National Committee on Vital and Health Statistics Medicare Fee For Service Testimony

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Today's Agenda

1. How did the implementation of 5010 D.0, 3.0 go from your perspective?
2. What was the value of the enforcement discretion period?
3. What were the most important business and technical issues that affected each transaction (claims, claims payment, eligibility, claim status, etc.)?
4. What are the top 2 or 3 lessons learned from the first national transition to a new version of existing standards?
5. Are there any issues for 5010 D.0, 3.0 that can be considered lessons learned?
6. Is there anything else you would like to bring up regarding the implementation of 5010 D.0, 3.0?

How Well Implementation Went

Benefits Achieved:

- Like many payers, Medicare Fee For Service (FFS) leveraged this transaction set upgrade to expand claims processing software and what was termed “Downstream” systems to accept the longer ICD-10 CM and PCS Medical Code Set.
- Based on the planned timing of MAC implementations, we decided not to upgrade legacy FIs and carriers to 5010. This turned out to be a challenge later when MAC transitions slowed down, so we used contingency plans.
- Medicare FFS eliminated the use of proprietary acknowledgements for claim submission and shifted to a national standard transaction set used by MACs for Part A, Part B and DME.

How Well Implementation Went

Benefits Achieved:

- Medicare adopted a processing environment which allowed claim submitters to reject claims as early in the process as possible to avoid going through the effort of processing a claim if it was eventually going to be denied or rejected.
- Medicare adopted the standardized Companion Guide format which was used across the Part A, Part B, and DME claim processing systems
- Medicare FFS created over 17,000 Test and Use cases in order to perform an internal system certification prior to testing with external entities.

How Well Implementation Went (Cont'd)

Benefits Achieved:

- Although we would prefer just one translator, we were able to reduce the total to three.
- Medicare FFS now posts its front end edit spreadsheets quarterly to WWW.CMS.GOV website.

How Well Implementation Went (Cont'd)

Concerns:

- Submitters waited longer than they should have in spite of our outreach efforts. Medicare did not receive its first external test file until the second quarter (May 2011) of the External Testing year.
- The publication of errata documents by the Standards Development Organization impacted Medicare FFS progress and resulted in delayed readiness.
- Industry interpretation of new material implemented can vary. All parties in the industry need to agree on definitions and usage.
- Medicare FFS was very ambitious in its implementation of 5010 by changing system and business processes (e.g. adopting a standardized claim acknowledgement) at the same time.

How Well Implementation Went (Cont'd)

Concerns:

- Medicare FFS used the same time period to re-verify the enrollment relationship of the Clearinghouse and providers. This caused confusion when the re-verification was not performed causing claim rejections not related to the 5010 program activities.
- Medicare FFS received few Congressional and other inquires related to the transition to version 5010. However, upon investigation by the MACs, results often were that the vendor was the cause of the provider's problem in filing Medicare claims.
- Medicare is also recommending that standards be tested prior to adoption and implementation by the healthcare industry

Value of Enforcement Discretion Period

- Enforcement discretion is a double-edged sword, as some submitters can use the extra time to complete work, but as soon as a delay is announced, momentum for the transition is lost.

Important Business and Technical issues

Claims - Medicare FFS educational points included:

- Use of Post Office Box for Billing Provider Information in Loop 2010AA
- Requirement for a 9 digit Zip Code in certain section of the transaction
- The Modification for the HI segment which allows for ICD-10 Diagnosis Codes
- The Present on Admission (POA) indicator moving
- The Errata Adoption Process

Important Business and Technical issues

Claim Payment - Medicare FFS educational points included:

- Medicare Fee For Service (FFS) provided guidance on the Reversal and Corrections aspect of the Claim Payment Advice. Specifically the handling of interest and prompt pay discounts through its National Provider Calls.
- Medicare FFS also provided guidance on the Advance Payment and Reconciliation processes.
- Medicare FFS is also reviewing the Claim Adjustment Reason Codes and Remittance Advice Remarks codes in order to standardize consistent usage across the MACs.

Lessons Learned During National Transition

1. **Communicate Early and Often Internally and Externally:**
   - Medicare FFS has hosted 24 National Provider calls between June 2009 and most recently May 2012.
   - Medicare FFS National Calls had participation throughout the series of calls from over 250,000 members of the health care industry.
   - Medicare FFS held a weekly status call with over 100 participants from all Medicare contractors and vendors/subcontractors supporting them from both within and outside the Medicare Program.

2. **Obtain Business and Systems Buy-in of the Efforts**
   - Medicare FFS was able to obtain support at all levels of the CMS for the 5010 Program. This began with Senior Management support and flowed throughout the organization.

Issues for D.0 Lessons Learned

- Medicare FFS has little claim activity related to NCPDP in the DME claim environment but expended time, effort, and resources to bring up systems which process these transactions in batch mode.
- Medicare FFS is considering whether we really need to continue use of the NCPDP claim format in the Durable Medicare Equipment area. NCPDP claims accounts for less than .01% of total Medicare FFS claim volume.