



Testimony of

The Healthcare Billing and Management Association

“ICD-10: Avoiding the 5010 Pitfalls”

Before

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Subcommittee on Standards

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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 again give you our perspective on the implementation of the ICD-10-CM coding system.

HBMA members process physician billing, non-physician billing, hospital billing and other claims integral to the U.S. healthcare delivery system. A typical HBMA member processes approximately 350,000 – 400,000 claims per year, some do much more.

In addition, 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.

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
- ◆ RVUs
- ◆ Denial codes
- ◆ Electronic claim submission
- ◆ Electronic funds transfer
- ◆ Evaluation and Management codes
- ◆ APCs
- ◆ NPIs
- ◆ HIPAA
- ◆ Electronic remittance
- ◆ Clearinghouses
- ◆ 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.

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. More importantly, CMS must communicate to the stakeholder community why this delay was necessary, despite assurances a year ago that the ICD-10 CM compliance deadline would not change. Failure to not only articulate the new policy, but also the rationale behind the delay could have long-term consequences for the agency in terms of industry compliance with future deadlines.

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 2014, then we must learn from our past mistakes in order to avoid repeating them.

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 cooperation 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. Even now, we know some Medicaid programs will not be able to meet this deadline and extensions for their compliance have (or will be) granted.

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 payer testing was severely limited. The first six months of 2012 underscore this point in that many payers only tested syntax prior to the implementation of 5010 and 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 full claim level adjudication and 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 clearer, more comprehensive and more broadly disseminated;
3. No time was planned for remediation and retesting before implementation;
4. Payers 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 payers announced they were going live and then subsequently announced they were not going live; and,
5. There was a lack of transparency that made it virtually impossible to know where problems were, i.e. one clearinghouse handed off to another and 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 denying because they did not know about steps 2 and 3.

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 been paid for covered services. It has been more than 5 months since the effective date for 5010 compliance and some plans are still not 5010 compliant. Segments of the industry are still using “contingency” plans and some payers are still incorrectly adjudicating claims under the 4010 requirements and the use of companion guides remains pervasive with some payers. 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. To further complicate the issue, HIPAA exempt payors use a wide variety of non-standard requirements.

As you know, ICD-10 has far more impact and involves far more change than 5010. Unlike 5010, physicians must be personally and actively involved in the ICD-10 process. 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. We know CMS shares our concern about provider viability and patients’ access to care if our worst fears become a reality.

In principle, HBMA supports delaying the ICD-10 effective date. But we also strongly recommend significant changes in the required methodology and work providers and health plans will need to demonstrate over the next 2½ years in order to avoid implementation problems.

We cannot stress enough 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 necessary to prepare for ICD-10

CM have been addressed by many vendors, payers, 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 payers 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/payer and payer-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 payers and vice versa.

Examples of the types of interfaces we mean are:

- ◆ Hospital/EHR systems
- ◆ PM/Lab systems
- ◆ EHR/EHR systems
- ◆ Lab/lab systems
- ◆ PM/Coding systems
- ◆ PM/EHR systems
- ◆ EHR/Lab systems
- ◆ PM/PM systems
- ◆ PM/Payer or clearinghouse systems

All of these interfaces exist because 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, while others may choose to extend maintenance and support of both ICD-9 CM and ICD-9 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 could 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 have, for the most part, been achieved, 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 payer 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 payers and providers.

Therefore, in the time remaining before full implementation of ICD-10 CM, we encourage CMS and the Secretary to establish periodic 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 payer 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 payers 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 payers. 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 CMS-3M project for DRG to ICD-10 comparison.

Because there is no definition of “ready,” plans and vendors can 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 successfully been 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.

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 would be subject to fines and penalties.

HBMA recommends Health Plan coverage policies be published by October 1, 2013. This would allow adequate time for education and training, programming, data analysis and other preparations for ICD-10 CM.

HBMA also recommends that the definition of “ready” include all of the transaction types, not just the ability to submit claims or process remittances containing ICD-10 CM codes.

RECOMMENDATION 2:

HBMA recommends that CMS create a national bulletin board where all health plans can enter their name, 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.

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 were ready could realize a market advantage during “open seasons” whereas plans that were 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 compliance deadlines.

RECOMMENDATION 3:

HBMA recommends that shortly after announcing the new ICD-10 CM effective date, CMS identify and publish specific, verified readiness milestones for providers and insurers.

If these readiness milestones 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 be prepared to exercise – and announce its intention 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 milestones be tiered as follows:

- a. One milestone date for all systems to complete data interchanges between systems other than payers.
- b. One milestone date for completion of testing with all payers
- c. One milestone date for production with all payers

Regardless of the final effective date at which ICD-10 CM will go live, a full year of true end-to-end testing should be provided with clear dates for when payers must have a testing schedule established. In addition, the testing should provide for a full weeks worth 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 itself in 2014 as we close in on the ICD-10 CM implementation date.

RECOMMENDATION 4:

Affected stakeholders (all payers, 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.** Payers should provide transparency as it relates to payment (fee) schedules or other contractual aspects of their relationship between themselves and providers. Payment schedules should be made available online for use by all systems on which providers are dependent for billing to enable automated checks and balances that correct adjudication has taken place.
- D.** 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);
- E.** All submitters and all claim recipients must have tested by a date certain.
- F.** 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 payers, 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 5:

HBMA recommends delaying implementation of any new initiatives 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.

In justifying the proposed ICD-10 CM delay a few weeks ago, 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 multiple other CMS initiatives, successful transition and implementation of ICD-10 CM has broad based implications.

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.

RECOMMENDATION 6:

HBMA strongly recommends that all providers, vendors, clearinghouses and health plans (including workmen's 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. We believe those needs can and should be resolved through claims attachments and other options. However, the so called "unique needs" of HIPAA exempt payors should not be permitted to exclude them from the requirement to use current codes sets. California, for example, has asked for codes dating back to 1999 and 2005 for claims in 2012.

PHYSICIAN ISSUES

Numerous surveys and reports by various 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. If that is to be the end result, why are we doing this?

Requiring specific and detailed provider documentation will require significant 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, you can just update a superbill, and the continued reassurances of the availability of "unspecified" codes have significantly contributed to lack of focus on preparation for ICD-10.

Equally important, critical work to adequately prepare for the transition is compromised by lack of information regarding payor coverage policies. 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.

We are well aware that various maps and crosswalks are believed to be the magic bullet to solve the challenges involved in implementing ICD-10. Likewise, many vendors are marketing and physicians believe an EHR that assigns codes will solve any and all issues in correctly coding ICD-10. The critical point that is omitted from the vast majority of conversations specific to this topic is that these are tools, ***not coding!*** One of the major payors recently summarized this issue very well. Because there are fundamental differences in language and codes, attempting to use a crosswalk or map as a work-around to learning and accurately reporting ICD-10 codes will result in catastrophic failure. It should be very clear that maps, crosswalks, and EHR are not a viable coding solution.

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. Sound business principles must be the guiding building blocks for the industry. Every man for himself will not work.