS PROPOSES TO ADOPT AN OPTIONAL IDENTIFIER FOR OTHER ENTITIES FOR USE IN STANDARD TRANSACTIONS (OEID).

Although this would be an optional identification, we approach this from the perspective that at some point, this would become mandatory.

While HBMA can see the potential value in having identifiers for these "other entities" we are concerned that this initiative has not been fully vetted within the healthcare transaction stakeholder community and are therefore reluctant to endorse this proposal at this time.

We concur with CMS's assessment that there are many entities involved in the electronic transactions on behalf of either Health Plans or Providers. We also concur that there could be benefit from having these entities identified as part of this process. Examples of entities that might benefit from having an OEID are:

- Clearinghouses
- Vendors
- Third Party Billing Companies
- Rental networks
- Benefit managers
- Third party administrators
- Repricers

The OEID could be used to identify entities that are neither Health Plans (i.e. eligible for an HPID) nor Providers (eligible for an NPI) but who need to be identified for a variety of purposes.

We do not dispute the fact that there are numerous entities engaged in the exchange of information between Health Plans and Providers. In most, if not all, cases, these are agents of the health plan or the provider. And therein lies the problem.

OEIDs, as identified by CMS, function in an agency capacity and are not the principals involved in the exchange between the Health Plan or the Provider. The agents serve at the pleasure of the Health Plan or the provider and their relationship can be terminated at a moment's notice. They do not "own" the information they are transmitting but simply serve as an efficient or convenient conduit through which information flows from the primary source: the Plan or the Provider.

While we see utility in establishing identification numbers for these "other entities" we do not believe these identification numbers should be used for anything other than internal reviews or analysis by the providers or plans. Further, they could be useful in terms of identifying where a backlog or problem may be occurring.

CMS implies in the narrative, that the provider or plan could use these identifiers to go directly to the OEID, thus avoiding the necessity of going through the Plan or Provider and eliminating a

potential choke point in the process. But it is important to reiterate that the "other entities" are agents for the Plans or Providers and serve at their pleasure. Therefore, we believe it is almost always appropriate for initial contact between a plan and a provider or a provider and a plan, to go through the principal, rather than the agent.

RECOMMENDATION 7:

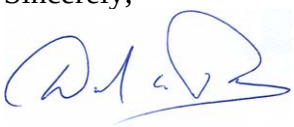
We think that at some point establishment of the OEID makes sense but given that this will be voluntary, the multitude of other administrative changes providers will be undertaking over the next two years, this is not the right time to start this initiative.

HBMA recommends that CMS postpone any action on this until providers have substantially completed the steps necessary to adopt and implement the ICD-10 CM coding system.

CONCLUSION

On behalf of the Healthcare Billing and Management Association, we appreciate your consideration of these comments. To reiterate, if we do not use the additional time CMS is seeking to establish realistic and enforceable interim milestones for ICD-10 CM conversion, we will find ourselves confronting a similar problem in 2013. CMS must work with the industry to develop meaningful transition steps to maximize the likelihood that the vast majority of providers, Health Plans, billing companies, clearinghouses, etc., will be able to submit, transmit and process ICD-10 CM claims effective 10/1/2014.

Sincerely,



Don Rodden, CPA, CHBME
President
Healthcare Billing and Management Association