MGMA Government Affairs

Panel 1: 5010/D.0 and 3.0 – Issues, Approaches to Solutions and Lessons Learned

NCVHS Subcommittee on Standards

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June 20, 2012

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Adopting 5010: the Provider Perspective

- Issues and concerns identified during the implementation process
- Current environment
- Recommendations:
  - Short term
  - Longer term

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5010: Provider Issues and Concerns

- Issues with practice management and/or billing systems getting upgraded in a timely manner
- Claims that showed no problems during the testing phase with their MAC and commercial plans, but once the provider moved into production phase, claims were being rejected
- Issues with secondary payers and inconsistent claim edits
- Rejections due to various address issues (pay-to address being stripped/lost from claims; pay to address can no longer be the same as billing address)
- Crosswalk NPI numbers not being recognized
- “Lost” claims with MACs

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Issues and Concerns con’t

- Old submitter validation information not being transferred
- Certain "not otherwise specified" claims being denied due to not having a description on the claim (CMS sent a notice of correction of this issue Jan. 27, 2012)
- Sporadic payment of re-submitted claims (with no explanation for rejections)
- Protracted call hold times (most typically 1-6 hours) when attempting to contact MACs for further explanation of unpaid and rejected claims (a problem that dates as far back as Nov 2011)
- Unsuccessful claims processing (with no reason cited for rejection) despite using a “submitter” that was approved after successful testing with CMS

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Not Getting Paid

- Large numbers of practices reporting no claims paid for months (some owed $1 million +)
- Rent/salaries not being covered
- Lines of credit/cash reserves exhausted
- Practices took action:
  - Switched clearinghouses / reverted back to 4010 / Some even dropped to the paper 1500 form

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Consistent Challenges

- Wherever regulation is open to interpretation, industry experience with OIG leads to fear and very conservative legal approaches.
- Insistence on perfection to be “compliant” (important COB issue)
- No industry agreement on testing schedule (other than Medicare)
  - No transition period before compliance date
- Issues with Medicaid (several states were not compliant by Jan. 1)
- Delays in vendor delivery of updates
  - Lack of information from PM vendor as to when they will deliver
- High cost of software updates (5010 = $16k+ per FTE physician)

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Current 5010 Environment

(MGMA research conducted June 6-15 with 205 practices responding)

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Since November 2011, has your practice experienced any 5010-related cash flow disruptions?

Answer Options	Response Percent
Yes	**63.5%**
No	30.3%
Not sure	6.2%

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Are you currently experiencing any 5010-related cash flow disruptions?

Answer Options	Response Percent
Yes	40%
Not anymore, our 5010 problems have been resolved	**60%**

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We are currently experiencing cash flow disruption due to problems with our: (check all that apply)

Answer Options	Response Percent
Practice management and/or billing system	32.7%
Clearinghouse	**59.6%**
Commercial health plan	53.8%
Medicare	34.6%
Medicaid	11.5%
Do not know/can't identify where the problem lies	1.9%

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What is the approximate amount of claims outstanding?

Average of claims outstanding:	$172,740

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Some health plans are adjudicating 5010 claims that have missing or inaccurate data content. How confident are you that you are submitting fully compliant 5010 claims?

Answer Options	Response Percent
No confidence	2.6%
Little confidence	5.8%
Moderately confident	35.6%
Very confident	**41.4%**
Completely confident	14.7%

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Short Term-What Needs to be Done Now?

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Immediate Action Required

- Preferably, CMS should immediately notify the industry that the “discretionary enforcement delay” is extended through the end of 2012
- At a minimum, CMS should permit health plans to accept non-compliant 5010 transactions
- CMS should (and encourage commercial plans and clearinghouses to) aggressively outreach to providers regarding data content errors and other 5010-related issues

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Longer Term-Can We Improve the Process?

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A revised implementation process for HIPAA and ACA Mandates should include the following:

1. **Analysis of the administrative and financial impact of overlapping initiatives.** Existing federal health information technology mandates on providers must be evaluated in the context of any new administrative mandate, including identification of compliance dates.

2. **Completion of a comprehensive cost benefit analysis.** HHS should complete and make public a comprehensive (and realistic) cost-benefit analysis to ascertain how each sector of the healthcare industry will be impacted by any change to any new administrative mandate. Explore funding options for providers to adopt these standards.

3. **Pilot testing.** Process should mirror eRx standards in the Medicare Modernization Act of 2003-mandated pilot testing of all standards not already in wide industry use.

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Process Change

4. **Staggered implementation dates.** Delineated staggered compliance dates for the different sectors. Clearinghouses and health plans should comply first and then providers would comply with any new standard a minimum of 12 months later. This builds in a designated testing period.

5. **Improved feedback loop.** Providers need to know the data errors on claims.
    - Problem: currently, not all health plans offer these standard transactions and not all PM systems can accept these transactions
    - Solution: mandate and leverage acknowledgement transactions:
        - TA1: reporting the receipt of the transmission--batch transmission "envelope"
        - 999: reporting any syntactical errors identified at the claim level between the data received and the transaction implementation guide requirements
        - 277 Health Care Claim Acknowledgement used to communicate to the practice the total number of claims that were accepted, pended, or rejected. If claims are pended or rejected, this transaction provides the health plan's reasons

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Process Change

5. **Certification.** HHS should adopt the approach of Section 1104 of the Patient Protection and Affordable Care Act of 2010 and require that:
   - All health plans should be certified to transact all e-standards and accept all new codes
   - All clearinghouses should also be required to be certified under the same criteria
   - Creation of certification process for PM and billing system software. Partner with one or more existing certification entities currently participating in meaningful use (ATCBs)
   - Creation of a national certification registry (similar to the ONC process)

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Process Change

6. **Augmentation of the problem identification and resolution process.** Sufficient resources should be provided by HHS to develop the infrastructure to identify roadblocks, issues and solutions before and after compliance dates. This process should include:
    - Contracting with an appropriate entity to conduct ongoing and robust industry surveys
    - Adopt an advanced payment policy prior to major conversions
    - The naming of a HIPAA “ombudsmen”
    - The creation of the “ONC for Administrative Simplification”
    - A more proactive enforcement approach that is not solely complaint-driven

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Summary

- Significant problems migrating to 5010
- Issues included protracted and expensive software upgrades, uncoordinated trading partner testing, data content issues, HIPAA “fog”
- Significant number of providers continue to experience 5010-related problems
- Short-term: CMS should extend the enforcement delay and continue to permit health plans to accept non-compliant 5010 transactions
- Long-term: implementation process needs to be significantly revised

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