Testimony of

The Healthcare Billing and Management Association

5010 – Lessons Learned

Before

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Members of the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards. My name is Holly Louie and I am the Chair of the ICD-10 Committee of the Healthcare Billing and Management Association (HBMA). I want to thank you for this opportunity to give you our perspective on lessons learned from 5010 implementation. Later today I will talk with you about how we can take those lessons learned and operationalize them so we do not repeat the same mistakes preparing and implementing ICD-10.

As you will no doubt recall from my previous presentations, a typical HBMA member processes approximately 350,000 – 400,000 claims per year, some do much more. This tremendous volume gives us a unique insight into the claims processing world and makes us qualified to address these issues.

July 1 is just around the Corner…

We sit here today, just a few weeks short of the July 1 "go live" date for 5010. As we all know, the original effective date for mandatory adoption and use of the 5010 standards was January 1, 2012 which CMS moved to April 1, 2012 and then moved again to July 1, 2012. All indications at this time are that the July 1 date will hold and we won't have another delay. We hope that is the case but, we are taking a wait and see approach.

The fact that we've experienced two delays of the 5010 effective date is an implicit acknowledgement that something went wrong on our way to 5010. In our comments this morning, we would like to highlight what we believe are some of the significant reasons why the January 1 deadline was not practical and this afternoon, we will talk about ways to prevent further delays in the adoption and implementation of ICD-10.

5010 - Lessons Learned

Mr. Chairman, for the past 3 years, HBMA has been an active participant in what is loosely referred to as the ICD-10 Stakeholders Group. Participants in this group represent virtually every stakeholder in the healthcare delivery system – except a patient group. Participants include the American Medical Association, the American Hospital Association, AHIP and Blue Cross/Blue Shield Association, the American Academy of Professional Coders as well as the Medical Group Management Association. WEDI. AHIMA and others. A diverse group, to say the least.

For the past two years, this group met on a near monthly basis to share information, provide industry updates and generally try to talk with one another to avoid problems and/or delays with both 5010 and ultimately ICD-10. We do not always agree and at times, we disagreed passionately but we all remained at the table in order to try to manage the change that is upon us.

I suppose one could flaunt the, "I told you so" mantra for all the hiccoughs and hurdles the industry experienced, but I have not found that to be helpful in my life. Unfortunately, virtually all of the concerns of those of us who live and work in the operational trenches were proven correct.

As you know, while some claims processing by some payors went smoothly at the outset, there were also many disruptions. Some, so significant, that the provider or entity had their very survival

threatened. We have heard, but have no confirmation that some practices or entities simply had to close. Even when claims were eventually paid correctly, a delay of weeks or months created untenable and unnecessary hardship. So what could we have done better? It is our belief that the need for contingency plans and delayed enforcement could have been avoided if some basic solid business premises had been developed and required. Frankly, CMS tried to be "nice" when it needed to wield the kind of power only the government can exercise.

Based upon the experience of our members, we offer the following observations.

1. 5010 "ready" was found to be a meaningless term. It meant any number of things that were essentially self-determined by the user of the term. In listening to various post-mortem explanations of "what happened", and why "ready" didn't really mean "ready" I couldn't help but be reminded of a famous politician who once said, "well that depends on what is, is."

   For some, "ready" meant that the claim got out the door or in the door depending upon whether you were a sender or a receiver. For most, it meant the most high level, superficial analysis of format. For very few, did it mean actual end-to-end testing from submission through adjudication.

   As a result, the healthcare industry had no idea who was able to correctly send, process claims and issue payment using the 5010 standards until we were in a live claims environment. Unfortunately, that was far too late to correct the problems and avoid the payment disruptions. Anytime a complex, multi-step process involving numerous participants is involved, the terminology must be clearly defined, clearly understood and used accurately, consistently and correctly in reporting status.

   HBMA recommended then and will continue to provide suggested verbiage to be adopted by the industry so that "ready" has only one meaning.

2. Successful testing was a misnomer. Testing was quantitative, not qualitative. We all heard terms like 60% are testing, 10% won't make it, etc. It sounded pretty good until the real claims processing began – or didn't. Because testing was at a high level and the test environment did not accurately represent what would happen with real claims, some had a false sense of security. In many cases, testing was successful but ongoing payor programming changes were not shared. Suddenly claims that had been successful were denied or rejected.

   Just as with the term "ready", successful testing must be at the live, claims adjudication level. To compound the testing problems, most payors tested the 837 part of the process (accepting a 5010 compliant claim), but not the 835 (issuing a 5010 compliant remittance advice on that claim).

   And the final straw was the profound lack of transparency. Multiple vendors, clearinghouses, payor hand-offs, etc. were not known to all parties and were not disclosed. Transparency is critical to success. This is not a hide the pea under the shell game and all the trading partners should be required to fully disclose all the parties in the adjudication chain as each has the potential to be the source of a problem.

While we recognize that progress will not always be simultaneous and some reasonable latitude must exist, allowing any schedule for testing creates no schedule for testing by default. If real testing of live claims had been required on a standardized schedule, all of the problems would have been known in adequate time to remediate the problems and avoid the disruptions.

Recommendation: For all future updates and changes of this significance, we strongly recommend allowing enough time to test adequately, correct problems, re-test and validate as many times as it takes to get it right before the implementation date. Problems should be disclosed and published so everyone is on a fair and level playing field.

3. The "go-live" date was whatever a given payor wanted it to be. Although January 1, 2012 was the implementation date, the actual dates varied from "significantly earlier" until "significantly later." Obviously, this created myriad additional problems for the industry.

   Recommendation: Mandatory changes should have one implementation date for everyone involved in the claims adjudication processes.

4. It wasn't a "technical" problem with a solely technical solution. As predicted, many physicians believed this was a technical problem their vendor, clearinghouse, or billing company could solve. How hard can a few programming steps be? Although it is true that this was predominately a programming and/or software capability need, all of the issues could not be "fixed" by a vendor with no input, collaboration or cooperation from the provider community. While we applaud the education CMS prepared and the diligent efforts of virtually all professional organizations, the fact is most physicians did not understand what 5010 or 835 or 837 or any other technical terminology meant to them.

   Recommendation: We believe everyone – payors, billing companies, clearinghouses, government – must do a better job of presenting information in a way that makes sense to providers in their daily practice.

5. Major problems were not anticipated. In the midst of preparing to move to the 5010 platform, CMS suspended, refiled, and suspended again, Medicare's policy on Place of Service and Date of Service. This type of indecision and disruption in the midst of a major changeover in the technical standards just simply cannot be allowed to occur. Making multiple simultaneous major changes in systems is not an easy process. Compounding this problem with additional changes only complicates the process and diverts resources from one area to another, meaning we do a lousy job at both.

   The fact is, although the proposed changes to POS/DOS would become CMS policy, other payors, systems and beneficiaries, as well as providers would be significantly impacted. For example, the myriad Medicare supplement policies, as well as each state's Medicaid program, will have to be prepared to adapt to this requirement in order for Medicare beneficiaries to have their services fairly and properly adjudicated. In addition, Medicare beneficiaries covered by a Medicare analog (Part C) plan may have additional difficulties, inasmuch as Medicare Advantage plans are geographically-specific, often with very narrow market areas and requiring practices to be under contract and/or obtain pre-authorization for certain services, in specific locations (i.e.

office vs. hospital) and within specific dates. In addition, commercial payors that choose not to or can't program these changes would require payor specific DOS and POS programming, another major and costly undertaking. As we sit here today, although the POS transmittal is projected for October 2012 implementation, the DOS instructions were not reissured by CMS, resulting in contradictory MAC or contractor policies. While this may or may not affect the anticipated additional 5010 standards, it will almost certainly divert resources from ICD-10 preparations.

Imagine asking your technical people to work through these POS/DOS issues at the same time they are trying to conduct the testing necessary to assess "readiness" for 5010 and the necessary much broader scope of work that will be required for ICD-10?

Recommendation: Do not propose or seek to adopt changes in policy while CMS is in the midst of other major changes unless statutorily required.

6. Specific to eligibility, claims status, etc., our members have identified very few payors currently offering these options.

   Mr. Chairman, you will recall from past testimony that we have expressed concern that very few payers are utilizing the various operational standards available to engage in fully electronic transactions/communication.

   For example, while virtually every health insurer can successfully accept a 5010 compliant claim (837) and remit a 5010 compliant notice (835), a very small percentage of plans can engage in other types of electronic transaction.

   Sadly, the current 835 notices can be virtually meaningless, even though the payor is allegedly "compliant". For example, the remittance advice specifies CO50 (a contractual adjustment because the service was not medically necessary) but no elaborating messages. This necessitates a call to the payor only to be told, the "real reason" for the denial is specific to a pre-authorization issue, There are specific, standard codes that explain this circumstance but many payors opt to use only a small subset of the standards explanations and reasons available, defeating the entire purpose of standardization and simplification.

   True end-to-end testing not only assesses the ability of the provider to submit and the payer to accept a 5010 compliant 837, and the ability of the payer to transmit and the provider to accept a 5010 compliant 835, it also tests the ability of the provider to submit a 5010, 270/271 (eligibility inquiry and response), 276/277 (Claims Status inquiry and response) and 278 (Request for Review and Response).

   Recommendation: CMS should require that all of the standards be used in the way administrative simplification was intended rather than giving wide latitude in how and when they are used.

Conclusion:

Mr. Chairman and Members of the Subcommittee I urge you to heed the advice of the industry and take advantage of the time we have to set in place policies that ensure we do not find ourselves sitting in this – or some comparable room – 3 years from now, doing a post mortem on “lessons learned” from poor implementation of ICD-10.

Thank you again for your attention and allowing me to address you today.