Testimony Before

National Committee on Vital and Health Statistics
Standards and Security Subcommittee

5010 and ICD-10 Update

Presented By:

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Mr. Chairman and members of the National Committee on Vital and Health Statistics (NCVHS). My name is Holly Louie and I am the co-chair of the ICD-10 Committee of the Healthcare Billing and Management Association (HBMA). On behalf of HBMA and the more than 600 companies that belong to our association, I want to thank you for this opportunity to give you an industry update on readiness for implementation of both 5010 and ICD-10 CM. Our members process an estimated 350 million claims per year, making us uniquely qualified to address these issues.

HBMA has been and continues to be a strong supporter of the move to more advanced and comprehensive electronic claim transactions. We also support the CMS position that the implementation dates are firm. However, we believe a much more organized and aggressive universal approach must be undertaken at once for a successful transition to 5010 and subsequently ICD-10 to occur.

As requested, I will go through the questions you have asked us to address.

HBMA PREPARATION FOR THE IMPACT OF 5010 and ICD-10

The transition to ICD-10 is the most far-reaching change our industry has seen in most of our professional lifetimes, touching every facet of healthcare delivery: documentation, operations and reimbursement.

In reviewing how resources have been allocated, it is our view that a disproportionate amount of time has been directed towards educating providers about the effective dates and too little time and too few resources have been directed towards educating providers about the operational and financial issues that will likely occur as a result of this transition. We are concerned that the emphasis on dates rather than the need for process change has caused many providers to conclude that this transition is largely a series of technical changes that will have little direct impact on their practice.

HBMA has continuously encouraged billing companies and their clients to prepare for both the 5010 and ICD-10 transition for several years. Beginning in 2009, we have conducted numerous educational programs at our semi-annual meetings, published articles in our monthly journal, “BILLING”, conducted webinars on these topics, and established a dedicated ICD-10 website with links to authoritative citations and industry stakeholder resources. These efforts will continue through 2013 and beyond.

In 2009, HBMA created our ICD-10 Committee as a means to bring together various entities involved in the healthcare transaction chain. The purpose of the Committee is to address the myriad issues involved in moving from both 4010 to 5010 and ICD-9 to ICD-10. Our committee is a multi-disciplinary group of billing companies, software vendors, health plans, physicians, coding experts, clearinghouse representatives and other entities involved in claims submissions and processing.

As you know, individuals representing software vendors and clearinghouses have testified before NCVHS during the past year on HBMA's behalf so that this committee could have the benefit of their insight and perspectives. In preparation for this testimony, we consulted with several software vendors and clearinghouses, as well as our members and various industry stakeholders.

Although we are confident that most billing companies and their vendors are as prepared as they can be for the transition to 5010, there are some troubling signs on the horizon that bear notice.

A. We remain concerned that many physicians (and billing companies) are relying upon their software vendors and clearinghouses to be 5010 compliant. While it is true that vendors and clearinghouses will be responsible for compliant claim submission, the perception appears to be that 5010 is a solely a technical issue that does not impact them and that no actions are required. It also appears physicians and billing companies may not fully appreciate the need for individual testing by client and specialty, in addition to the work their vendor and clearinghouse are doing with payors. We are concerned that provider-specific information in vendor and clearinghouse databases is not up-to-date (consistent with PECOS) because physicians are unaware of the potential issues, have not budgeted the time and labor required, and/or some physician practice management systems are unable to accommodate the required modifications. This situation will lead to claims rejections – not because the claim is out of compliance with the technical standards for 5010, but because the information in the payor database is not identical to information in the vendor/clearinghouse database. New 5010 requirements for data consistency will, we believe, cause claims payment delays and disruptions, seriously impairing physician cash flow. Our primary concern is that testing will not expose these discrepancies and only when live claims are processed will providers and payors learn that the claims have failed.

B. Further, we are concerned that there is a disconnect between what vendors, clearinghouses and health plans mean when they say they are "5010 ready" and how those words are being interpreted by physicians and billing companies. We have learned that "5010 ready" may mean only internal testing is complete, external testing is in process, external testing is scheduled, external testing has been successfully completed with a (or some number) of payors, or external testing has been successfully completed with all payors.

We are also concerned that "5010 ready" appears to apply almost exclusively to claim submission and does not include other functionality available with 5010 implementation. In 2009, we testified before this committee on this issue.

As we sought to determine the full scope of insurers' compliance with the accepted HIPAA transactions we sought input from the Cooperative Exchange, the clearinghouse industry trade association. They were able to provide a very detailed "map" of nearly 1,700 insurers and which HIPAA transactions they supported. If you would like, we would be happy to provide the committee with the complete set of spreadsheets but in the interim, the summary statistics

are provided in **TABLE 1**. This table identifies all 12 variants of HIPAA transactions and how many of each variant are supported by third party payors. It should be noted that this list should not be construed as absolute, which is to say that there is a possibility that the Cooperative Exchange survey may indicate that a payor does not support a certain transaction set; however, this could be a result of clearinghouses not having a need to develop the transaction set with the payor. Additionally, the Cooperative Exchange members do not have direct connections with every possible payor; therefore this analysis is only applicable for those payors for which they have direct connections.

Even with these caveats, we believe the above data confirms what HBMA's members have observed since HIPAA TCS was implemented; that insurers support the transactions that lower their own operating expenses – receiving claims via the "837" transactions, but largely fail to support the transactions that lower providers' operating expenses. The overall conclusion is that active support of HIPAA transaction codes is far from widespread despite years of opportunity for insurers to implement them.

TABLE 2. shows the number of insurers that support a given total number of transaction types. Virtually none support every form of HIPAA transaction (again, please note the explanation provided above) and "one" is the most prevalent number of transaction types supported! Further, 88.2% of insurers support no more than 3 HIPAA transaction types. It is noteworthy that only 14 insurers do not support even 1 HIPAA transaction type; one might conclude from this that almost every insurer has made a determined effort to be able to report that they "support HIPAA transactions," although that claim would have to omit the extent of that support.

HBMA believes the information garnered from the Cooperative Exchange survey is extremely relevant to the work of this Committee. Those of us who are in the business of handling and processing medical claims are concerned that the same level of support and compliance we are seeing with the current standards will be reflected in the new standards. In other words, the physicians and billing companies will do everything to comply with the 5010 and ICD-10 standards – at considerable expense to the provider. But the payors will, once again, find ways to circumvent the law. This cannot be allowed to continue to happen.

C. Very few health plans (published averages range from 8–12% to <15%) have successfully completed testing with providers, billing companies, software vendors or clearinghouses. There are approximately 134 business days to complete 5010 readiness. We are very concerned that given the large number of health plans that have planned but not yet begun testing, the number that have no estimated date for testing and the amount of time it takes (typically 2 – 3 days) to conduct and complete the testing process (with no guarantee it will be successful), we are out of time to complete the testing by the January 1, 2012 go-live date. We are also concerned about conflicting testing information. For example, we have been advised

by our clearinghouses and vendors that some MACS have instructed them to test once and some have instructed one test per provider or group, a potentially enormous difference.

Given past experience and the current industry lack of readiness, we anticipate significant delays with the processing of claims during the initial phase of implementation and beyond. We also anticipate some payors that are unable to meet the January 1, 2012 deadline will reverse map 5010 to 4010 as an interim solution. As these payors complete programming and system changes and are able to process 5010 claims in 2012, we believe we will see additional issues arise.

The lack of readiness is further complicated by the inefficiencies, costs and delayed payments associated with the necessity to support 4010 and 5010, to accommodate payors that are HIPAA exempt and do not update to 5010, and for payors with disparate implementation schedules. If a primary payor is 5010 compliant on January 1, 2012 and a secondary payor is not (a typical Medicare/Medicaid scenario), manual processes, paper claims and other costly interventions will be required. The bottom line for the physician or provider is additional increased costs and delayed payments for the foreseeable future.

D. IMPLEMENTATION STRATEGIES AND SENSE OF URGENCY

In all candor we are concerned that the sense of urgency amongst physicians and health plans is nowhere near where it should be. As I mentioned earlier, we believe there is a major disconnect between what "being ready" means and how these words are interpreted by physicians and some billing companies.

We are concerned that the level of testing between clearinghouses and health plans and vendors and health plans is nowhere near where it should be 134 days from the "go-live" date for 5010. In addition, there appears to be a less than optimal level of testing between physicians and their clearinghouses and vendors and an even more suboptimal level of testing with payors.

Based on our communications with the vendors supporting our members, we believe that by and large, most software vendors and clearinghouses long ago completed their internal testing and have been ready, willing and able to test with health plans for several months, and many since last year. Unfortunately, these vendors and clearinghouses have not had anyone with whom to test. Billing companies, software vendors and clearinghouses are very concerned with the slow pace with which health plan testing is moving.

At the rate things are going, we are concerned that it will be impossible to complete all of the testing that will be required by the January 1, 2012 go-live date.

E . WHAT'S MISSING?

The testing process between health plans and vendors and clearinghouses must be accelerated. At the current pace, there will be insufficient time to complete all of the testing required between now and the January 1, 2012 go-live date.

We strongly urge the Office of E-Health Standards to assess the readiness for health plans to test – now and determine why so few – as a percentage of the health plan industry – have successfully completed or are able to offer live testing with their partner?

In addition, we urge the office of E-Health Standards to seek from the plans their own internal assessment of readiness for both testing and compliance.

Finally, we believe the Office of E-Health Standards should obtain from plans that will be unable to meet the 1/1/2012 deadline a contingency plan in the event the plan is unable to accept a 5010 compliant claim.

Frankly, the need for providers, vendors, clearinghouses and payors to internally convert 4010 to 5010 or 5010 to 4010 to allow claim processing should be prevented, as much as possible, and should not be as prevalent as it appears it might be. There should be a compliance contingency plan that would extend for a short and specified period of time after January 1, 2012.

Assuming all the current readiness data and statistics are accurate, completing the 5010 conversion will continue well into, and perhaps beyond 2012. Considering this is relatively simple, compared to the ICD-10 conversion, we are deeply concerned about the negative impacts on physicians and the healthcare industry and the lack of credible contingency planning.

F . WHAT DOES 5010 READY MEAN?

We (that's all of us) need to better explain to providers what it means when a vendor, clearinghouse or health plan attests to being "5010 ready."

We must educate physicians that an attestation from their software vendor or clearinghouse that they are 5010 compliant does not mean 5010 claims will process seamlessly.

We are very concerned that through the use of the 5010 format, health plans will adopt new edits which will cause claims to be rejected. Although technically these rejection notices will not be directly related to the 5010 standards, the provider will not see things that way.

This is why we think we need to redouble our educational efforts to avoid these cases of mistaken blame. Along these lines, HBMA has arranged for a free webinar for next Tuesday, June 23rd to address these issues and work with our billing company colleagues to get their cooperation in quickly addressing these concerns.

G. COLLATERAL IMPACT ISSUES

For almost a decade, the Sustainable Growth Rate (SGR) has calculated a negative adjustment in the payments to physicians. Because the SGR formula is cumulative, the projected payment adjustment for 2012 will be –30%. Almost every year, Congress intervenes – mostly, but not always at the last minute (sometimes retroactively) – and neutralizes the reduction or implements a nominal increase. The legislative brinkmanship that has always accompanied this annual event (three times in 2010!) wreaks havoc with the Medicare contractors who must program last-second changes to their claims processing systems.
Six months later, the chaos that followed the 2010/2011 changes are not yet fully resolved. Many of the after-the-fact adjustments and "fixes" that resulted from the legislative process have required multiple, highly complex reprocessing of already submitted, already processed and/or already paid claims.

We are concerned that yet another SGR crisis on December 31, 2011 will add another dimension to the "perfect storm" of a 4010A1 – 5010 transition. We are well aware that NCVHS, CMS and others responsible for the transition to 5010 are unable to affect this issue. However, we wish to point out that this transition is not occurring in a vacuum and there are many other economic factors impinging on physician practices. Even a minor "glitch" or "meltdown" in the 5010 transition, if coupled with another nearly inevitable SGR crisis may cause more physicians to abandon the Medicare program, as well as other payors that stumble out of the 5010 gate.

In addition, there is a well-known active federal initiative to promote adoption of electronic medical records. While adoption may or may not be as brisk as hoped or predicted, practices are actively engaged in EMR adoption and many of the practices are just now beginning to work with, or about to begin working with a new product offered by a vendor in its own infancy, as many of the hundreds of EMR products are offered by start-up companies with little or no prior experience in health care transaction.

H. STRATEGY FOR PROCESSING TRANSACTIONS WITH ICD-10 CODES – THE USE OF CROSSWALKS, ICD MAPPING TOOLS AND GEMS.

ICD-10 does not appear to be a priority or have a sense of urgency for most physicians at this time. Although some facilities have begun work on ICD-10, it is not universal and does not have widespread physician participation. Numerous stakeholders have addressed the competing issues facing physicians and providers that require prioritization and allocation of

resources. While there is no disputing the criticality of planning for ICD-10, the fact is there is simply not enough money, staff and time to tackle all of the competing requirements at once.

HBMA believes a major factor in the lack of urgency is the unknown reimbursement impact. Yes, there are crosswalks, GEMS, and various mapping tools. Yes, CMS has analyzed the payment impact using GEMS, but only on inpatient claims. However, the key question is one of payment, not coding. This key question, which neither CMS, nor the commercial payor community has definitively answered is, "Will unspecified diagnosis codes be reimbursed under ICD-10?" Similar to 5010 communications, the message to physicians has been that this conversion will be easy, they do not need to modify behavior, an EHR or mapping software will be the solution to any issues and there are still unlisted codes.

As anyone who deals with physician documentation on a regular basis can attest, many medical records lack the details necessary to support the specificity in ICD-9 CM, much less ICD-10 CM! If payors intend to require the most specific diagnosis code ***for payment***, significant time will be required to educate physicians and assist them in accurately and completely documenting their services. We believe until such time as the payment effects are known, physicians will not have any sense of urgency or believe any modifications or actions on their part are required. Again, they will look to vendors for the solution to any issues that may arise.

We also understand that many payors will rely upon internal, proprietary mapping to adjudicate claims. An ICD-10 CM code will be mapped to an ICD-9 CM code, a payment determination will be made based on the ICD-9 CM code but the ICD-10 CM code will be reported with the payment or denial. The effect is that the plan adjudicates a claim based upon a completely different code than the one intended – or submitted – by the provider. This can result in the denial of a claim that should have been paid by the plan or a payment from the plan that is different from the amount expected by the provider. Of equal, or greater concern, is that the patient will be "labeled" with a diagnosis that may be inaccurate and which might, in the future, affect their treatment by another provider, their ability to purchase life insurance, or be granted a security clearance.

HBMA learned at a recent HIMMS meeting that some commercial payors anticipate a minimum of two years, and potentially five years, of this internal mapping will be required to rebuild risk and claims databases. It was also stressed that payment delays, increased denials, increased operational work and costs to practices and the need for practices to have increased cash reserves should be expected. HBMA has been warning of this eventuality for the past two years. However, we do not believe most physicians, providers and their billing companies have planned for two to five years of additional costs, staffing, and operational challenges after the October 2013 implementation date.

As discussed above with 5010, we are also concerned that HIPAA exempt payors will choose not to implement ICD-10. Given current experience, the fact that ICD-9 will not be maintained is not a deterrent. In fact, one might speculate that HIPAA-exempt payors will appreciate that

ICD-9 CM is "frozen," allowing them to streamline their claims process with more stability! Two coding protocols will require maintenance of parallel systems, or the purchase of a new system, that supports both ICD-9 and ICD-10, an additional cost with no end date.

Based on our current experience with 5010, we are very concerned the industry will not be ready for the conversion to ICD-10. Preparation for much of the industry is in the infantile stages or has not begun, no coordinated testing is on the horizon, no payment policies have been announced, variable unknown mapping programs will be relied upon, and no published study has fully examined the financial and payment impact for physicians and no known contingency plans exist. Given the literally hundreds of payors and thousands of plans, this is a monumental undertaking.

We strongly urge CMS and other health plans to clearly publish their policies with respect to the level of coding that will be expected and more importantly – ***reimbursed*** – by the health plans. While some flexibility with the use of the unspecified codes may be necessary in the early stages of the transition, CMS and health plans should seek to ***gradually*** raise the bar in terms of the expectation for accurate coding by the providers and/or their staffs.

While we are obviously concerned about whether these claims will be paid, our larger concern is that the answer to this question will by-and-large dictate the sense of urgency a provider feels in terms of appropriately using the ICD-10 codes. If a provider knows that health plans will continue to process and pay claims using the unspecified codes, then he/she or the provider's staff have little or no incentive to document services more thoroughly or to really learn and apply the specificity available with ICD-10.

Equally important, we lose the one reason for moving to the ICD-10 system – the ability to have greater detail and information about what is occurring in the provider-patient encounter.

In essence, if the current widespread use, acceptance and payment of the unspecified codes allows the provider to be technically compliant with the HIPAA requirements but functionally, continue to use minimum, generic codes, we will have spent millions – possibly billions – to adopt and implement a coding system that in the end, will be no better than the current coding system.

I. DUAL PROCESSING OF CLAIMS

This phrase has two meanings:

a. Dealing with payors that will accept ICD-10 CM or ICD-9 CM, but not both;

b. Dealing with claims submitted to more than one payor for a single service, one that only accepts ICD-10 CM and one that only accepts ICD-9 CM.

NOTE: A variant of this are the so-called "cross-over" claims, where the initial payor – most commonly Medicare – forwards the claim information to a secondary insurer ("Medi-Gap" plans). If Medicare accepts ICD-10 CM codes and passes those code(s) to a secondary insurer that can only process an ICD-9 CM code, chaos will result.

This will mean that providers, vendors, clearinghouses and health plans will need to maintain due capability – submit and process both ICD-10 CM claims, as well as ICD-9 CM claims.

We fully expect that there will be some plans that will be unable to process an ICD-10 claim after the deadline but more importantly, there are some third-party payors who are not subject to the HIPAA standards – most notably, workers compensation, auto insurance and tort liability plans. Therefore, it is inevitable that providers and billing companies will have to maintain both an ICD-9 CM capability as well as an ICD-10 CM capability, for at least a year, and perhaps indefinitely-a significant and costly problem.

Clearly, the Office of E-Health Standards can address the non-compliant health plan concern through their enforcement authority. We intend to work closely with OESS to identify, work with and if necessary, seek penalties against health plans that fail to comply with the HIPAA standards.

The issue of non-covered plans is entirely different. OESS can encourage these plans to become ICD-10 compliant but because they technically have no jurisdiction over these HIPAA exempt plans, there is little they can do from an enforcement standpoint. Clearly the underlying HIPAA law needs to be re-examined and a concerted effort by the provider, vendor, clearinghouse and health plan communities to seek uniform application of the HIPAA standards to all third-party payors.

SUMMARY OF KEY CONCERNS

In conclusion, I want to reiterate HBMA's key concerns:

1. Testing is going too slowly and only focuses on successful claim submission, not complete adjudication, eligibility and benefit verification, claim status, claim query, etc. Providers are overly reliant upon assurances by vendors and clearinghouses to ensure the successful submission of claims post-2011.

2. Providers unaware of and are not taking the necessary steps to monitor and work with their vendors and clearinghouses to ensure that the information on file with their vendors and clearinghouses is up-to-date and consistent with information in the health plans database.

3. The level of testing between health plans and providers, vendors and clearinghouses is severely behind schedule. Testing schedules must accelerate their plans or we will not meet the January 1, 2012 "go-live" date. HBMA also wants to emphasize that we are not in favor of a postponement of the January 1 date; instead, we believe that the industry must intensify its efforts and CMS must become more aggressive in monitoring the industry's progress.

4. Reliance on crosswalks and intermediaries to convert to required standards – 5010 or ICD-10 – will cause unforeseen but predictable problems in payments, resulting in unnecessary delays or inappropriate payments for legitimate services rendered by providers.

5. The convergence and nearly simultaneous need for providers to make numerous technological and administrative changes will place a tremendous financial and human resource burden on providers. Uncertainty about future payments due to projected Medicare cuts causes providers to be reluctant to make the types of financial commitments necessary to comply with the 5010 and ICD-10 standards.

6. The 5010 transition is too often viewed as a technical endeavor; the technical advancement of administrative simplification, a programmers' delight and job security for technicians. It is not. This is about the life-blood of providers – cash flow – and 99% of all efforts should be focused on protecting and sustaining the cash flow of all providers during this transition. Medical practices, in particular, have been beset by a vast array of industry and economic changes that have undermined their income and their ability to sustain their businesses. If the 5010 and/or ICD-10 CM transitions fail them, many will be forced to shun the patients whose insurers are problematic, affecting the individuals our health care system is designed to serve – the patients.

HBMA will continue to aggressively educate our membership – and our members' clients – about the need to engage in testing and updating with vendors and clearinghouses. In addition, we urge CMS and the health plan community to do more outreach with providers educating them on ALL of the steps they must engage in to ensure little to no disruption in claims payments after January 1, 2012.

On behalf of the Healthcare Billing and Management Association, our member companies and the hundreds of thousands of physicians we bill for, I want to thank you for this opportunity to present our views and concerns and I look forward to answering your questions.

TABLE 1.													
Transaction Codes	**837**			**835**		**270 – 271**			**276 – 277**		**278**		**Total**
	P	**I**	**D**	**P**	**I**	**P**	**I**	**D**	**P**	**I**	**P**	**I**	
# of Insurers = 1,689	**784**	**783**	**266**	**301**	**306**	**347**	**27**	**47**	**84**	**94**	**18**	**8**	**3,065**
Percent Supported	**46.4**	**46.4**	**15.7**	**17.8**	**18.1**	**20.5**	**1.6**	**2.8**	**5.0**	**5.6**	**1.1**	**0.5**	**15.1**
Total Number of Possible Matches = 1,689 Insurers X 12 Codes = 20,268													

TABLE 2.		
TRANSACTIONS	**COUNT**	**PERCENTAGE**
12	**0**	**-**
11	**2**	**0.1%**
10	**0**	**-**
9	**0**	**-**
8	**3**	**0.2%**
7	**5**	**0.3%**
6	**22**	**1.3%**
5	**39**	**2.3%**
4	**114**	**6.7%**
3	**173**	**10.2%**
2	**365**	**21.6%**
1	**952**	**56.4%**
0	**14**	**0.8%**
TOTAL	**1,689**	**100.0%**