National Committee on vital and Health Statistics Subcommittee on Standards

Nancy Spector, Director, Electronic Medical Systems
American Medical Association

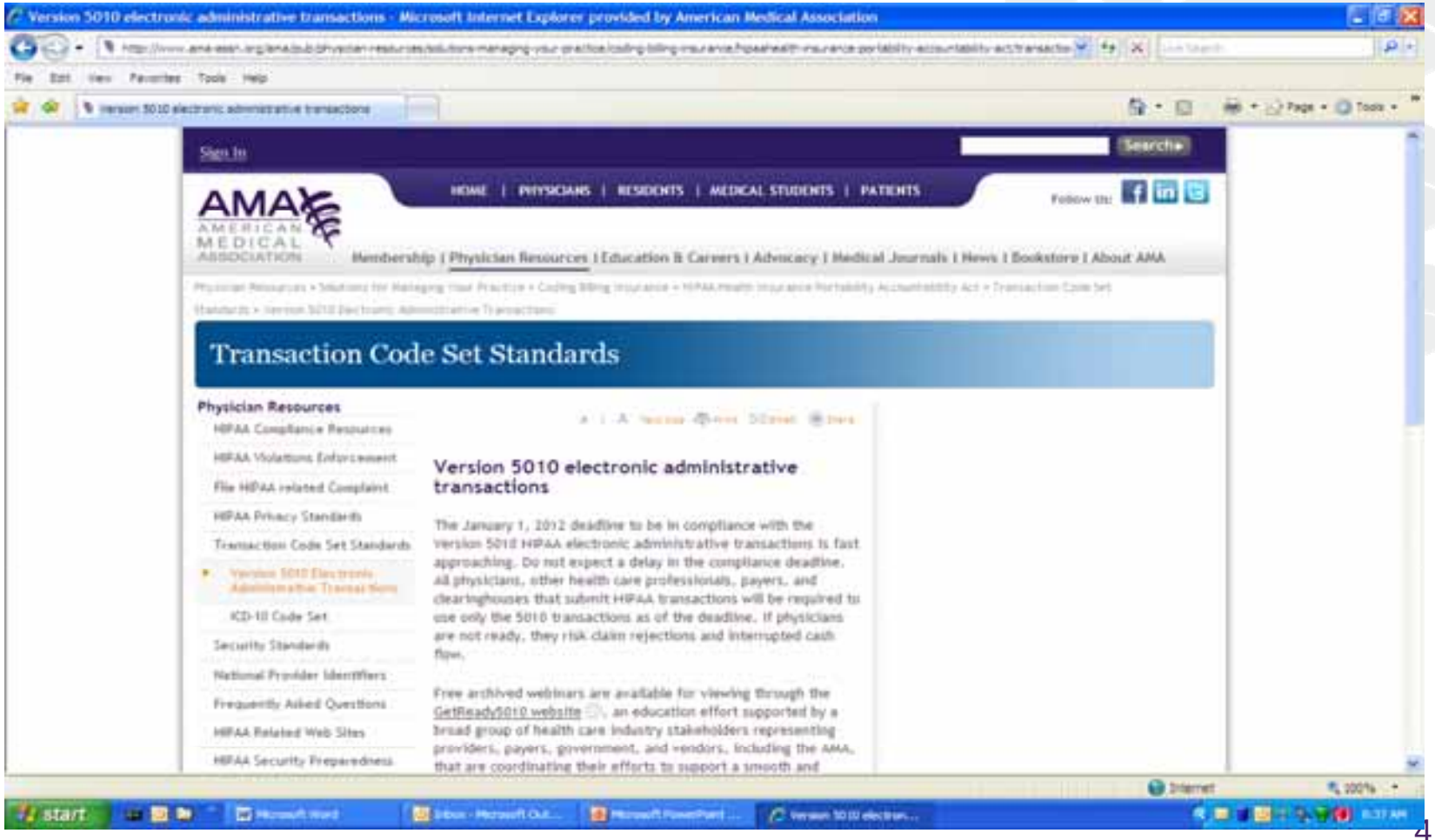
Testimony Overview

- 5010 Readiness
  - Outreach and education work
  - Survey results
- ICD-10 Readiness
  - Outreach and education work
  - Survey results
- Awareness Issues
- Risk Areas with Implementation
- Issues Identified with the HIPAA Transactions
- Barriers to Implementation

AMA 5010 Outreach and Education Work

- Updated Web site content
- Educational materials
- Articles
- Announcements/Alerts
- Presentations
- Collaboration work
- Surveys

AMA 5010 Web Site
www.ama-assn.org/go/5010



5010 Educational Materials

- 5010 Data Reporting Tips
- Be Compliant for 5010
- 5010 Checklist
- 5010 Project Plan Template - Helping Practices Prepare for the New HIPAA Standards
- 7 Steps Practices Can Take Now to Prepare for 5010

5010 Educational Materials (cont.)

- 5010 Fact Sheet Series
  - #1 HIPAA 101: How it Started and What's New
  - #2 5010 Timeline: Getting the Work Done in Time for the Deadline
  - #3 HIPAA Terminology
  - #4 What's Different in the 5010 Transactions
  - #5 Testing Your Readiness for the 5010 Transactions
  - #6 Complying with the HIPAA Transactions and Code Sets
  - #7 "Errata": What It Is and What It Means for Practices
  - #8 Preventing Cash Flow Interruptions during Transition to 5010
  - #9 Using the Acknowledgements Transactions

5010 Educational Materials (cont.)

- AMA – MGMA Selecting a Practice Management System Toolkit
  - Available at: www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/practice-management-center/pms-toolkit.page
  - Criteria checklist of what a practice should look for in a system to meet 5010 requirements
  - Online directory of vendors for AMA and MGMA members to search

5010 Articles

- Published in various AMA print and electronic publications
  - An Update to the Current Version of Electronic Administrative Transactions Is on the Horizon: Understanding How This Impacts Your Practice, *CPT Assistant*, June 2009
  - Need Help with New HIPAA "5010" Standard Transactions and ICD-10 Code Sets?, *AMA eVoice*, December 4, 2009
  - Compliance deadlines approaching for "5010" standard transactions, ICD-10 code sets, *AMA eVoice*, April 23, 2010
  - Prepare to implement "5010" standard transactions, *AMA eVoice*, May 7, 2010
  - Have you contacted your vendor yet about "5010", ICD-10?, *AMA eVoice*, July 2, 2010
  - Testing for version 5010 to begin Jan 1, *AMA eVoice*, September 29, 2010
  - Are you prepared for 5010 and ICD-10? , *AMA Wire*, December 15, 2010
  - Version 5010 transactions: Are you testing yet?, *AMA Wire*, January 5, 2011
  - Don't let your HIPAA claims be rejected, *AMA Wire*, February 16, 2011
  - Not e-claim compliant? Expect no pay in 2012, *AMNews*, April 25, 2011
  - Compliance deadline for new version of HIPAA administrative transactions approaching: Will you be ready?, *CPT Assistant*, May 2011

5010 Announcements/Alerts

- Sent via AMA listservs, Facebook, and Twitter
  - New resource on 5010 implementation
  - 5010 fact sheet series and project plan template
  - Just over 90 days until Jan 2011 testing for version 5010
  - Prepare for HIPAA Version 5010 deadline with free webinars - first is Jan 11
  - Are you prepared for 5010 and ICD-10? Archived webinar can help
  - Physician practices must prepare now to use version 5010 HIPAA transactions
  - GetReady5010 offers free webinars April 4-8
  - Test HIPAA version 5010 transactions with Medicare on June 15
  - Prepare for Jan. 1 HIPAA compliance date with resources outlining easy steps
  - Prevent rejected claims and cash-flow interruptions
  - Webinars, data reporting tips and fact sheets available to prepare you for the 5010 HIPAA compliance date

5010 Presentations and Webinars

- CPT Panel meetings
- CPT Symposium
- AMA Federation
- Iowa Medical Society
- HIMSS 5010 and ICD-10 Symposium
- American Medical Billing Association
- Archived webinar available on Web site

5010 Collaboration Work

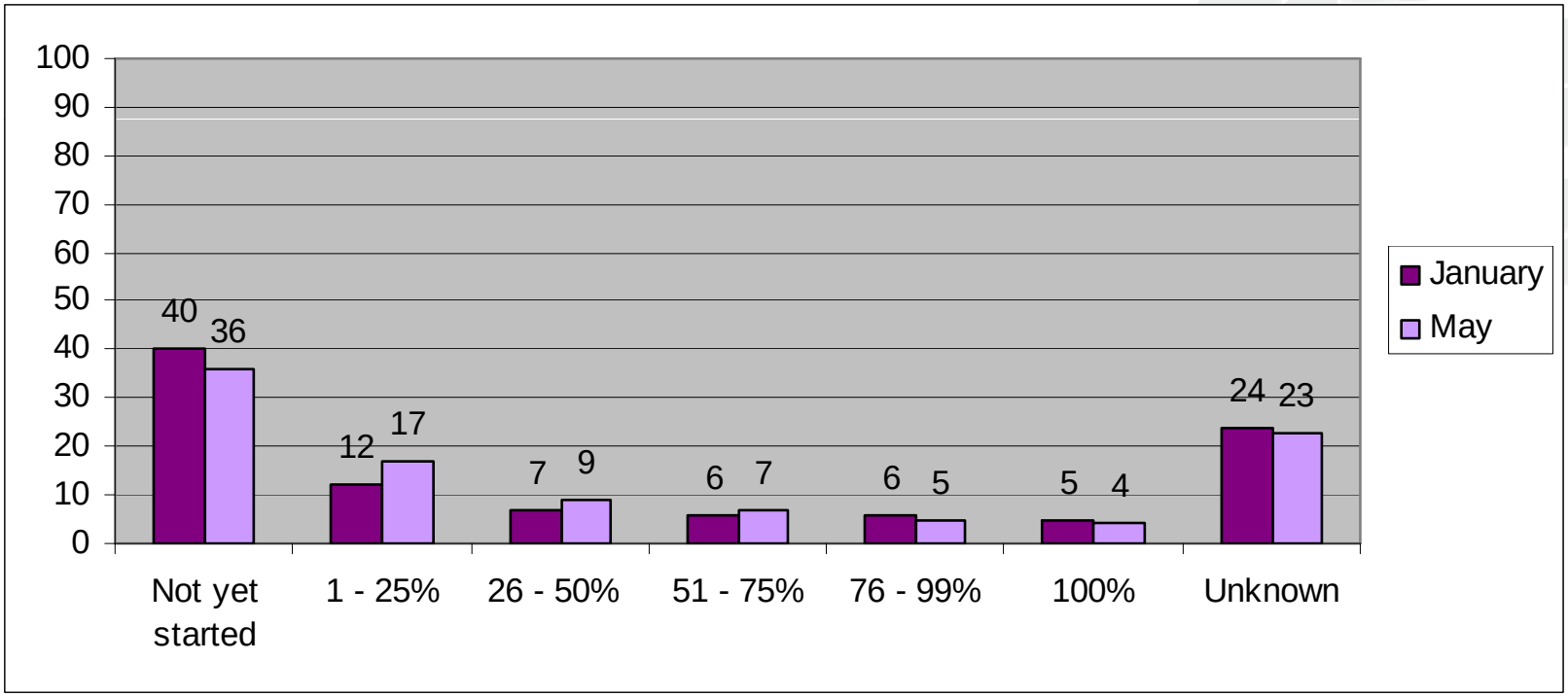
- Have been collaborating with other industry organizations
  - MGMA
  - CMS
  - WEDI
  - ICD-10 Stakeholders Group
  - GetReady5010
    - www.getready5010.org

5010 Readiness Survey Results

- Conducted in January 2011 and May 2011
- Web-based survey tool sent to a sample of 30,000 physicians
- Respondents
  - 407 in January
  - 334 in May
  - 76% in practices with 1-5 physicians (January and May)

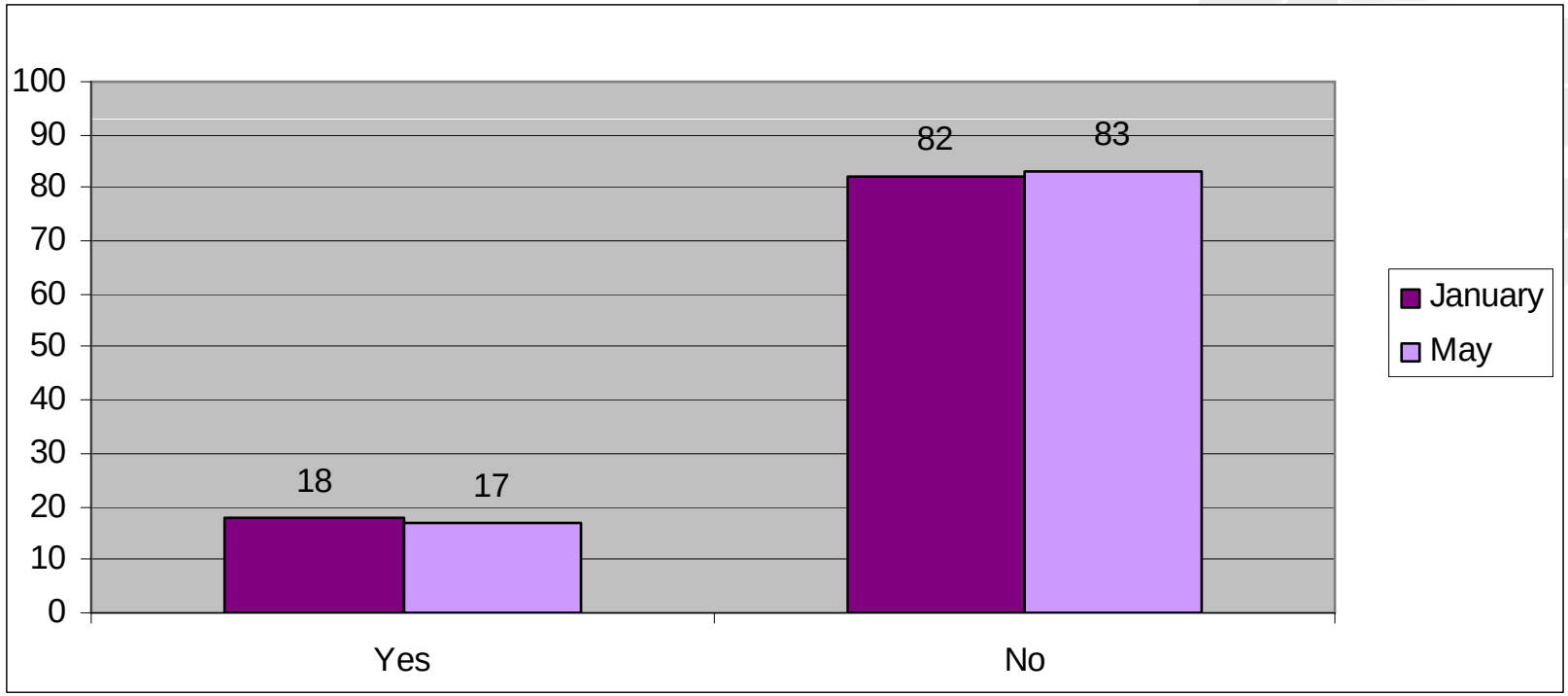
5010 Readiness Survey Results

How complete is your analysis of the impact the 5010 transactions will have on your practice?



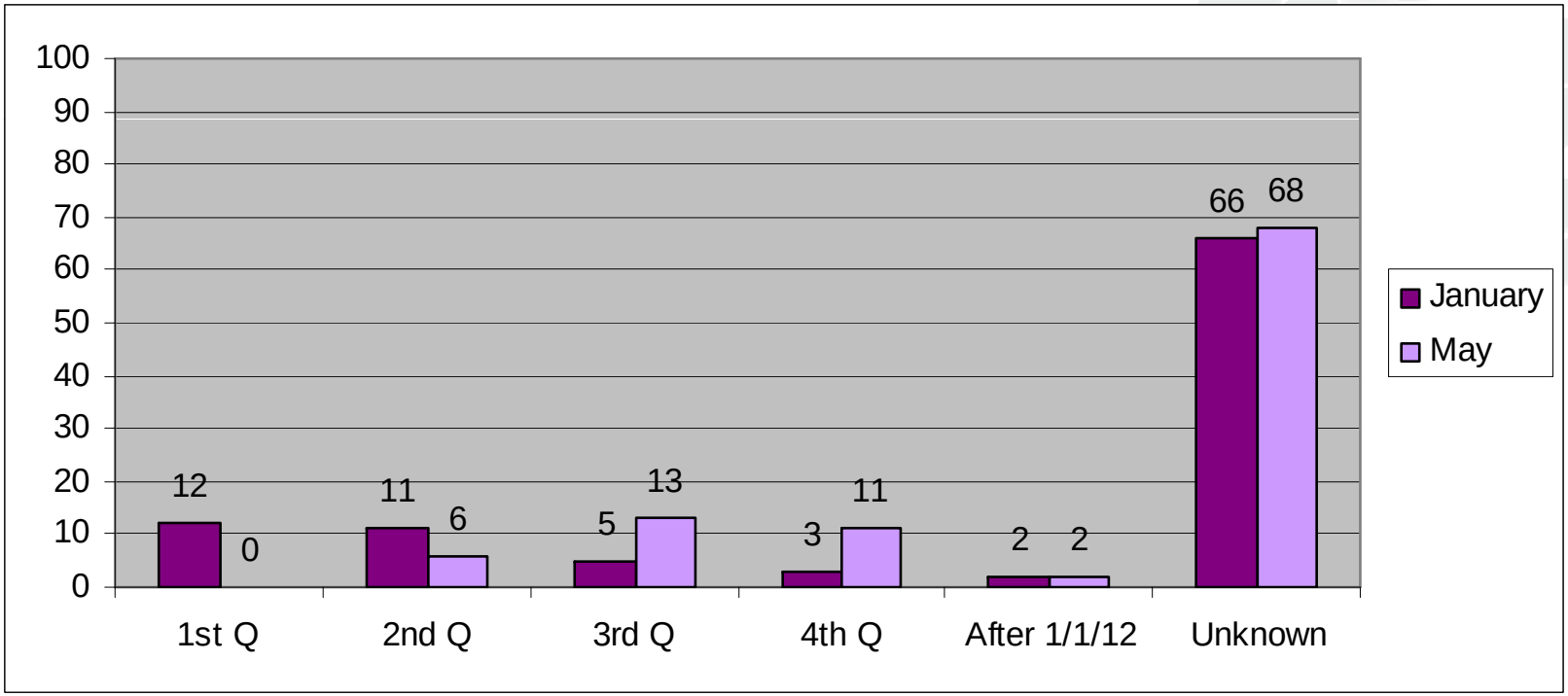
5010 Readiness Survey Results

Has your practice management system vendor installed your system upgrades?



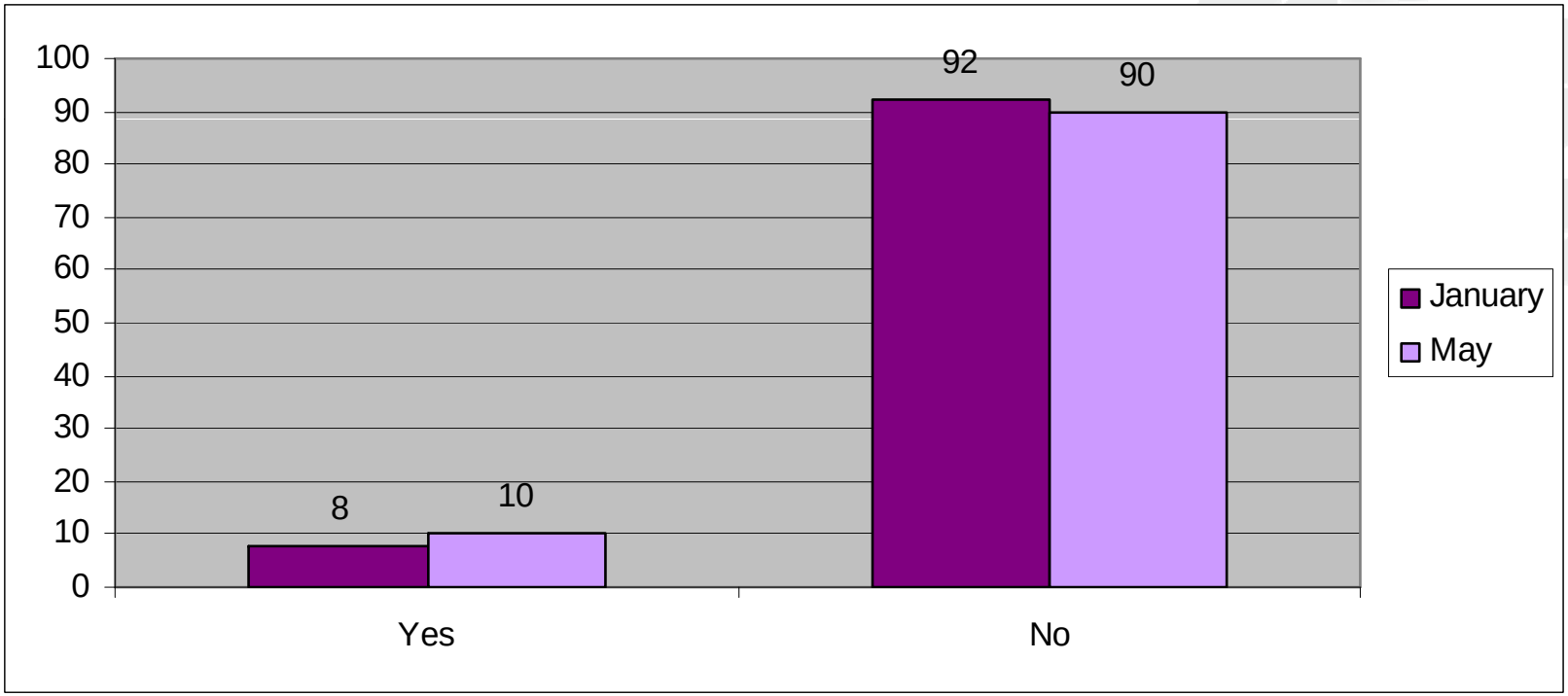
5010 Readiness Survey Results

If "no", when will your system upgrades be installed?



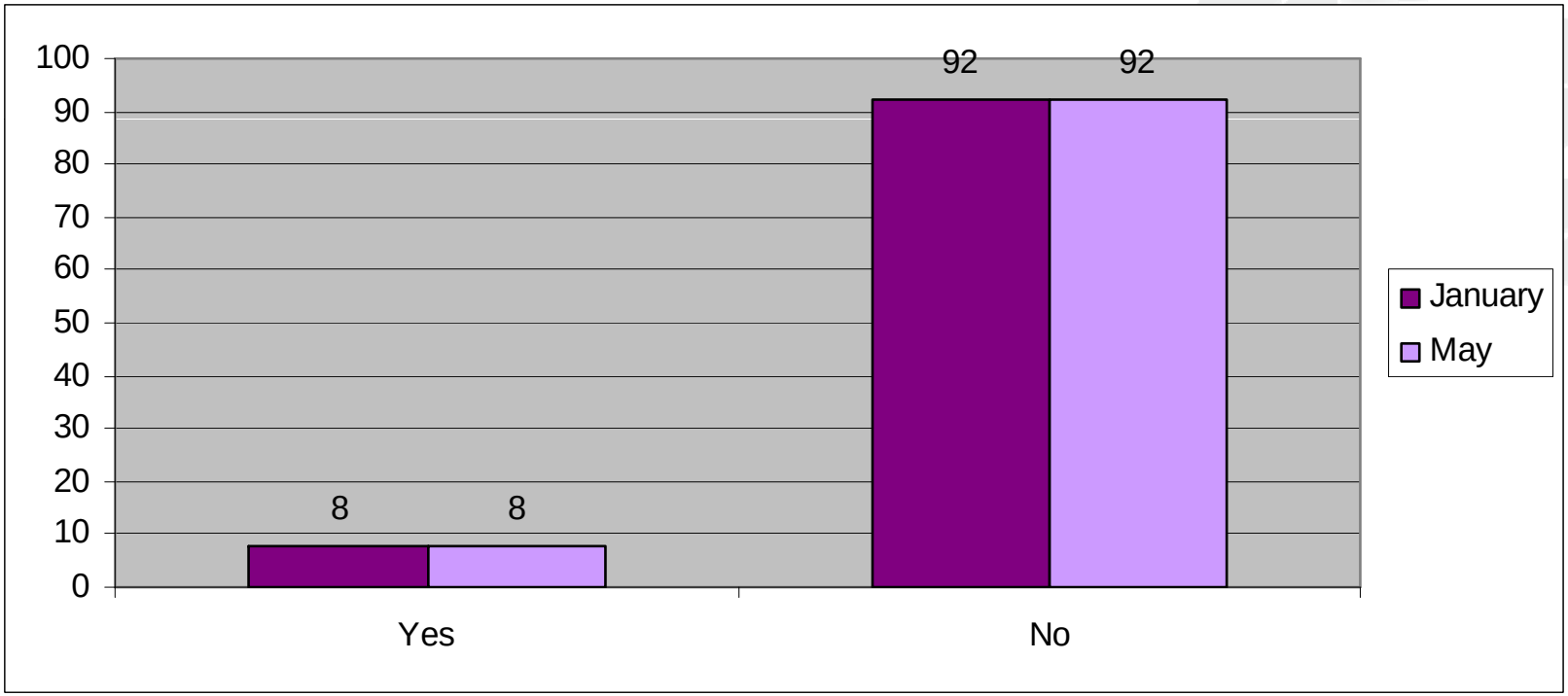
5010 Readiness Survey Results

Have you begun testing of the 5010 transactions within your practice?



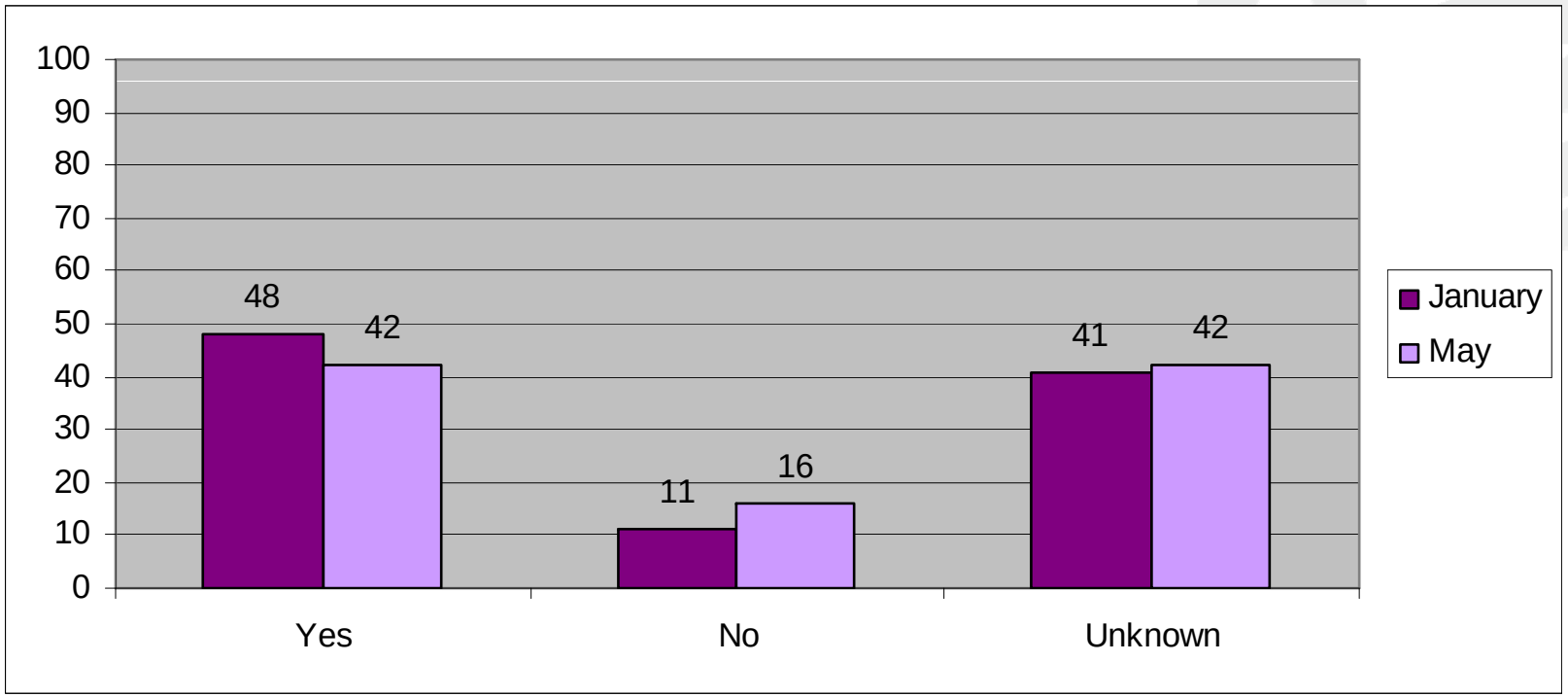
5010 Readiness Survey Results

Have you begun testing of the 5010 transactions with your payers, clearinghouse, or billing service?



5010 Readiness Survey Results

Do you expect to be prepared to send and receive only 5010 transactions as of January 1, 2012?



AMA ICD-10 Outreach and Education Work

- Updated Web site content
- Educational materials
- Articles
- Announcements/Alerts
- Presentations
- Collaboration work
- Surveys

AMA Web Site

www.ama-assn.org/go/ICD-10

ICD-10 Educational Materials

- ICD-10 Checklist
- ICD-10 Project Plan Template - Steps to Take to Implement ICD-10
- Preparing for the Conversion from ICD-9 to ICD-10: What You Need to Be Doing Today

ICD-10 Educational Materials (cont.)

- ICD-10 Fact Sheet Series
  - #1 ICD-10 101: What It Is and Why It's Being Implemented
  - #2 The Differences Between ICD-9 and ICD-10
  - #3 ICD-10 Timeline: Meeting the Compliance Date
  - #4 Implementing ICD-10 in Your Practice - Part 1
  - #5 Implementing ICD-10 in Your Practice - Part 2
  - #6 Testing your Readiness for ICD-10
  - #7 Crosswalking Between ICD-9 and ICD-10
  - #8 Partial Freeze to ICD-9 and ICD-10 for Smoother Transition

ICD-10 Articles

- Published in various AMA print and electronic publications
  - Preparing for the Conversion from ICD-9 to ICD-10: What You Need to Be Doing Today, *CPT Assistant*, June 2010
  - Compliance deadlines approaching for "5010" standard transactions, ICD-10 code sets, *AMA eVoice*, April 23, 2010
  - Have you contacted your vendor yet about "5010", ICD-10?, *AMA eVoice*, July 2, 2010
  - Get the latest information about ICD-10, 5010, *AMA eVoice*, July 23, 2010
  - Be prepared for 5010 and ICD-10, *AMA Wire*, December 8, 2010
  - AMA webinar available for 5010 and ICD-10 transactions, amednews.com, March 14, 2011

ICD-10 Announcements/Alerts

- Sent via AMA listservs
  - 5010 and ICD-10 compliance deadlines approaching
  - Are you prepared for 5010 and ICD-10? Archived webinar can help
  - Free ICD-10 code-a-thon with AAPC and CMS
  - Prepare for ICD-10 with free resources from AHIMA

ICD-10 Presentations and Webinars

- CPT Panel meetings
- CPT Symposium
- AMA Federation
- Iowa Medical Society
- HIMSS 5010 and ICD-10 Symposium
- Archived webinar available on Web site

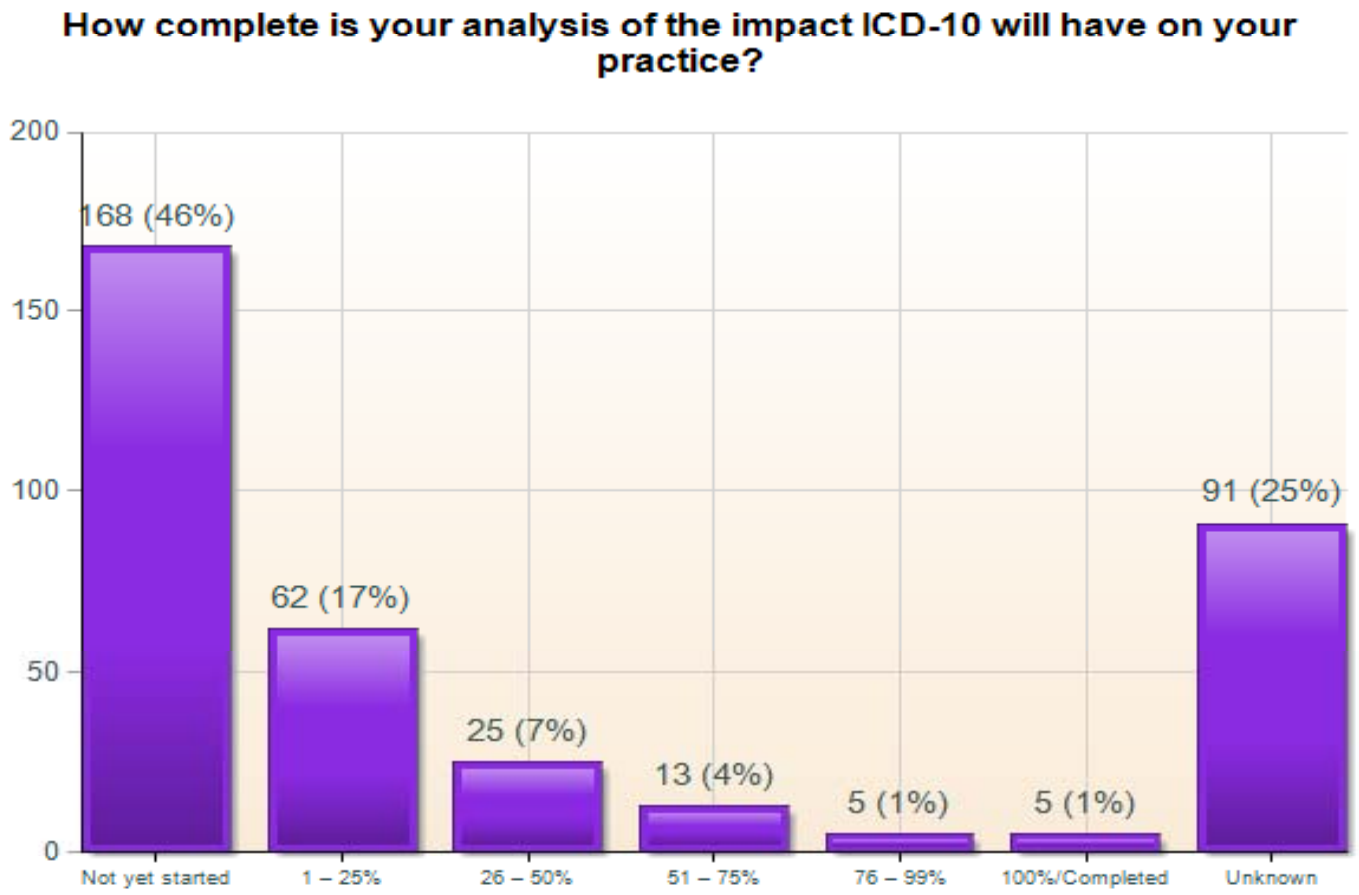
ICD-10 Collaboration Work

- ICD-10 Stakeholders Group
  - American Academy of Professional Coders
  - American Chiropractic Association
  - American Clinical Laboratory Association
  - American College of Physicians
  - American Dental Association
  - American Health Information Management Association
  - American Hospital Association
  - American Medical Association
  - America's Health Insurance Plans
  - Blue Cross Blue Shield Association
  - Centers for Medicare & Medicaid Services
  - Cooperative Exchange
  - Emdeon
  - Healthcare Billing and Management Association
  - Healthcare Information and Management Systems Society
  - Medical Group Management Association
  - National Council for Prescription Drug Programs
  - SSI Group
  - TK Software
  - Workgroup for Electronic Data Interchange

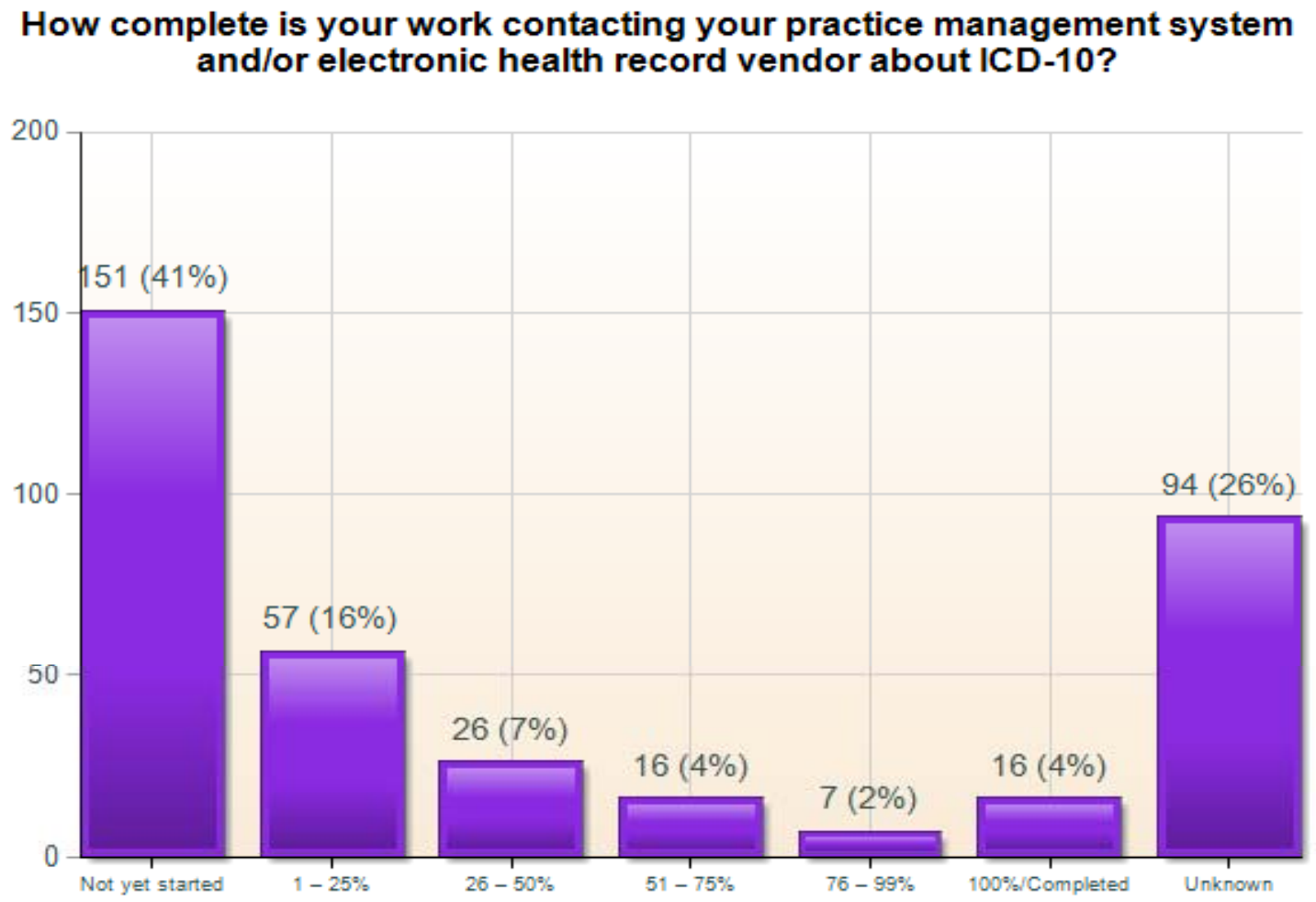
ICD-10 Readiness Survey Results

- Conducted in May 2011
- Part of the 5010 Readiness Survey
- 370 respondents

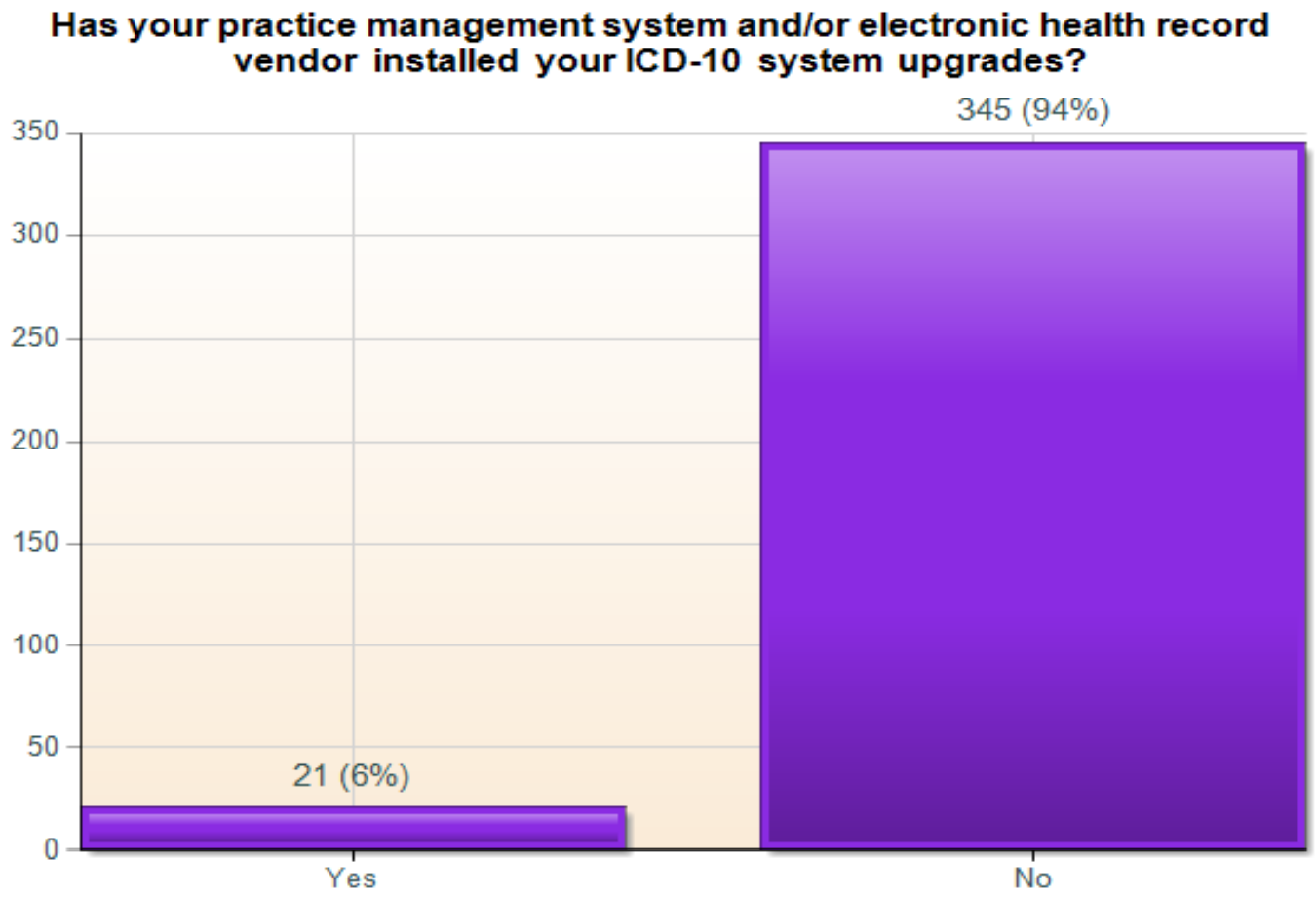
ICD-10 Readiness Survey Results



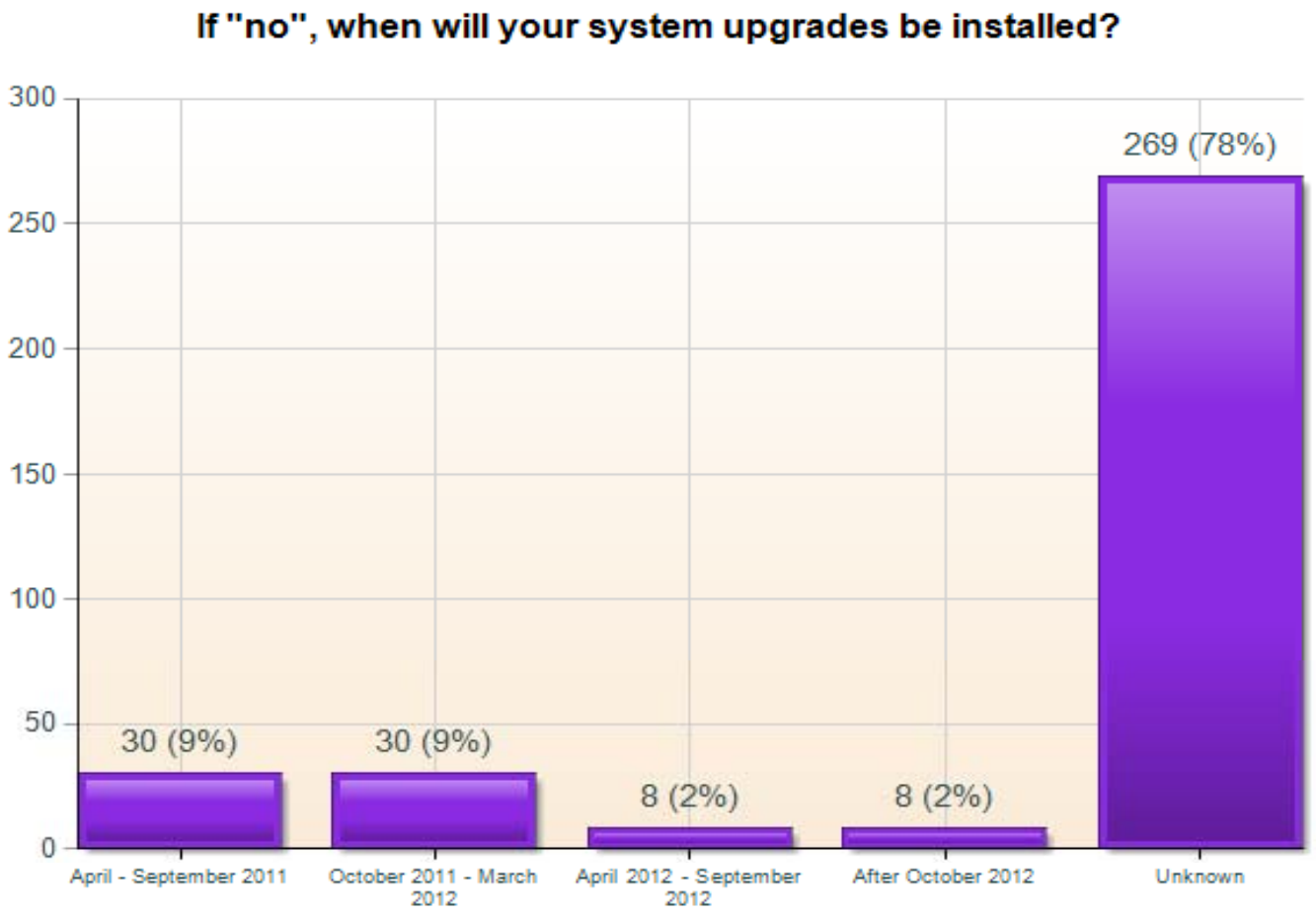
ICD-10 Readiness Survey Results



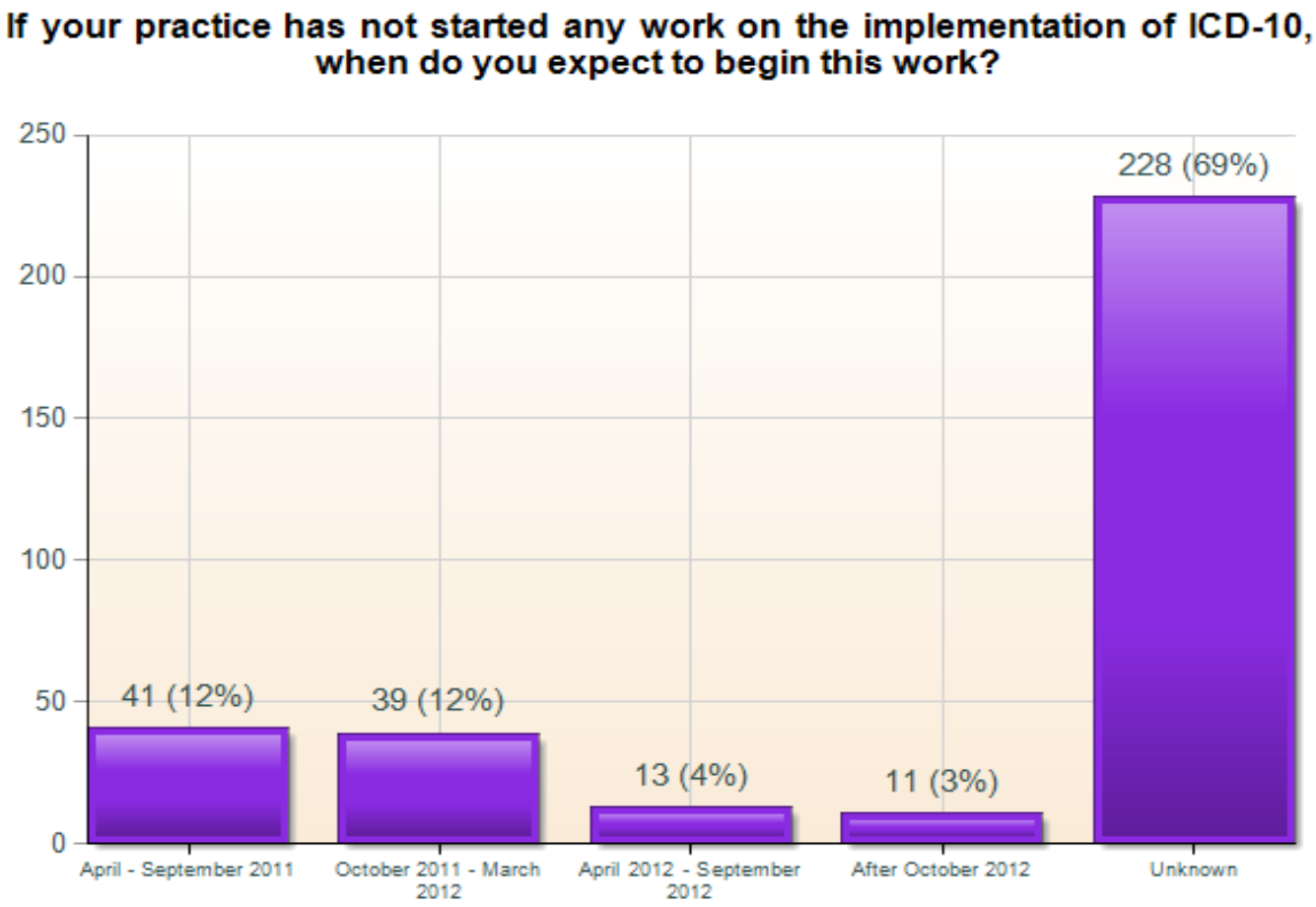
ICD-10 Readiness Survey Results



ICD-10 Readiness Survey Results



ICD-10 Readiness Survey Results



Awareness Issues

- 5010 Concerns
  - Some physicians are not aware of the requirement or do not understand the work they need to do, despite efforts by many
  - Some physicians still expect a delay in the deadline, despite consistent messaging
- Requests
  - We ask payers, clearinghouses, and vendors to consider sending messages to their physician enrollees and customers explaining what the physician needs to do to become compliant by the deadline.
  - **The AMA urges NCVHS to recommend to the Secretary that CMS send reminder letters and add messages to remittance advices to the physicians enrolled in the Medicare program explaining what the physician needs to do to become compliant by the deadline.**
  - **The AMA also urges NCVHS to recommend to the Secretary that CMS evaluate closely the information provided at this hearing as to the industry's readiness for the 5010 transactions and develop additional outreach and education efforts to address gaps in readiness that are identified.**

Awareness Issues

- ICD-10 Concerns
  - Physicians expect a delay in the deadline, despite consistent messaging
- Request
  - **The AMA urges NCVHS to recommend to the Secretary that CMS continue to provide outreach and education, including national provider calls, frequently asked questions, and other resources on the implementation of ICD-10.**
  - **In addition, we recommend the creation of an ombudsman office to respond to physician and other health care professional requests for information in a timely and uniform manner to aid them with the implementation of 5010 and ICD-10 and to help them troubleshoot problems with the transitions.**

Risk Areas with Implementation

- Concerns
  - Vendor readiness
  - Systems' abilities
  - Cash flow interruptions
  - Business impacts of ICD-10
- Request
  - **The AMA strongly recommends that NCVHS recommend to the Secretary that Medicare create clear guidelines on advance payments and that the policy be made widely available to all physicians, something that did not happen with the transition to the NPI.**

Results

Table ES-1 summarizes the impact analysis findings.

Table ES-1: Impact Analysis Findings

Business Areas	Associated Functional Areas	Major Risk if the Business Areas is Not Prepared for ICD-10
Medicare FFS Claims **Very High Impact[3]**	▪ Payment Policy ▪ NCD/LCD ▪ FFS Claims Processing ▪ MSP and COB ▪ Manage Claim Repositories ▪ Provider Cost Reporting ▪ Appeals	▪ Payments to FFS providers could be incorrect.
Risk Adjustment **Very High Impact**	▪ Risk Adjustment	▪ Payments to Medicare Advantage (MA) and Part D Plans could be incorrect.
Quality **High Impact**	▪ Quality Assessment Tools ▪ Quality Measures and Payment Initiatives ▪ Quality Improvement Activities and ESRD Networks	▪ CMS' ability to: (1) adjust the FFS payment methodologies could be limited; (2) analyze and improve the quality of healthcare could be limited and (3) make accurate quality incentive payments could be compromised.
Medicare Integrity **High Impact**	▪ Medicare Integrity[4]	▪ CMS may not be able to recoup incorrect payments to providers, resulting in a loss of CMS Trust Funds.

Issues Identified with HIPAA Transactions

- Concerns
  - Lack of enforcement of HIPAA standards and code sets
  - Variability with requirements in the HIPAA transactions
- Request
  - **The AMA recommends better enforcement of the HIPAA transactions by CMS to ensure payer compliance.**

Barriers to Implementation

- Concerns
  - Costs
  - Decreasing reimbursement
  - Numerous other regulatory requirements
  - Lack of coordination among various government bodies related to regulatory requirements
- Request
  - **The AMA urges NCVHS to recommend to the Secretary that one entity within the government track the various requirements and make recommendations to the appropriate overseeing bodies about the realistic timeframes for sequencing and completing all of the incentive and/or penalty programs and mandates.**

"In the midst of rapidly and precipitously declining reimbursement, coupled with a paucity of patients due to lack of insurance or inadequate insurance, physicians' offices continue to be inundated with very expensive and technically challenging mandates. Out of necessity, our administrative and clerical staff has grown out of control. After 30 years, we are literally on the edge of a financial precipice, such as I have not seen before. We are part of the small business community of the USA and we are rapidly nearing extinction. I'm sick of hearing of the government's use of RAC auditors to recoup $$ as if we were all criminals. I'm tired of dealing with deadlines related to NPIs, PECOS, HIPAA, e-prescribe, EMR, (or is it EHR?), 5010 code set conversion, ICD-10, NDCs, ASP drug reimbursement methodology, CLIA inspection and mandated Workplace Surveys."

- Physician Practice Administrator


AMA
AMERICAN
MEDICAL
ASSOCIATION

Medical Group Management Association

National Committee on Vital and Health Statistics, Subcommittee on Standards

Group Practice Readiness: HIPAA Version 5010

June 17, 2011

Robert M. Tennant, MA

Senior Policy Advisor

Medical Group Management Association

MGMA
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About MGMA and our 5010 Research

- MGMA serves 22,500 professional administrators and leaders of medical group practices who lead 13,600 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States
- MGMA online Legislative and Advocacy Research Network (LEARN)
- Research conducted May 25 – June 10
- 359 respondents
- Average practice size: 22.7 FTE physicians

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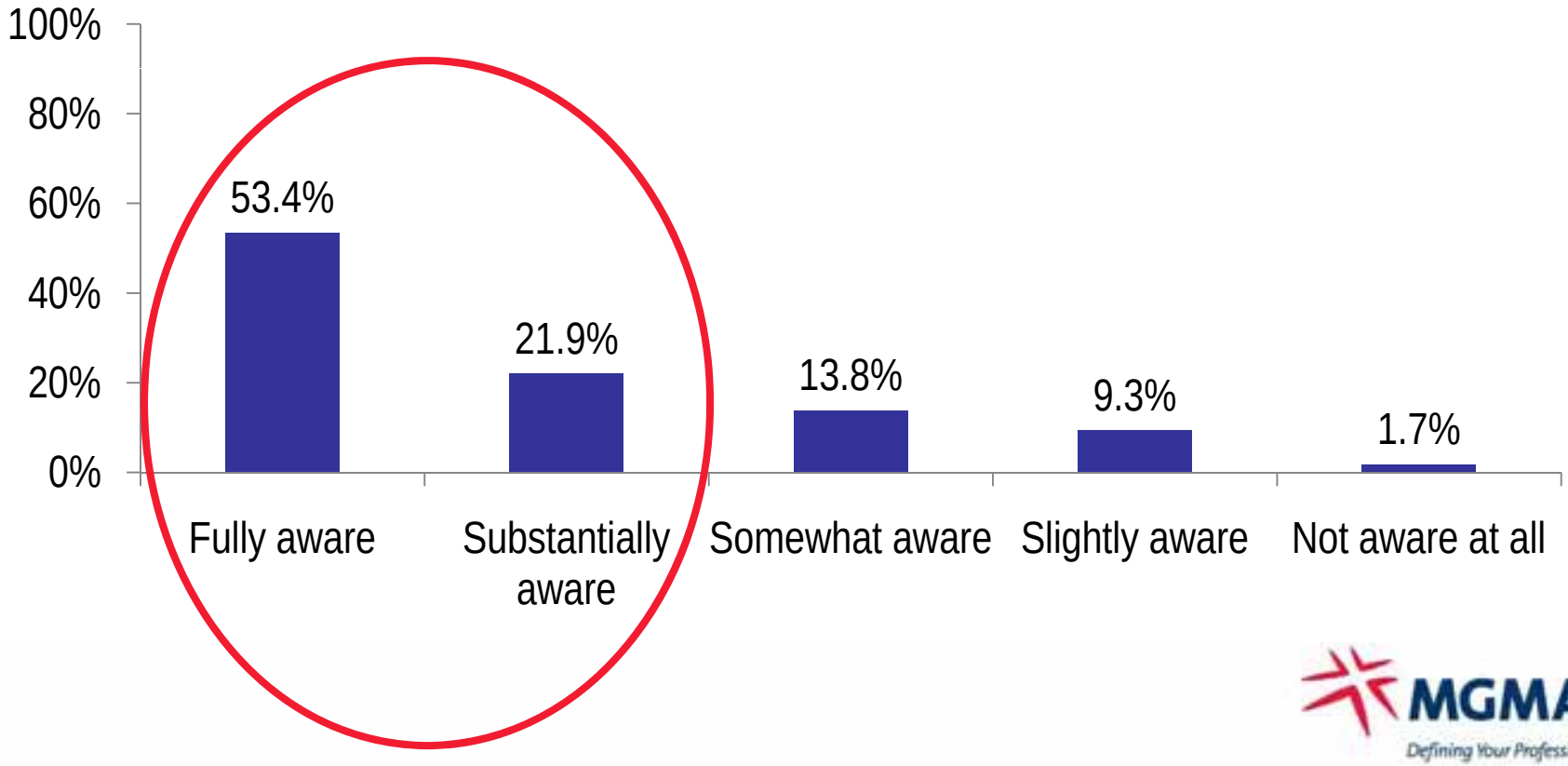
Awareness

How aware were you that the federal government had mandated all covered entities to convert from the current HIPAA Version 4010 electronic transaction standards to HIPAA Version 5010?



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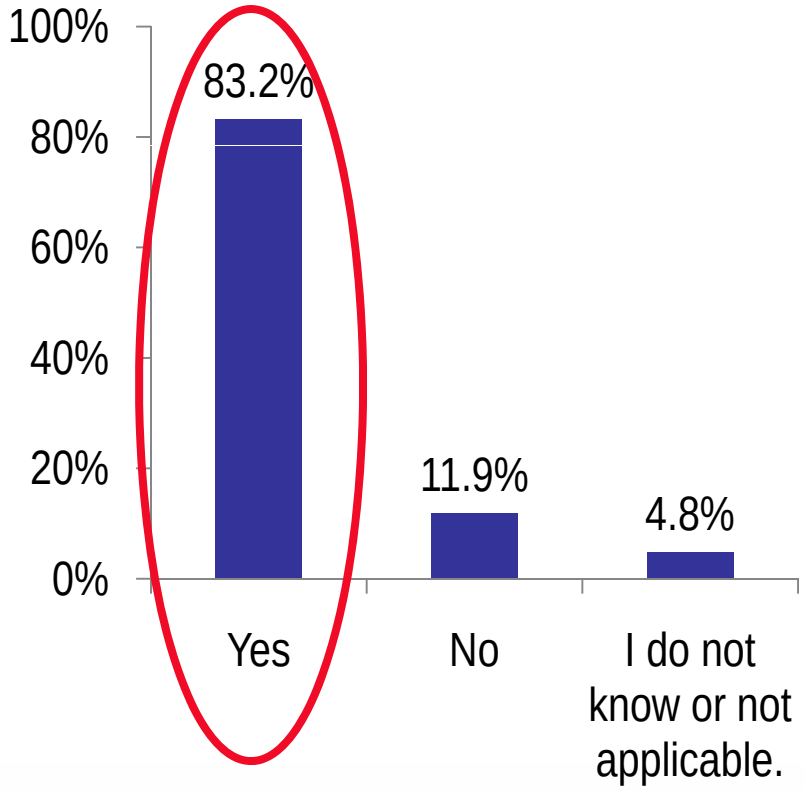
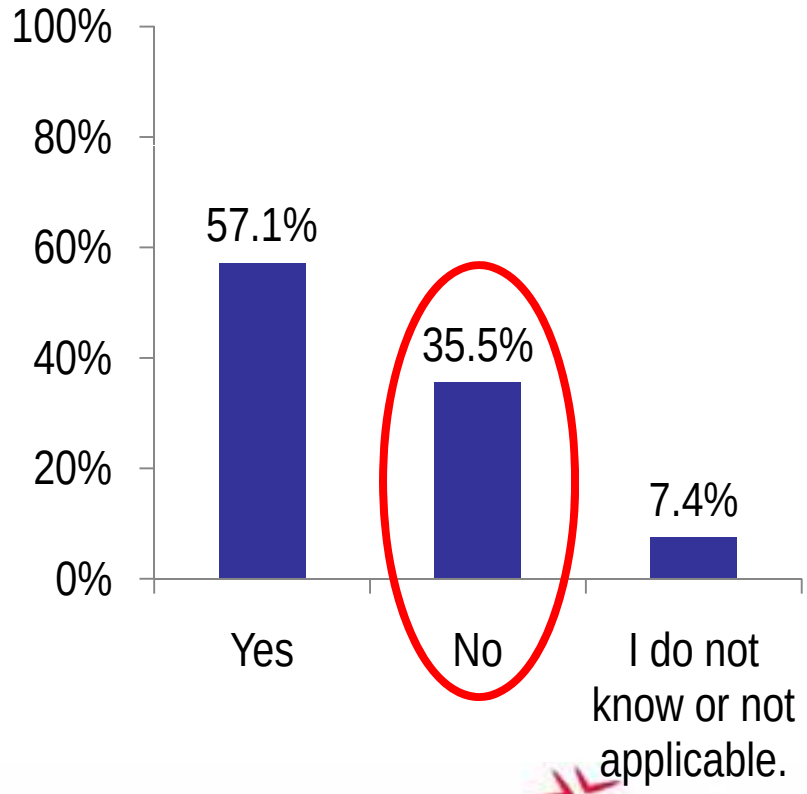
Practice Management System Vendor Communication

Practice Contacted PMS?



PMS Contacted Practice?



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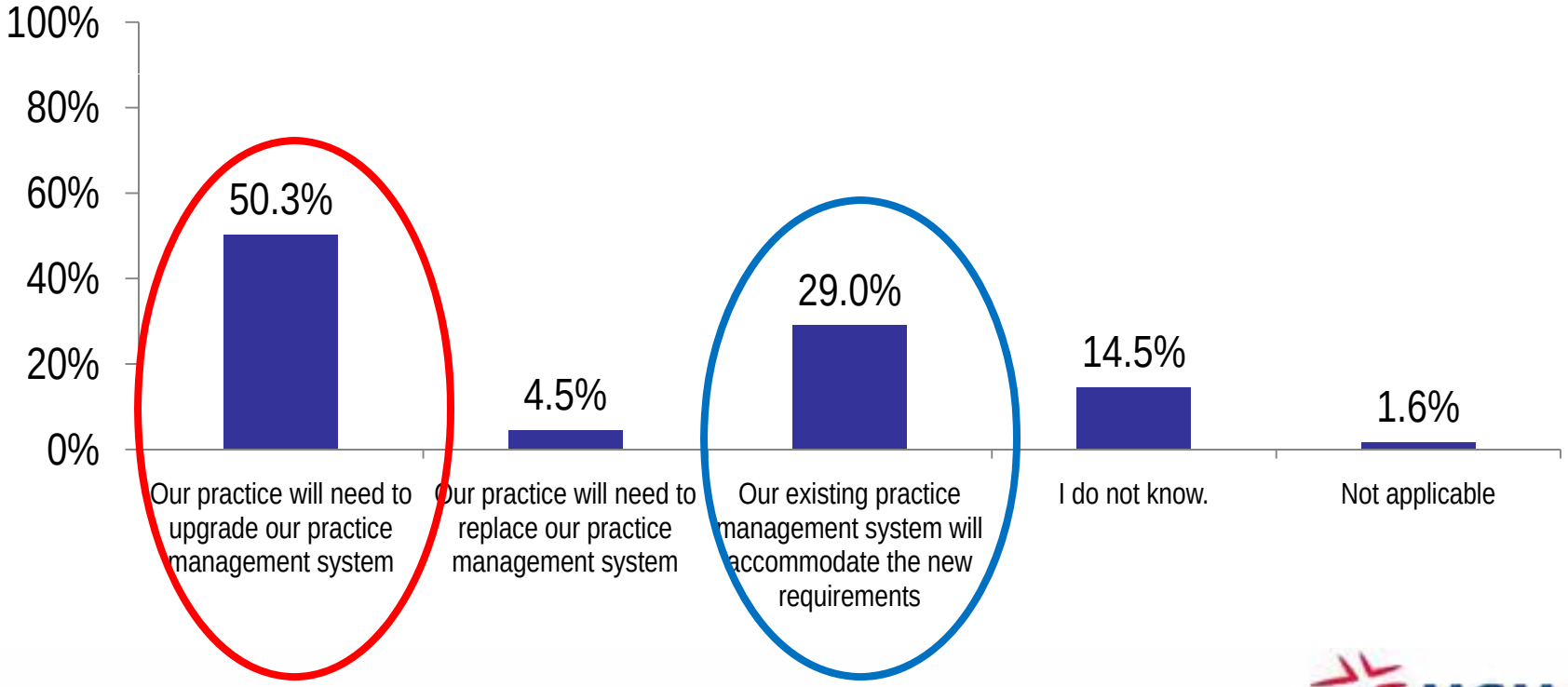
Practice Management System Status

Will your practice management system require an upgrade or replacement to accommodate HIPAA Version 5010?



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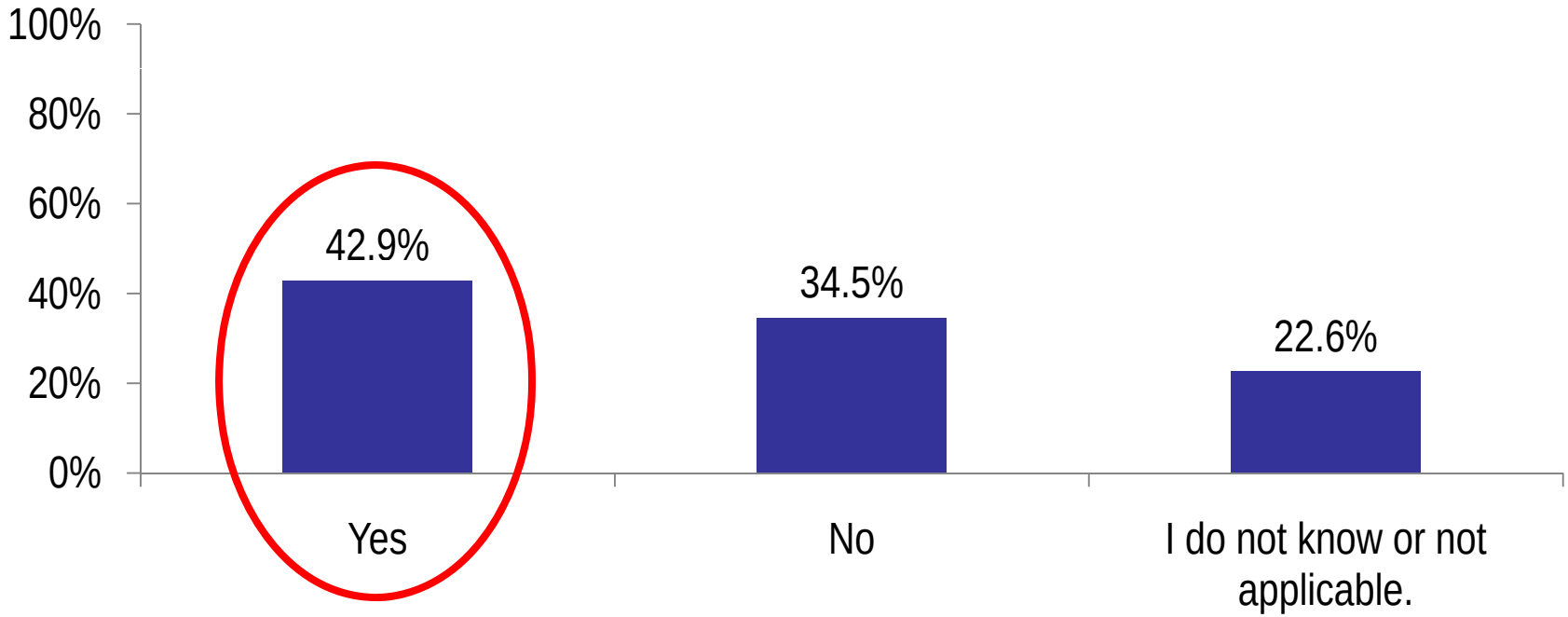
Practice Management System Vendor Plans

Is your practice management system vendor planning to charge your practice to upgrade or replace your practice management system to accommodate HIPAA Version 5010?



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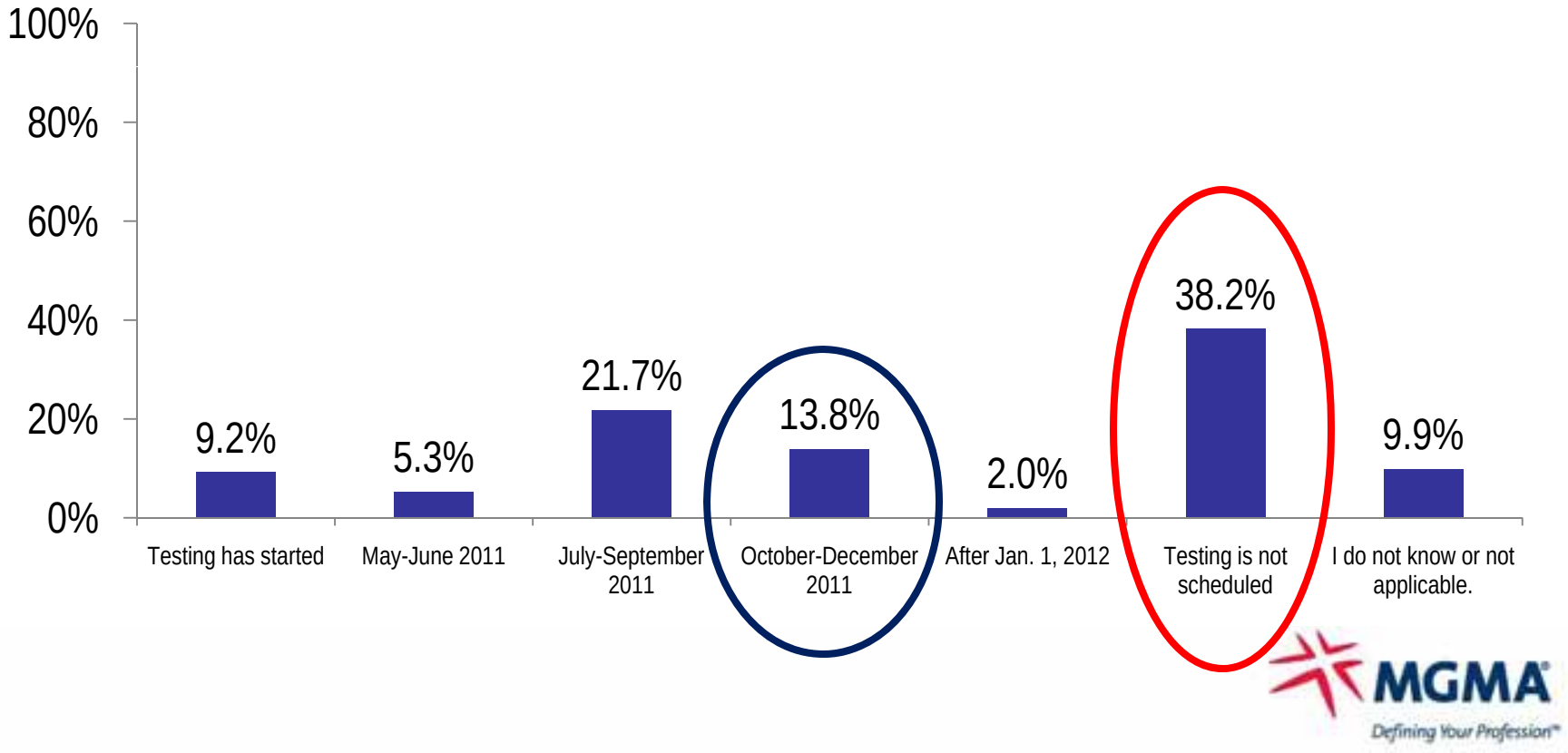
Cost to Upgrade or Replace PMS

Reported average cost $16,575 per FTE Physician

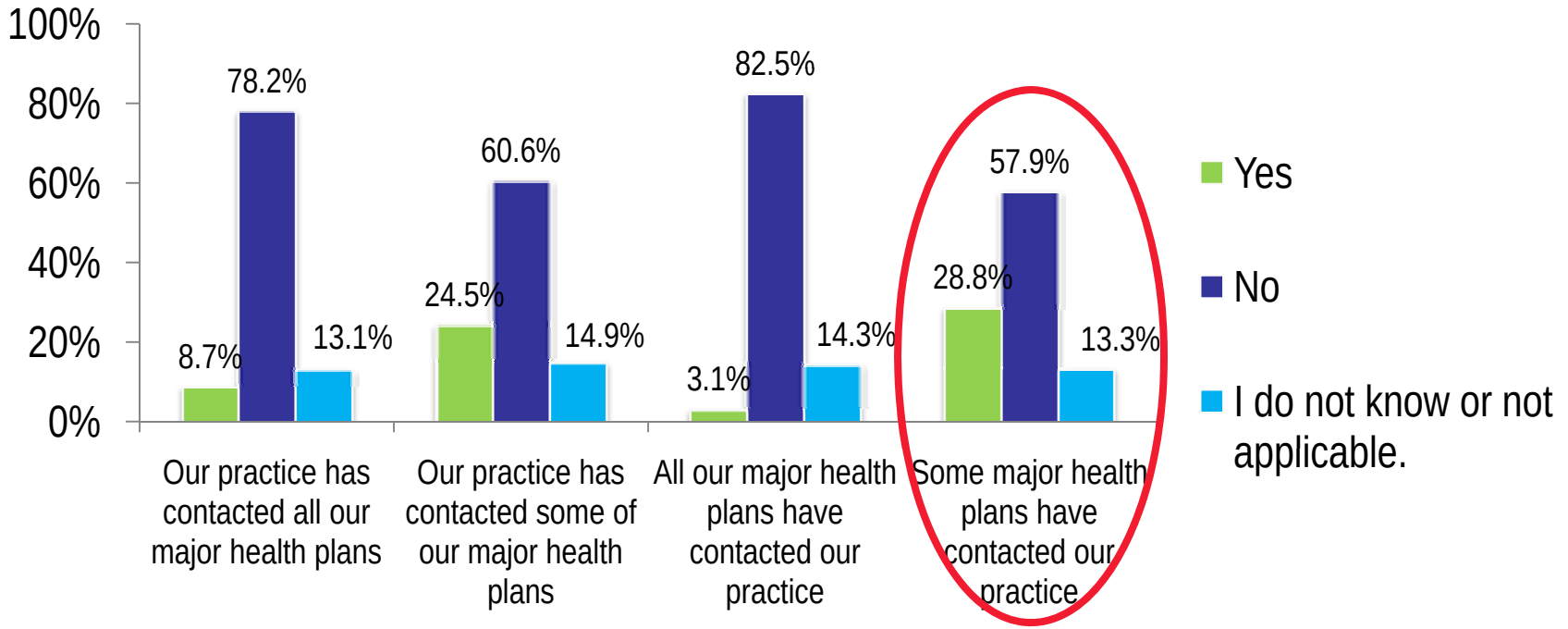
Internal Testing

What is your scheduled date to begin HIPAA Version 5010 internal testing (testing systems in your practice)?



Coordination with Health Plans

Has the following coordination occurred regarding HIPAA Version 5010 implementation?



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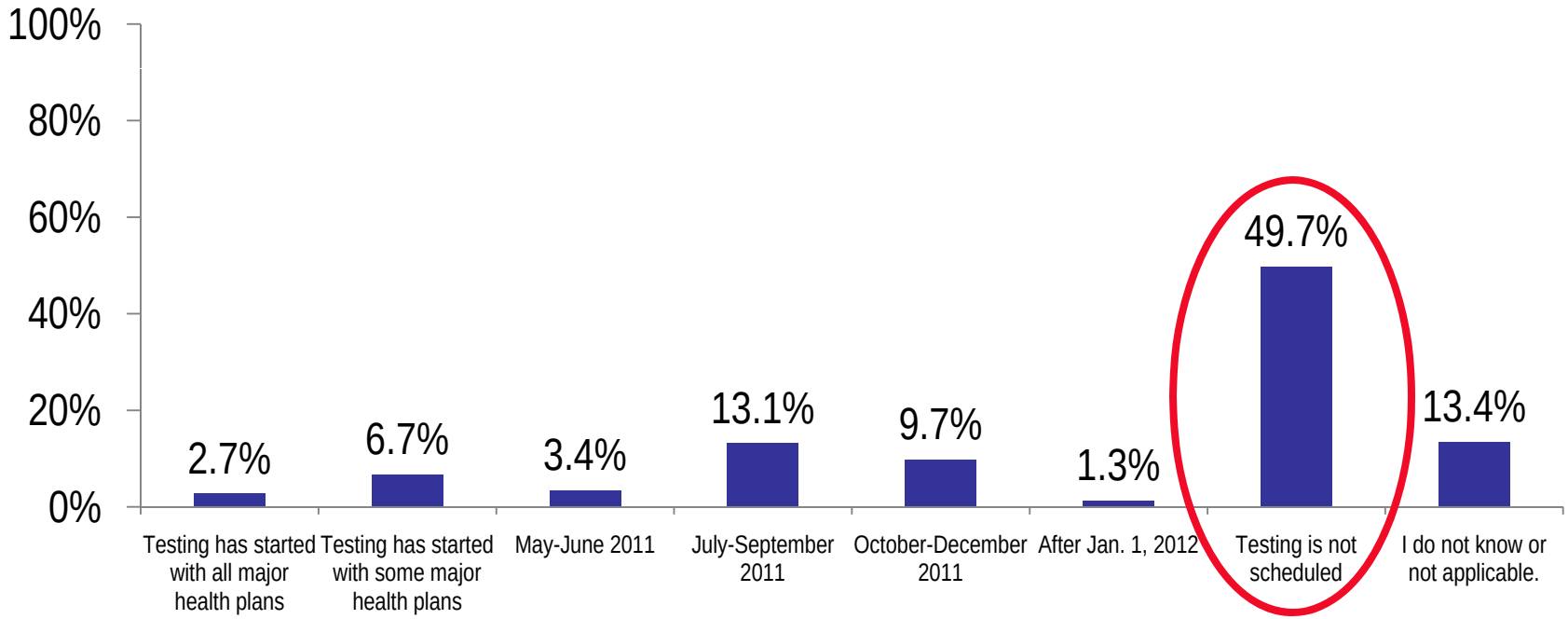
Testing with major health plans

What is your scheduled date to begin HIPAA Version 5010 testing with your major health plans?



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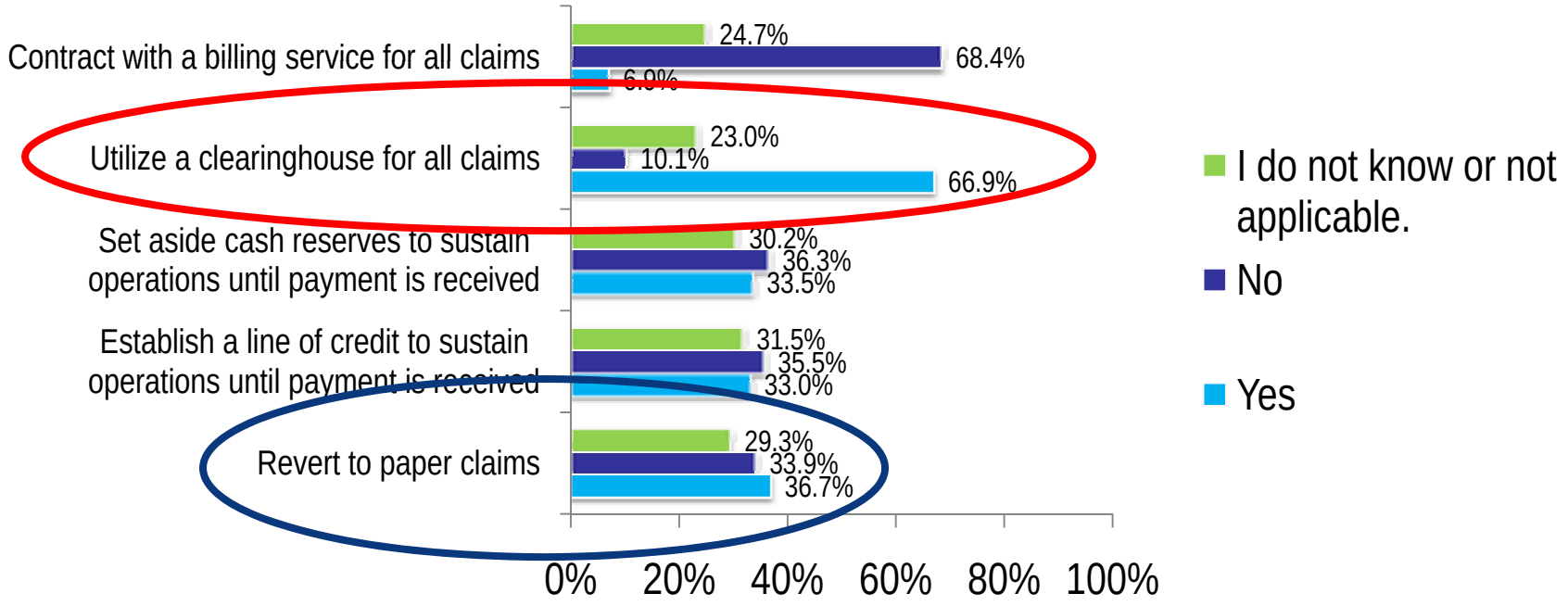
Contingency plan

What is your contingency plan should claims payments be disrupted following the Jan. 1, 2012, HIPAA Version 5010 compliance date?



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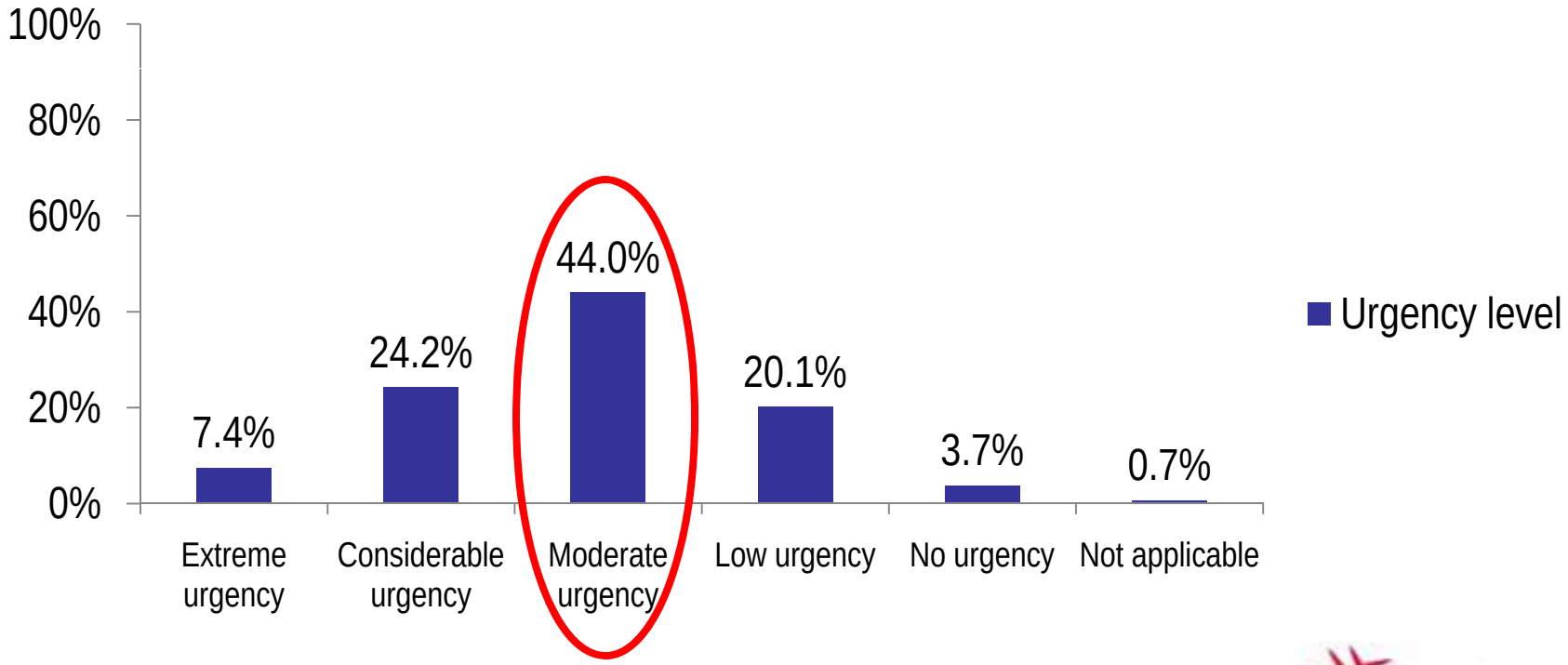
Sense of urgency

How would you rate your organization's sense of urgency regarding HIPAA Version 5010 implementation?



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Current Environment

- Weak economy
- Stagnant growth in Medicare payments / continual threat of Medicare cuts / increasing practice expenses
- Challenging payment / incentive programs that require financial investment (ACOs, eRx, meaningful use)
- Numerous unfunded mandates (5010, ICD-10, privacy)
- Unproven 5010 / ICD-10 ROI
- Practice reliance on trading partner readiness

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MGMA Education and Outreach

- MGMA 5010 member education:
  - Face-to-face national and state conferences
  - Several 5010 / ICD-10 Webinars
  - Updates via *Washington Connexion* email news service
  - Numerous print articles
  - Online resources-guides, checklists, links to external resources
  - Social media (blogs, twitter, online member communities)
- Partnership with AMA (PMSS Toolkit/Directory, PMS Vendor Conference)

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Recommendations

- NCVHS should consider recommending that CMS:
  - Expand tracking of and outreach to vendor and provider communities
  - Quickly disseminate data from the June 15 Medicare testing day
  - Leverage provider association meetings in Summer/Fall/Winter
  - Publish concise and easy-to-understand set of 4010 to 5010 changes for providers who will have to manually make the changes
  - Expand the August Medicare testing day to include commercial plans and clearinghouses
  - Plan on an additional national testing day late Fall
  - Based on survey data and results from national testing days, develop, at a minimum, a data content-based contingency plan

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Testimony
of the
American Hospital Association
before the
Standards Subcommittee
of the
National Committee on Vital and Health Statistics

"Industry implementation of updated and new HIPAA Standards and Code Sets
X12 Version 5010, NCPDP Version D.0, NCPDP Version 3.0 and ICD-10"

June 17, 2011

Good morning. I am George Arges, senior director of the health data management group at the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the AHA thanks you for the opportunity to participate in today's National Committee on Vital and Health Statistics (NCVHS) hearing on the implementation progress for the updated HIPAA Standards version 5010 and the new code set ICD-10.

The AHA has engaged a cross-section of our member hospitals to obtain input on the progress and implementation issues surrounding the transition to the newer HIPAA standards, as well as the adoption of ICD-10. Our member discussions have included hospitals ranging in size from small Critical Access Hospitals to large multi-site and multi-state hospitals. The following observations stem from multiple conference calls and e-mail correspondence with members.

OVERLAPPING IT INITIATIVES

One of the more important themes to emerge from our member discussions, but not directly addressed by the NCVHS questions, is the overwhelming number of overlapping federal information technology (IT) initiatives impacting providers. Overlapping IT initiatives, such as Stage 1 and the pending Stage 2 of the Medicare and Medicaid electronic health record (EHR)

programs, along with health reform initiatives such as value-based purchasing, accountable care organizations, bundled payments and readmissions, as well as upcoming operating rules, are making it difficult for hospitals to find the necessary resources to complete them. Capital and qualified IT staff already are in short supply, and when these IT initiatives are stacked on top of ICD-10 implementation, it makes the task enormously difficult. Our members are seeking breathing room as well as leadership that can provide a thoughtful coordinated pathway to help them manage all of these important IT initiatives. (Enclosed is a graphic depicting these overlapping IT initiatives.)

Our members support the adoption of ICD-10, but recognize that it is no easy task that becomes more complicated as other overlapping IT initiatives are introduced. There is a lack of coordination among the competing IT initiatives, which results in the dilution of already scarce resources and further complicates efforts to properly implement ICD-10. As a first step, we suggest delaying the start of Stage 2 of "meaningful use" for the EHR programs to no sooner than fiscal year 2014, and only after at least 75 percent of all eligible hospitals and physicians/ professionals have successfully achieved Stage I and not before ICD-10.

NECESSARY RESOURCES AND TESTING

While many hospitals indicated that they have completed their ICD-10 assessment, they also mentioned that the cost for doing so was much larger than they had anticipated. The added costs associated with the assessment phase placed a further strain on their ability to find the necessary funds to carry out the remaining work. But more importantly, they foresee manpower shortages to carry out the essential system changes, training and testing associated with the implementation phase.

Most hospitals mentioned that their own transition effort to the HIPAA version 5010 is on track. They are, however, concerned that the testing phase is unfolding more slowly than they expected. The testing phase for 5010 is at least six months behind the original timeline. Testing delays have the affect of encroaching on the next phase of ICD-10 implementation – namely installation of system changes. Many indicated that they were encouraged by the Centers for Medicare & Medicaid Services' (CMS) national day of testing and hope that commercial plans, as well as Medicaid plans, also would provide similar testing days.

A growing area of concern is the state Medicaid programs. We understand that some programs – such as California, Illinois, New York, and Pennsylvania – will not be ready to handle the newer version of 5010 by January 2012, or even use the ICD-10 codes by October 1, 2013. This is particularly troublesome because it would result in dual reporting of ICD-9 and ICD-10. Such delays are unacceptable and add significant operational costs and administrative burden to an already costly undertaking. CMS could potentially facilitate our understanding of Medicaid readiness status by surveying states to gauge their readiness for 5010 and their ICD-10 progress as well as undertaking a national day of testing for state Medicaid programs.

PROCEED CAUTIOUSLY

The combined effect of limited staff, costly conversion, overlapping IT initiatives, delays in 5010 testing, as well as delays among the Medicaid programs, have caused our members to question whether they can meet the October 1, 2013 start dates for ICD-10. Unless there is an orderly transition to 5010 by January 2012, then a one year extension for ICD-10 must be considered to provide the least disruptive and costly pathway. Staying with the scheduled October 1, 2013 date could prove calamitous if there are not sufficient resources, adequate education and testing with trading partners.

Preparations for establishing a contingency plan will be needed to prevent payment disruptions. But if there are gaps in ICD-10 readiness, a contingency plan by itself will not likely include the added administrative costs for dual processing of ICD-9 and ICD-10. While some have suggested a strategy to utilize the General Equivalence Mappings (GEMs) as a tool to convert an ICD-9 to an ICD-10, or vice versa, it is important to note that the GEMs were not designed for this purpose: they were intended as an aid to help users translate their internal system logic to handle ICD-10 codes. The GEMs were not designed as a plug-in module to crosswalk or convert codes. While the GEMs identify 90 percent of the matching codes, 10 percent do not have a corresponding code. That is precisely why more time was given for the adoption of ICD-10 in the final rule – to allow the user community time to prepare and make their system logic and contract changes.

Again, if version 5010 requires additional time to test, or correct problems, it will take away from the remaining time needed to prepare for ICD-10 implementation. The issue of finding the necessary resources to carry out ICD-10 remains critical. Many hospitals are now being asked to reach out to the physician community to help educate them on ICD-10 changes.

The AHA is actively engaged in providing a variety of ICD-10 educational programs to inform our members about the upcoming changes and challenges. In 2009, the AHA sent to each hospital CEO an Executive Briefing – *HIPAA Code Set Rule: ICD-10 Implementation*. Since 2009, we have had a series of ongoing audio and onsite programs along with member advisories and articles. In our CEO briefing, we described various implementation stages and the importance of creating a cross-functional team to manage the implementation effort. At this point, our members have indicated that they have completed the assessment of information system changes that are needed. While many have completed this phase, few of our members have moved onto the next phase – the implementation of system changes.

When asked the reasons for the delay, we heard once again about overlapping IT initiatives and the competing resource needs to tackle each IT change. Some indicated that once they completed their assessment of the ICD-10 changes needed, they could not evaluate whether the vendor solution or product was available since many of the vendor solutions also seem to be behind. This may be a signal that many vendors also are struggling with the resource issues associated with overlapping IT initiatives. It is not unusual for hospitals to have more than 50 different vendor products, all of which must be tested for their ICD-10 solution prior to installation.

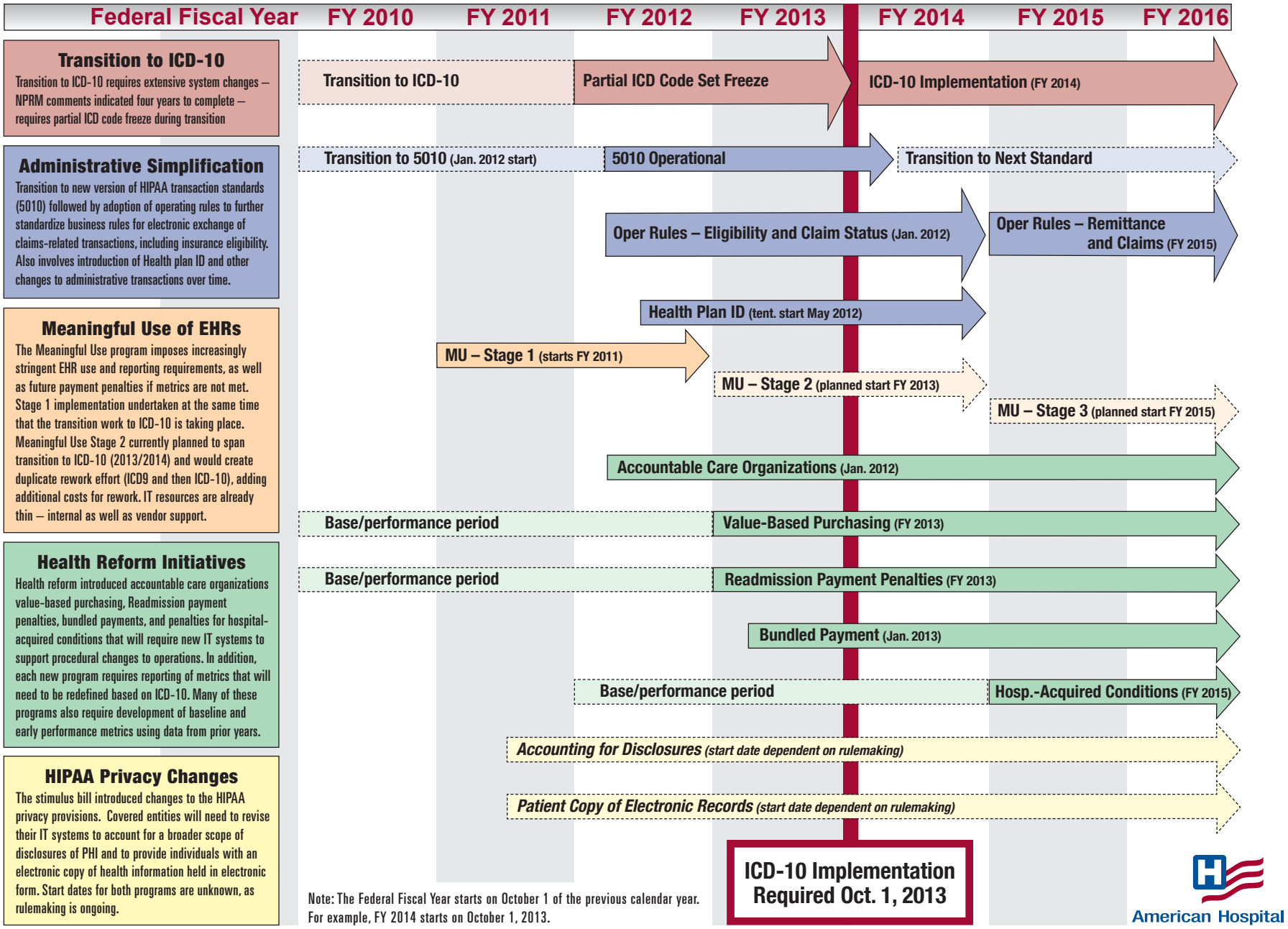
SUMMARY

The AHA supports adoption of the ICD-10 code set and sees it as an important first step in a series of IT changes geared toward improving our understanding of the quality and performance of patient care. The AHA recommends:

- That the Secretary of Health and Human Services (HHS) and the Office of E-Health Standards and Services (OESS) work with the provider community to coordinate the overlapping IT initiatives to create a manageable timeline that is sensitive to the resources needed by the hospital community, as well as others, to move forward.
- Support for the HIT Policy Committee's recommended one-year delay so that Stage 2 meaningful use begins no sooner than fiscal year 2014, and only when at least 75 percent of all eligible hospitals and physicians/professionals have successfully achieved Stage 1 and no earlier than ICD-10 implementation.
- That NCVHS and CMS OESS closely monitor the outcome of version 5010 testing and to urge the Medicaid plans, as well as commercial plans, to begin a similar day(s) of testing.
- That NCVHS and CMS OESS conduct a survey to gauge the readiness of the different sectors of health care – the providers, government plans and commercial plans, as well as the vendor community, to determine where they are in relation to ICD-10 implementation.
    - To avoid dual-processing of ICD-9 and ICD-10; and
    - Map out a strategy for a possible one-year extension on the implementation of ICD-10 – in lieu of dual processing or a long-term contingency plan.

Thank you for the opportunity to share our member's thoughts and insights on how we can collectively move forward with these IT initiatives, especially the 5010 and ICD-10 implementation.

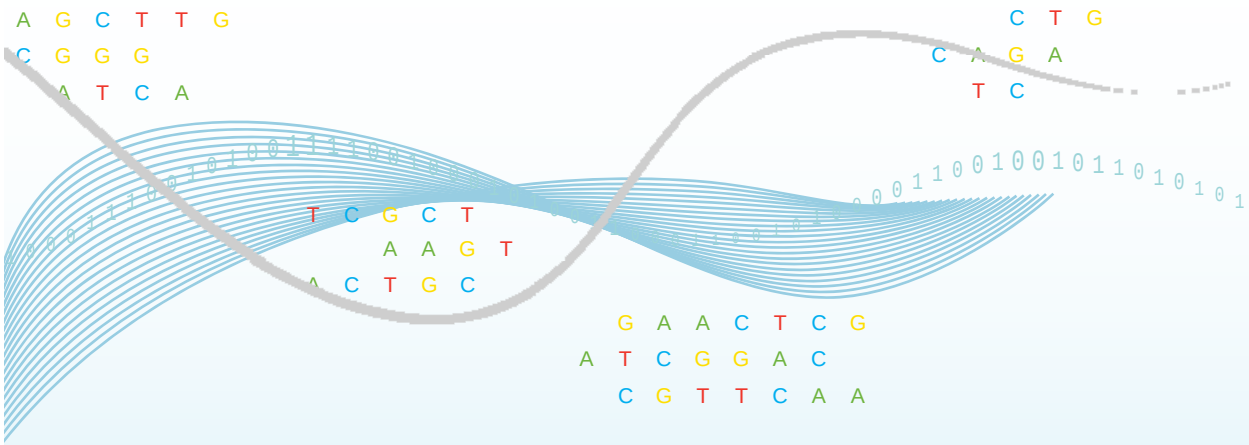
Overlapping Timelines of ICD-10, Meaningful Use of EHRs, and Health Reform Initiatives



Note: The Federal Fiscal Year starts on October 1 of the previous calendar year. For example, FY 2014 starts on October 1, 2013.

American Hospital Association

Medco Health Solutions, Inc
Implementation Status on HIPAA Transactions and Code Sets



MAKING MEDICINE SMARTER™

NCVHS Subcommittee on Standards

June 17, 2011

Annette Gabel Executive Director Standards Compliance

Telecommunication Standard D.0

- Impact assessment complete used internal resources
- Key issues found during the impact assessment include
  - Underestimated resources
  - Business requirements changed
  - Lack of understanding of standards
  - New transition issues from 5.1 to D.0 identified
- External testing started in January 2011 for Medco PBM, Medco Mail Pharmacy, Accredo and Liberty
  - Medco PBM identified issues not found in test
    - COB and compound claims
    - Client benefit set up
  - Medco mail pharmacy tested with Medco PBM
    - Other trading partners not ready to test
  - Accredo and Liberty testing delayed until February and March
    - Software not deployed from vendors
    - Trading partners not ready to test

Telecommunication Standard D.0

- Trading partner external testing
  - Medco PBM has completed 5% of certification testing (47 out of 200 have tested)
  - Medco mail service pharmacy completed testing with Medco PBM and in process of testing with one trading partner
  - Liberty has tested with Medco PBM and Medicare for the D.0 standard
  - Accredo is in the process of testing with two trading partners, represents only 2% of trading partners
- Production claims
  - Medco PBM has been accepting D.0 claims since 1/1/2011.
    - Chain pharmacies stopped submitting to make changes for Medicaid COB claims due to transition issues. Expected to start again in June or July.
    - Medco found issues in production not found in test and are making changes as needed
  - Medco Mail Pharmacy has been submitting D.0 claims to Medco PBM since March
    - No other trading partner testing is complete
  - Accredo and Liberty pharmacies are not submitting claims in production expected start date July

Medicaid Subrogation Standard

- Medco PBM completed impact assessment using internal resources
  - Crosswalk between the 5.1 standard used for subrogation and the 3.0 standard was an issue

- Implementation of standard
  - Ready to conduct transaction in production
  - Testing with 3 trading partners which represents 50% of trading partners
  - Expect to start transaction use in production in July if trading partners are ready
  - No urgency in industry waiting for D.0 to be complete

ASC X12 Standards

- Impact assessment completed with internal resources
  - Issues found include mapping from 4010 to 5010 and insufficient resources
- Medco PBM 270/271version 5010
  - Full use of standard in production
- Medco PBM 834 5010
  - External testing completed with 60% of trading partners
  - Conducting transaction in production with 50% of trading partners
- 835 5010 transaction
  - Medco PBM ready to external test and conduct transaction in production
    - Waiting for trading partners
  - Medco Mail service pharmacy completed development
  - Accredo tested with one trading partner
  - Liberty has completed development
- 837 5010 transaction
  - Accredo started external testing in May
  - Liberty started external testing in April

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ICD 10

- Medco PBM, Medco Pharmacy, Liberty and Accredo impact assessment not complete
  - In business planning stage
- Strategy for processing ICD10 codes after October 1, 2013
  - Will process using ICD 10 codes on dates of service 10/1/2013 and later
  - History files will remain with ICD 9 codes
- Liberty and Accredo pharmacies
  - Use ICD codes on Part B claims
  - Expect to start outreach to providers to obtain ICD 10 codes prior to October 1, 2013
  - Will develop testing for entire organization
  - Timeline includes internal testing first quarter 2013 and external testing second quarter

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Statement of the American Clinical Laboratory Association Before the National Committee on Vital and Health Statistics Standards Subcommittee

Donald E. Horton, Jr.
Chairman, ACLA ICD-10 Workgroup
Vice President, Public Policy & Advocacy
Laboratory Corporation of America Holdings
(LabCorp)

June 17, 2011

Version 5010 and ICD-10 Implementation Issues for Clinical and Anatomic Pathology Laboratories

Statement of the American Clinical Laboratory Association Before The National Committee on Vital and Health Statistics Standards Subcommittee
June 17, 2011

Donald E. Horton, Jr.
Chairman, ACLA ICD-10 Workgroup
Vice President, Public Policy & Advocacy
Laboratory Corporation of America Holdings (LabCorp)

Introduction

Dr. Suarez, Dr. Warren, and members of the Subcommittee and staff, thank you for the opportunity to testify today on behalf of both the American Clinical Laboratory Association (ACLA) and LabCorp regarding the issues faced by clinical and anatomic pathology laboratories in implementing Version 5010 of the HIPAA standard transactions and the ICD-10-CM code set. ACLA represents national, regional and local laboratories, and its members play a critical role in our health care system, providing accurate and timely clinical and anatomic pathology laboratory test results which influence over 70 percent of all medical decisions.

It is our view that the health care industry is generally behind schedule in the transition to Version 5010, and timely ICD-10-CM compliance is in jeopardy as a result of that delay as well as other factors. As indirect providers, clinical and anatomic pathology laboratories are particularly vulnerable to cash flow interruption in the event that ordering providers, payers, or clearinghouses are not ready for either conversion. A recent ACLA survey indicating significant ongoing ICD-9-CM error and omission rates suggests that the negative impact of ICD-10-CM on clinical and anatomic pathology laboratory reimbursement could be significant unless the conversion process speeds up and regulatory solutions are adopted to prevent labs from being penalized for failure to submit diagnosis data that is beyond their control.

Implementation of Version 5010

While LabCorp's experience to date in implementation of the Version 5010 837P claim transaction and 835 remittance transaction does not represent the experience of all ACLA member laboratories, it is illustrative of the issues that many ACLA member laboratories are facing.

LabCorp uses the 837P transaction with 846 different public and private payer groups, including Medicare, Medicaid, and Managed Care plans. Due to a lack of communication from most of its trading partners, LabCorp is currently reaching out to nearly 700 payers on a weekly basis to determine when testing can begin. With nearly half of the testing year behind us, payers that are ready are experiencing a backlog of providers that are ready as well. To handle the backlog, payers are creating waiting lists; however, there is no way for a provider to know where it is on the waiting list, or to plan for an estimated testing date.

Medicare represents 29% of LabCorp's third party revenue. To date, 6 of the 48 Medicare payers, representing 13% of LabCorp's third party revenue, are not ready to test; MAC

jurisdiction transitions are impacting 5 of those payers. LabCorp is actively testing the Version 5010 837P with 17 Medicare payers representing 15% of LabCorp's third party revenue, and there are 25 Medicare payers in line for testing that represent 1% of third party revenue. Of the top 10 Medicare payers for LabCorp, 4, representing 14% of third party revenue, are either not ready to test or are experiencing system issues.

Medicaid represents 8% of LabCorp's third party revenue, through 49 payers. While Georgia Medicaid is the first payer to have promoted LabCorp to production status, 8 of LabCorp's top 10 Medicaid payers representing 6.2% of third party revenue are not ready to test and have not provided estimated dates for testing.

Managed Care represents 63% of LabCorp's third party revenue, through 749 payers. LabCorp is actively testing with 32 payers that represent 33% of third party revenue. Another 18 payers, representing less than 1% of third party revenue, are currently in line for testing. One payer representing 3% of third party revenue is ready, but its clearinghouse is not. Another large payer will not allow LabCorp to move to production until it has been certified by all of its different subsidiary adjudication systems, because the payer does not have the ability to convert claims from one format to another internally. Among the top 10 Managed Care payers, 7 payers representing 29% of third party revenue are actively testing with LabCorp. Three payers in the top 10, representing 6% of third party revenue, are not ready to test, and of those three, only 1 has an estimated testing date.

Most payers will not test the Version 5010 835 remittance transaction until the testing for the Version 5010 837P is complete. LabCorp has tested the Version 5010 835 remittance transaction with a couple of payers that represent less than 1% of third party revenue. Only 46% of LabCorp's third party revenue is currently posted through an 835 remittance transaction. Several payers that do not currently use the Version 4010 835 remittance transaction responded to LabCorp's request to test Version 5010 by asking LabCorp to test the 4010 version. In an effort to increase the percentage of revenue posted electronically, LabCorp is moving forward with testing the Version 4010 835 remittance transaction with these payers.

In the interest of administrative simplification, ACLA urges NCVHS to recommend to HHS the establishment of a certification program for validating conversion to new versions of the HIPAA standard transactions. Designated Standards Maintenance Organizations (DSMOs) could evaluate candidate entities to serve as the certifying body and to ensure that its certification program would appropriately validate the published standards. Payers and providers could submit test files to this entity for certification. Once certified, a covered entity's trading partners would be required to accept the new version of the transaction.

This proposal has several advantages. Payers and providers would only have to test with one entity instead of every trading partner. The certifying body could maintain a list of certified organizations, which could be used to assess industry readiness. The certification process would encourage the adoption of the transactions without payer or provider special requests due to system challenges. In addition, the certification process could be funded with the savings each organization would save under the streamlined approach.

ICD-10-CM Implementation Issues

In our December 2009 testimony to this Subcommittee, we noted that labs were understandably concerned about the potential impact of ICD-10-CM because after more than 30 years of experience with ICD-9-CM, insufficient diagnosis coding data from ordering providers remains the single biggest billing problem for labs. A recent survey of ACLA member laboratories confirmed that errors and omissions in ICD-9-CM diagnosis data from ordering providers continue to result in significant front end claims suspensions, rejections or denials of claims due to inadequate diagnosis information, and wasted resources devoted to following up with the ordering provider to obtain necessary diagnosis data that should have been submitted with the test order.

For the six-month period of July 2010 through December 2010, the survey asked ACLA member laboratories to provide average monthly third party billed accession volume, average monthly diagnosis errors, average third party billing price per accession, average monthly adjustment due to unresolved diagnosis errors, current full time employees (FTEs) 100% dedicated to resolving diagnosis errors, estimated monthly staff hours spent resolving diagnosis errors, and average FTE annual salary. Diagnosis errors were defined as including receiving narrative diagnoses, invalid diagnosis codes, diagnosis codes not at the highest level of specificity, diagnosis codes that do not support medical necessity, and omission of diagnosis.

Based on the data submitted in response to the survey, nine percent (9%) of average monthly third party billed accessions contained diagnosis errors, placing at risk $37,671,067 in average monthly revenue. Of that amount, on average, 17.3%, or $6,529,237, remained uncollectable after follow up with ordering providers each month and was written off. On average, 201 FTEs were fully dedicated to resolving diagnosis errors, spending 31,681 monthly staff hours in that effort. The average annual expense of FTEs dedicated 100% to resolving diagnosis errors was $6,902,340.

Our experience with ICD-9-CM makes it clear that provider education and familiarity with the code set, while important, will not be sufficient to avoid even greater errors and omissions in provider submission of ICD-10-CM diagnosis data to clinical and anatomic pathology laboratories.

A primary source of this issue is that clinical laboratories, which cannot render or determine diagnosis codes for clinical laboratory testing themselves, are typically required under both HIPAA and payor rules to submit diagnosis codes in HIPAA standard transactions under circumstances in which there appears to be no requirement for referring providers to submit such codes to the laboratory, and as a result, they are often not submitted by referring providers. Where the law currently requires referring providers to submit diagnosis codes to the laboratory at the time of the test order when needed for payment, such as the Medicare billing rule at 42 U.S.C. § 1395u (p) (4), the law has been narrowly interpreted by CMS to apply only to services covered by a national coverage decision or local coverage decision under Medicare, and is rarely if ever enforced. These regulatory gaps between diagnosis code submission requirements for labs and ordering providers are problematic for clinical laboratories, providers, health plans and patients today, using an ICD-9-CM code set with which the healthcare industry is familiar. If not

resolved, they could become a much greater problem as the industry transitions to the new ICD-10-CM code set.

We urge NCVHS to recommend to HHS that it issue guidance reinterpreting 42 U.S.C. § 1395u (p)(4) to mean that referring providers must submit to the laboratory, at the time the test is ordered, the diagnosis data needed by the laboratory for payment, whether or not the test is the subject of an NCD or LCD. The diagnosis data needed by the laboratory for payment consists of valid diagnosis codes at the highest level of specificity. We would urge private payors to adopt the same position without delay. In addition, we urge NCVHS to recommend to HHS that it issue guidance to clarify the circumstances under which a laboratory may translate or crosswalk an ICD-9-CM code received from an ordering provider to one or more ICD-10-CM codes for submission to a payor.

Conclusion

We commend the Subcommittee for holding hearings on the issues related to planning for and implementation of Version 5010 and ICD-10, and encourage the Subcommittee to continue to monitor closely the progress being made on implementation of both of these standards. We ask the Subcommittee to carefully consider the issues faced by clinical and anatomic pathology laboratories in these transitions as well as the solutions we have suggested, and to make appropriate recommendations for HHS to take action to address these issues accordingly in a prompt and effective manner. Thank you again for the opportunity to testify, and I look forward to your questions.

APPENDIX

Table 1: LabCorp Payer Matrix for Professional Health Care Claim (837P)

	Medicare		Medicaid		Managed Care	
	Payer Count	% of Revenue	Payer Count	% of Revenue	Payer Count	% of Revenue
Number of Payers with 837	48	29%	49	8%	749	63%
% of Total Payers	5.6%		5.8%		88.6%	
5010 Conversion Status						
Readiness Status To Be Determined	0	0%	30	2%	671	14%
Payers Not Ready to Test 5010	6	13%	12	5%	27	13%
Clearinghouse Not Ready to Test 5010 but Payer Is	0	0%	0	0%	1	3%
Payers In Line for Testing 5010	25	1%	0	0%	18	0%
Payers Testing 5010	17	15%	6	1%	32	33%
Payers Converted to 5010	0	0%	1	0%	0	0%
Totals	48	29%	49	8%	749	63%

Table 2: Status of LabCorp's Top 10 Medicare Payers for 837P Conversion

Rank	Status	Detail	ECD
1	Payer not ready to test 5010	Jurisdiction transition	6/1/11
2	Payer not ready to test 5010	FTP site not ready	None given at this time
3	5010 Testing in progress	Pending further testing	
4	5010 Testing in progress	Files accepted. Pending move to production.	None given at this time
5	Payer not ready to test 5010	Jurisdiction transition	6/1/11
6	5010 Testing in progress	Pending further testing	
7	5010 Testing in progress	Files accepted. Pending move to production.	None given at this time
8	Payer not ready to test 5010	System issues at MAC	6/1/11
9	5010 Testing in progress	Pending further testing.	
10	5010 Testing in progress	Pending further testing.	

Table 3: Status of LabCorp's Top 10 Medicaid Payers for 837P Conversion

Rank	Status	Detail	ECD
1	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
2	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
3	Payer not ready to test 5010	Additional information to be provided next month.	None given at this time
4	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
5	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
6	Payer not ready to test 5010	Payer requested we monitor website for further information.	Summer 2011
7	5010 Testing in progress	Pending further testing.	
8	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
9	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
10	5010 Testing in progress	Pending further testing.	

Table 4: Status of LabCorp's Top 10 Managed Care Payers for 837P Conversion

Rank	Status	Detail	ECD
1	5010 Testing in progress	Production dependent on 5010 certification for all of the payer's systems.	
2	5010 Testing in progress	Pending further testing.	
3	Payer not ready to test 5010	Base 5010 testing complete. Pending payer's Errata program.	6/1/11
4	Clearinghouse not ready to test 5010	Payer is ready to test	6/1/11
5	Payer not ready to test 5010	Payer supplying weekly updates.	6/1/11
6	5010 Testing in progress	Pending further testing.	
7	5010 Testing in progress	Pending further testing.	
8	5010 Testing in progress	Several rejections are being researched by payer.	
9	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time
10	Payer not ready to test 5010	Payer requested we monitor website for further information.	None given at this time

Table 5: LabCorp Payer Matrix for Health Care Claim Payment Advice (835)

	Medicare		Medicaid		Managed Care	
	Payer Count	% of Revenue	Payer Count	% of Revenue	Payer Count	% of Revenue
Number of Payers with 835	48	28%	49	8%	201	10%
% of Total Payers	5.6%		5.8%		23.8%	
5010 Conversion Status						
Readiness Status To Be Determined with 837 Testing	48	28%	49	8%	174	6%
Payers In Line for Testing **4010**	0	0%	0	0%	7	0%
Payers In Line for Testing **4010**	0	0%	0	0%	15	1%
Payers Not Ready to Test 5010	0	0%	0	0%	0	0%
Clearinghouse Not Ready to Test 5010 but Payer Is	0	0%	0	0%	1	3%
Payers In Line for Testing 5010	0	0%	0	0%	2	0%
Payers Testing 5010	0	0%	0	0%	2	0%
Payers Converted to 5010	0	0%	0	0%	0	0%
Totals	48	28%	49	8%	764	10%

42 U.S.C. § 1395u (p) (4)

In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) [42 U.S.C § 1395x(s)] ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.