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Subcommittee on Standards
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Cooperative Exchange 5010 Lessons Learned Testimony
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The Cooperative Exchange would like to thank NCVHS for holding these important hearings and inviting us to participate. The Cooperative Exchange is the recognized resource and representative of the clearinghouse industry for the media, governmental bodies and other outside interested parties. Our mission is to promote and advance electronic data exchange for the healthcare industry by improving efficiency, advocacy, and education to industry stakeholders and government entities.

Our members include: ACS EDI Gateway; American Medical Association (AMA); Availity; CareMedic Systems; Caparío; ClaimLogic; Claimsnet; eProvider Solutions; Gateway EDI; GE Healthcare; GHN-Online; HDM Corp.; Healthcare Billing and Management Association (HBMA); Health-e-Web; Jopari Solutions; Medical Electronic Attachment; OfficeAlly; OptumInsight; RealMed Corporation; Secure EDI; Siemens HDX; and The SSI Group, Inc. In 2010, our membership connected with over 686,000 submitting providers, over 5,200 payer connections, processed over 1,219,972,000 claims transactions with a value of over one trillion dollars.

The clearinghouse facilitates the exchange of *any* type of data (benefit verification, treatment authorization, claims transport, claim status, remittance, attachments) between *any* type of entity (provider, pharmacy, lab, health plan). They translate *any* data from one format to another (e.g. print image to ANSI X12 or HL7 standards).

The transition from 4010 to 5010 was difficult for all those involved. Today, I am focusing on issues our clearinghouse members had with Testing, Medicare Administrative Contractors (MACs), and Industry Calls. This is by no means the complete list. Please refer to Appendix A for a full list of Cooperative Exchange's "Lessons Learned during the Implementation of 5010."

We also want to commend Lorraine Doo, Senior Policy Advisor for OESS for bringing her staff, the Cooperative Exchange, WEDI, MGMA, the SSI Group and Emdeon together to conduct collaborative webinars. This allowed stakeholders to work together to identify issues and solve them. It's a good model that should be implemented earlier in the future.

<u>Testing</u>
In some respects, testing prior to the implementation date was a mirage. Varying scenarios that payers accepted made testing inconsistent, and other lingering 4010 issues complicated testing. Trading partners were unaware that some payers tested 5010 transactions in the then current 4010 platforms, and provided approval for production. This resulted in high rejection rates once the payer went live with their 5010 software updates. All trading partners should have coordinated activities to allow implementation and testing of internal software changes prior to the initiation of external trading partner testing at least one year prior to the mandated effective date. All trading partners should have tested systems in place with the capability of conducting software/hardware tests, but also the capabilities of simulating testing of the new requirements with trading partners**.** Some of the payers utilized a ramp manager testing system which was not identical to the production environment. Clearinghouses needed payers to be forthright and confirm the actual platforms being tested.

Lack of communication from payers regarding edits/requirements impacted successful 5010 transactions submission and compliance. Once payers provided these requirements, rejections diminished significantly to pre-5010 levels. Some payers don't have testing systems at all, which further impacts prevention of issues prior to production. The industry needs to include revenue management systems in the testing process. True end-to-end testing through actual claim adjudication will be necessary for any regulatory implementations, such as ICD-10, to be successful.

Testing days provided important feedback. The following transactions were supported during the testing days: Inbound 837 Institution and Professional Claim; Outbound 835 Remittance Advice; Interchange Acknowledgement TA1; Acknowledgement for Health Care Insurance 999;Health Care Claim Acknowledgement 277CA; and Health Care Claim Request and Response 276/277. The data from testing days was used to refine implementation approaches and reduce production issues.

However, re-enrolling every Medicaid providers NPI and Tax ID with their state prior to the test date for electronic submission stressed already stretched resources. NHIC, Palmetto and Trailblazer had the extra PTAN requirement, a data field that clearinghouses don't regularly utilize, and which caused delays and added unnecessary work. This process took two weeks and added additional workload to the personnel already managing regular testing duties.

We recommend that testing days are necessary and bring value. We suggest a collaborative effort with government and industry to begin monthly industry test dates starting a year in advance until the compliance date.

Medicare Administrative Contractors (MACs)

There were inconsistencies with many of the MACs. Some accepted dual versions 4010/5010, some did not. There were different acceptance dates, and some are still not accepting. There were different enrollment requirements and different rejection codes. Medicare Fee-for-Service should do a better job managing the MACs more quickly addressing issues that were identified (i.e. phones not being answered, providers not being paid). Also, CMS/OESS and the central Medicaid office should do more to manage the state Medicaid agencies, and more quickly address issues that were identified with the states, and hold them accountable for non-compliance.

Industry Calls

Medicare Fee-for-Service teleconferences regarding the status of 5010 implementation compliance, the Q&A was never transcribed or posted and the resolution of issues was not timely. They also lacked follow-up with entities regarding specific issues related to providers and payers.

Thank you again for giving us the opportunity to share our lessons learned and present our recommendations.

Sincerely,

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APPENDIX A

Lessons Learned during the Implementation of 5010

1. Develop and Implement a 999 rejection manual that specifically states the reason for the claim rejection;
2. Require an interactive X.12 website where stakeholders can view interpretations, make comments and track progress in real-time, prior to finalization of the rules/processes;
3. All trading partners should coordinate activities to allow implementation and testing of internal software changes prior to the initiation of external trading partner testing at least one year prior to the mandated effective date;
4. Project management accountability must be assumed by each trading partner.
5. Providers must anticipate and realize that new systems have to be implemented and tested prior to transaction testing with trading partners;
6. All trading partners should have test systems in place with the capability of conducting software/hardware tests, but also the capabilities of simulating testing of the new requirements with trading partners. Some of the payers utilized a ramp manager testing system which was not identical to the production environment;
7. Industry impacts included 4010 issues that have not been resolved, further impacting the 5010 implementation;
8. Trading partners were unaware that some payers tested 5010 transactions in the current 4010 platforms, and provided approval for production. This resulted in high rejection rates once the payer went live with their 5010 software updates. Need trading partners to be forthright and confirm the actual platforms being tested;
9. Implementation of software updates just prior to the compliance date should be deemed unacceptable by trading partners;
10. Actual production didn't resemble testing;
11. Lack of communication from Payers regarding edits/requirements impacted successful 5010 transactions submission and compliance. Once payers provided these requirements, rejections diminished significantly to pre-5010 levels;
12. Some payers don't have testing systems at all, which further impacts prevention of issues prior to production;
13. No true end-to-end testing exists today. Varying scenarios that payers accepted made testing inconsistent, and other lingering 4010 issues complicated testing. Need to include revenue management systems in the testing process. True end to-end testing will be necessary for any further implementations;
14. Entire batches were rejected because of one claim affected all providers that batch. Request payers review processes for batch rejection and modify to prevent entire batch rejections;
15. Medicare Fee-for-Service should do a better job managing the MACs more quickly addressing issues that were identified (i.e. phones not being answered, providers not being paid);

16. CMS/OESS and the central Medicaid Office should do more to manage the state Medicaid agencies and more quickly address issues that were identified with the states and hold them accountable for non-compliance;
17. There were inconsistencies with MAC's (some accepting dual versions 4010/5010, some not, different acceptance date, some still not accepting, enrollment requirements, rejections, etc.);
18. Re-enrollment of providers caused numerous rejections and delayed payments;
19. Requirements for re-enrollment should be made known early during the pre-implementation phase as well as defining process and requirements for such registration;
20. Inconsistencies amongst trading partners and payers in identifying issues with the 5010 implementation, with irregularities in 999's, 277CA's or lack thereof, resulted in difficulties in tracking claims as well as proper adjudication;
21. Recommend implementation of the tracking number for transactions;
22. Proactively engage providers regarding their accountability and responsibilities with any implementation;
23. Creating pathways for providers for 4010 to 5010 was needed. Those on older systems have to be aware of deadlines. Clearinghouses must engage providers early in the process and track progress;
24. Medicare Fee-for-Service calls regarding the status 5010 implementation compliance which included industry Q&A lacked timely website FAQ posting or resolution of issues and also lacked follow-up with entities regarding specific issues related to providers and payers;
25. Payers have to "staff up" for communications. Help Desks should be engaged, knowledgeable and responsive;
26. Testing days provided good feedback, however, there was a lot of prep work to get there. Recommend monthly industry test dates until compliance date;
27. Financial impacts/cost evaluations should have been more in-depth for payers, providers, vendors, clearinghouses and other entities, identifying not only overall costs to the industry, but also the financial and staff resources expended by organizations.