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Department of Health and Human Services

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

Subcommittee on Standards
June 17, 2011

Implementation and Updates on New HIPAA Standards and Code Sets for X12 Version 5010, NCPDP Version D.O. and Version 3.0 and ICD-10

Double Tree Hotel
300 Army Navy Drive
Arlington, VA 22202-2891

The National Committee on Vital and Health Statistics Subcommittee on Standards convened on June 17, 2011 in Arlington, VA. The meeting was open to the public and was broadcast live on the Internet. A link to the live broadcast is available on the NCVHS homepage.

Present:

Committee Members

Walter G. Suarez, M.D., M.P.H., Co-Chair
Judith Warren, Ph.D., R.N., Co-Chair
Justine M. Carr, M.D.
Raj Chanderraj, M.D., F.A.C.C.
William J. Scanlon, Ph.D.
James M. Walker, M.D., FACP

Staff and Liaisons

Lorraine T. Doo, M.P.H., Lead Staff
Vivian Auld, NLM
J. Michael Fitzmaurice, Ph.D., AHRQ
Marjorie Greenberg, NCHS/CDC, Executive Secretary
Donna Pickett, NCHS
James Scanlon, ASPE
Jim Sorace, M.D., ASPE
Karen Trudel, CMS
Michelle Williamson, NCHS
Nicole Wilson, VA

Presenters

Brent Antony, TN Medicaid
George Arges, AHA
Rhonda Buckholtz, AAPC
Rhonda Butler, 3M

Janice Chase, Indian Health Service (by phone)
Kelley Coleman, VA
C. Todd Couts, Noblis
Rich Cullen, BCBSA
Jim Daley, ICD-10
Laurie A. Darst, 5010, Mayo Clinic
Annette Gabel, NCPDP, Medco
Donald Horton, LabCorp/ACLA
Chris Handler, Ketchum
Lawrence Howe, Ingenix
Holly Louie, Healthcare Billing & Mgmt. Association
Linda McCardel, MI Medicaid, MPHI
Debbie Meisner, Emdeon (by phone)
Don Oaks, TN Medicaid; TN Dept. of Finance & Administration
Ruth-Ann Phelps, VA
Elizabeth Reed, Medicaid/CMCS
Melissa Shelk, Property & Casualty
Nancy Spector, AMA
Chris Stahlecker, Medicare
Rob Tennant, MGMA
Tom Wilder, AHIP
Dennis Winkler, BCBSMI
Lisa Wichterman, Workers Compensation, MN Dept. of Labor & Industry
Ira Woody, Leading Age (written)
Ann Zeisset, AHIMA

Others Present:
Robert Barbour, AMA
Peter Barto, PWC
Bruce Cohen, NCVHS National Committee member, MA Dept. of Public Health
David Connolly, Capitol Associates, Inc.
Bill Finerfrock, HBMA D.C. Rep, Capitol Associates, Inc.
Lynne Gilbertson, NCPDP
Dan Rode, AHIMA
Gladys Wheeler, CMS

EXECUTIVE SUMMARY
Friday, June 17, 2011

ACTIONS

- The Subcommittee will draft a letter with observations and recommendations with the intention of presenting a formal letter to the Committee at the September 2011 meeting.

CALL TO ORDER, WELCOME, INTRODUCTIONS, AGENDA REVIEW
Judith Warren, Co-Chair; Walter G. Suarez, M.D., M.P.H., Co-Chair

SESSION I: Federal Update

Donna Pickett, NCHS and Rhonda Butler, 3M
Chris Stahlecker, Medicare
Todd Couts, Noblis
Ruth-Ann Phelps, VA
Kelley Coleman, VA
Janice Chase, Indian Health Service
Elizabeth Reed, Medicaid/CMCS
Chris Handler, Ketchum

Discussion

Mr. Handler addressed the challenge inherent in knowing or controlling who responds to the surveys, particularly within the AMA and ACP. OMB has not yet approved a larger, more statistically relevant study. In a larger study (sample size: 400), a vendor targets specific demographics to ensure provider representation across the spectrum. Then, the data can be cut to differentiate between different kinds of provider groupings. Ms. Phelps clarified that she was speaking in general about a belief that an industry-wide transition to 5010 by January 1, 2012 is improbable. The VA also has concerns about payer testing (the end-to-end process) although as a large entity, the VA is better positioned than small providers to effect the change. While it will "flip the switch" on the designated date, there are concerns about ramifications.

The Indian Health Service has not yet let vendors know about additional vendors or contracts that will result from 5010 and ICD-10 or about a competition. They are working on meaningful use and reporting requirements needed for the incentives. Outreach to the Vendor Committee began in July 2011; and the first meeting to discuss revenue cycles took place in August 2011. Also discussed were state difficulties with the change due to different systems and revenue challenges.

A concern about adequate testing prior to the changeover date was raised. A week or a month of testing was suggested as well as a recommendation that the Secretary include testing in 2011. As contingency plans must be in place by January 1, 2012, guidance may be needed. One solution to follow (as laid out by X12 relative to standard or implementation specification adjustments) will come in the form of a request for information issued by an entity that has discovered a problem. Resolution would be the formal equivalent of a TR3 update or an implementation guide correction; or it would set the stage for the next version of HIPAA standards to incorporate that language into the upcoming release. An emergency approach would use the RFI request for information Q&A (wherein the industry would enter an RFI question to the standards development organization). Issue resolution would be documented, noting that a TR3 change is expressed as a response to the RFI. This would provide sufficient documentation to vendors to modify products as products now match TR3.

Within Medicaid, there is no set defined data. The VA's ICD-10 program manager is working within IPT resources to determine how the payment cycle will be affected. The importance of helping departments identify cost savings was noted. A concern was raised about data bias relative to the prospective use of crosswalks. A question was raised about whether CMS could offer an implementation incentive to physicians. The GEMS text files (content provided by federal agencies, not software) were described. Extended provider outreach education that clarifies the meaning of GEM, crosswalk and how to wisely choose will be implemented.

SESSION II: Health Plans, Clearinghouse and Vendors

Tom Wilder, AHIP
Dennis Winkler, BCBSMI
Rich Cullen, BCBSA
Debbie Meisner, Emdeon
Lawrence Howe, Ingenix
Don Oaks and Brent Antony, Tennessee Medicaid
Linda McCardel, Michigan Medicaid

Discussion

A question about use of crosswalks versus adopting the native ICD-10 was raised. BlueCross indicated that even those plans using crosswalks plan to convert to ICD-10. What are the high priority codes and are there resources to identify them? Organizations must analyze their own data (e.g., high impact codes for Medicare might differ from commercial). Provider communities are behind on 5010 and significantly behind on ICD-10 relative to readiness and awareness. Therefore, remediation must be available and consistent between states and their contractors (e.g., within companion guides with comments).

It was noted that more attention is being paid to health plans and administrators than to providers and patients. While plans are not yet coordinating or evaluating systemic approaches to changing from ICD-0 to ICD-10, such efforts present great opportunities to highlight greater commonality in data collection. Some initiatives of multi-payer databases and the ACA provision on providing, for example, Medicare data for qualifying entities allow data review across plans that also may increase commonality.

Mr. Wilder (AHIP) believes that the industry's testing capacity is adequate to move toward 5010 compliance, noting a Deloitte educational series. Rather than educating providers, Emdeon is evaluating tools and customer needs. A question about ease of use of the state Medicaid subrogation standard, the NCPDP 3.0, was raised. Michigan and Tennessee assign this responsibility to a pharmacy benefit manager (PBM). Other states are not 3.0 compliant but plan to be.

SESSION III: Other Entity Types and Industry Stakeholders

Rhonda Buckholtz, AAPC
Holly Louie, Healthcare Billing & Mgmt. Association
Ira Woody, Leading Age (written)
Lisa Wichterman, Workers Compensation
Melissa Shelk, Property & Casualty
Ann Zeisset, AHIMA
Laurie Darts, 5010
Jim Daley, ICD-10

Discussion

Core themes include education, outreach and testing. A question was raised about how sectors other than medical/clinical (e.g., long-term care; physical therapy; dental; pharmacy) are doing

with compliance and the surveys. It was noted that the surveys do not break down types of provider responders but that dental and pharmacy are included in the "provider" category. In Minnesota, workman's compensation is exempt from the eligibility transaction because it takes so long from the first report of injury. Each state has a different workman's compensation set-up.

The benefits of the cross-over to ICD-10 (largely unmeasured) and the costs (relative to type and volume of business as well as an upfront but also ongoing investment) were major considerations of today's presentations. In-patient or procedure-based documentation is different than that of PCPs (paid on their ENM codes). Relative to provider impact and individual incentives, one must consider two competing camps (SNOMED and ICD) for how to populate EHR problem lists. Claims data granularity was discussed, using the example of injury from burning water skis. Complication will occur during a period when payers use ICD-9 and ICD-10 for claims. It would impact liability and might also trigger the payer's need for further information. The way that companies put diagnosis codes into their claims system varies. Increasing regulations place a burden on providers. The adequacy of the number of coders was discussed. At present, 1800 people are prepared to train coders around the country along with training that state associations offer (although some in remote areas may not have access to trainers). Those who know ICD-9 must learn ICD-10. It is too soon for the average coder to learn code sets because they will not retain the information until they use it.

SESSION IV: Providers

Nancy Spector, AMA
Rob Tennant, Medical Group Mgmt. Association
George Arges, AHA
Annette Gabel, Pharmacy
Donald Horton, Labs – LabCorp/ACLA
Laurie Darst, Mayo Clinic (written)

Discussion

Ordering physicians enter the diagnostic code (laboratories are prohibited from doing so). There is no "one size fits all" for 5010 compliance for billing purposes: some vendor clearinghouses supply more information to practice management systems than others (e.g., smaller rural sites). Hospitals generally use IT staff to handle such changes although achieving a desired volume of testing has been difficult, especially when health plans do not test in conjunction with the hospitals. Most desirable would be a CMS-like program with national data testing. Medicaid plans must also be ready for testing. Ms. Doo stressed the importance of reporting complaints in order to help parties become compliant. The national testing day is meant to be a rallying call to begin testing. Often, physicians don't know where the problem lies in the process, only that a claim has been rejected. Unsolicited audits on 5010 compliance were suggested as was a "HIPAA Whistleblower Protection Act" to prevent retribution.

It will be important for the appropriate mapping to cross over the EHR lab ordering (different than the administrative lab payment process). Also raised was consideration for a vendor certification program that supports administrative transactions; and a suggestion was made to turn this idea into a recommendation. A concern about possible financial hardship of certification requirements on smaller practices was voiced. The issue of invalid codes for billing purposes was raised. Also mentioned was fear of Medicare audits that discourage physicians

from complaining about regulations (although, in fact, Medicare does very little auditing). Assembling a toolkit for practices and hospitals was recommended.

Concluding Comments and Next Steps

Themes of these hearings include: the 5010 change-over date is "the date;" emphasis on education, communication, outreach, coordination and testing; concerns about readiness of state Medicaid programs; special consideration issues such as the creation of an ombudsman office to address 5010/ICD 10 issues; policy implementation and enforcement ideas; and cost implications. Specifically with regard to 5010, major themes include testing; continuity of business operations; and thinking collaboratively about what happens on January 1, 2012, keeping the notion of progression versus perfection in mind. Other concerns include 278, the Health Care Authorization Request for Referrals; the paper "blizzard" to come; the transition to D.O. and the need for testing; and Medicaid subrogation. ICD-10 themes include the concept of crosswalks and GEMS; link to products; resources; and whether there are enough coders. Worker's compensation and property and casualty were additional topics.

Next Steps: The Subcommittee plans to present a formal letter to the Committee at the September 2012 meeting. There are opportunities to lay out good practices and useful scenarios about activities that contribute to a successful progression as well as coordination between approaches. It would be useful to communicate how 5010, ICD-10, pharmacy issues, meaningful use and other mandates relate to and support each other. The take-home message is the Department's mandate to work with many stakeholder groups to get the "bigger picture" out to the different aspects of the industry.

Dr. Warren adjourned the meeting at 5:00 p.m.

To the best of my knowledge, the foregoing summary of minutes is accurate and complete.

Judith Warren, Ph.D., R.N. DATE
Co-Chairman

Walter G. Suarez, M.D., M.P.H. DATE
Co-Chairman