TESTIMONY BEFORE

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

DECEMBER 10, 2009

PRESENTED BY

HOLLY LOUIE, CHBME

CO-CHAIR HBMA ICD-10 TASK FORCE

MR. CHAIRMAN AND MEMBERS OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS (NCVHS). MY NAME IS HOLLY LOUIE AND I AM A BOARD MEMBER OF THE HEALTHCARE BILLING AND MANAGEMENT ASSOCIATION (HBMA) AND CO-CHAIR OF OUR ICD-10 TASK FORCE. ON BEHALF OF HBMA AND THE MORE THAN 600 COMPANIES THAT BELONG TO OUR ASSOCIATION, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PRESENT OUR VIEWS ON THE PLANNING AND IMPLEMENTATION OF THE UPDATED HIPAA TRANSACTION STANDARDS AND CODE SET (VERSION 5010) AND ICD-10 CM.

IN ADDITION TO MY RESPONSIBILITIES AS CO-CHAIR OF THE TASK FORCE, I AM CORPORATE COMPLIANCE OFFICER FOR PRACTICE MANAGEMENT, INC. A MEDICAL PRACTICE MANAGEMENT COMPANY LOCATED IN BOISE, IDAHO.

HBMA MEMBERS PROVIDE MEDICAL BILLING AND OTHER CLAIMS PROCESSING SERVICES INTEGRAL TO THE HEALTHCARE DELIVERY SYSTEM. BASED UPON RECENT MEMBER SURVEYS, WE ESTIMATE THAT HBMA MEMBER COMPANIES SUBMIT MORE THAN 200 MILLION CLAIMS A YEAR FOR REVENUES EXCEEDING $15 BILLION PER YEAR. HBMA IS THE ONLY TRADE ASSOCIATION REPRESENTING THIRD-PARTY MEDICAL BILLING COMPANIES.

ALTHOUGH A LARGE PERCENTAGE OF BILLING COMPANIES WORK FOR THE HOSPITAL BASED SPECIALTIES – EMERGENCY MEDICINE, PATHOLOGY, ANESTHESIOLOGY, AND RADIOLOGY, BILLING COMPANIES CAN BE FOUND WORKING FOR PHYSICIANS IN VIRTUALLY EVERY SPECIALTY AND IN EVERY STATE.

BEFORE GETTING INTO THE SPECIFICS OF OUR TESTIMONY, I DO WANT TO SAY AT THE OUTSET THAT HBMA HAS BEEN A STRONG SUPPORTER OF THE MOVE TO ELECTRONIC TRANSACTIONS IN THE HEALTHCARE ENVIRONMENT. WE SUPPORTED THE ORIGINAL HIPAA LEGISLATION; AND, AS I HOPE YOU WILL SEE FROM MY TESTIMONY, WE HAVE WORKED WITH ALL OF THE MAJOR ENTITIES INVOLVED IN THE PROCESSING OF MEDICAL CLAIMS – TO DEVELOP A WORKABLE SYSTEM.

AS REQUESTED, I WILL GO THROUGH EACH OF THE QUESTIONS YOU HAVE ASKED US TO ADDRESS.

1. <u>WHAT IS THE CURRENT STATE OF PLANNING FOR 5010/D.0/3.0 AND ICD-10 IN YOUR INDUSTRY SECTOR</u>?

HBMA HAS BEEN ENCOURAGING BILLING COMPANIES AND THEIR CLIENTS TO PREPARE FOR BOTH THE 5010 AND ICD-10 TRANSITION FOR SEVERAL

YEARS. WE HAVE CONDUCTED NUMEROUS EDUCATIONAL PROGRAMS AT OUR SEMI-ANNUAL MEETINGS, PUBLISHED ARTICLES IN OUR MONTHLY JOURNAL, "BILLING" AND CONDUCTED WEBINARS ON THESE TOPICS.

THE NUMBER ONE QUESTION ON THE MINDS OF MOST BILLING COMPANIES AND THEIR PHYSICIAN CLIENTS IS "WILL I GET PAID?" AS EVERYONE CAN EASILY UNDERSTAND, INTERRUPTION OF A PRACTICE'S CASH FLOW CAN BE DEVASTATING TO THE PRACTICE AND THE PRACTICE'S WILLINGNESS TO SERVE PATIENTS WHOSE INSURER(S) HAVE STOPPED PAYING THEIR CLAIMS.

TO HELP MAKE SURE THAT THE ANSWER TO THAT QUESTION IS YES, EARLIER THIS YEAR, HBMA CREATED OUR ICD-10 TASK FORCE AS A MEANS TO BRING TOGETHER VARIOUS ENTITIES INVOLVED IN THE HEALTHCARE TRANSACTION CHAIN. THE PURPOSE OF THE TASK FORCE IS TO ADDRESS THE MYRIAD ISSUES INVOLVED IN MOVING FROM BOTH 4010 TO 5010 AND ICD-9 TO ICD-10. OUR TASK FORCE IS A MULTI-DISCIPLINARY GROUP OF BILLING COMPANIES, SOFTWARE VENDORS, HEALTHPLANS PHYSICIANS, CODING EXPERTS, CLEARINGHOUSE REPRESENTATIVES AND OTHER ENTITIES INVOLVED IN CLAIMS SUBMISSIONS AND PROCESSING.

DURING OUR REGULAR CONFERENCE CALLS, WE DISCUSS OUR CONCERNS WITH VENDORS AND CLEARINGHOUSES AND THEIR ASSERTIONS OF

"READINESS." WE HAVE AN OPEN DIALOGUE WITH THE SOFTWARE VENDORS AND CLEARINGHOUSES TO DETERMINE THEIR READINESS FOR BOTH 5010 AND ICD-10 IMPLEMENTATION. ONE OF OUR MEMBERS IS A MEMBER OF WEDI AND WE RECEIVE REGULAR UPDATES ON THEIR WORK AND RECOMMENDATIONS. WE DISCUSS STEPS BILLING COMPANIES CAN TAKE TO MAKE SURE THEIR CODING STAFF ARE APPROPRIATELY TRAINED AND PREPARED FOR ICD-10 IMPLEMENTATION. IN TURN, WE CONDUCT EDUCATIONAL PROGRAMMING FOR THE HBMA MEMBERSHIP AND REGULARLY SHARE OUR COMMENTS AND/OR CONCERNS WITH THE APPROPRIATE STAFF AT CMS.

ALTHOUGH WE ARE CONFIDENT THAT MOST BILLING COMPANIES WILL BE PREPARED FOR THE TRANSITION TO 5010, IT MUST ALSO BE NOTED THAT LIKE MOST PHYSICIANS, WE ARE LARGELY DEPENDENT UPON OUR VENDORS AND CLEARINGHOUSES TO ACTUALLY BE ABLE TO SUBMIT CLAIMS USING THE 5010 STANDARDS.

THE SOFTWARE VENDOR AND CLEARINGHOUSE COMMUNITIES HAVE ASSURED BILLING COMPANIES AND OUR PHYSICIAN CLIENTS THAT THEY ARE (OR WILL BE) READY BUT WITHOUT TESTING, WE TRULY DO NOT KNOW. WE ARE CONCERNED THAT DESPITE THE BEST INTENTIONS OF THESE PARTNERS, THERE WILL BE PROBLEMS, AS THERE WERE WITH THE IMPLEMENTATION OF THE 4010 CODE SET.

OUR CONCERNS STEM LARGELY FROM THE PERSPECTIVE THAT WHILE WE ARE CONFIDENT THAT MOST, IF NOT ALL, VENDORS AND CLEARINGHOUSES WILL BE ABLE TO MEET THE TECHNICAL REQUIREMENTS OF 5010, IMPLEMENTATION AND USE OF THE SOFTWARE FOR 5010 IS ANOTHER MATTER. WE HAVE ENCOURAGED OUR MEMBER COMPANIES TO BEGIN TESTING AS SOON AS IT IS OFFERED BY THEIR VENDORS AND PAYERS AND TO CONDUCT GAP ANALYSIS TO DETERMINE THE CAUSE AND POSSIBLE SOLUTIONS TO PROBLEMS THAT ARE SURE TO ARISE.

IF PAST IS PROLOGUE, WE ANTICIPATE SIGNIFICANT DELAYS WITH THE PROCESSING OF CLAIMS IN THE INITIAL PHASE OF TESTING AND THEREFORE STRONGLY RECOMMEND THAT TESTING BEGIN AS SOON AS POSSIBLE SO THAT THESE “SURE TO OCCUR” DISRUPTIONS CAN BE IRONED OUT BEFORE THE SYSTEM GOES LIVE IN 2012.

HBMA IS AWARE OF THE COMMITTEE ON OPERATING RULES FOR INFORMATION EXCHANGE (CORE) AND OTHER 5010 D.0 TESTING INITIATIVES AND WE WELCOME OPPORTUNITIES FOR EARLY TESTING. HOWEVER, TO DATE, WE ARE NOT AWARE OF ANY ACTUAL TESTING THAT HAS OCCURRED.

UNTIL TESTING BEGINS – AND THE SOONER THE BETTER – THE MORE COMFORTABLE WE WILL FEEL ABOUT THE ABILITY OF THE INDUSTRY TO MEET THE 5010, 2012 DEADLINE. WITH REGARD TO ICD-10 PLANNING, WE BELIEVE, AGAIN, THAT MOST BILLING COMPANIES ARE AS PREPARED AS THEY CAN BE IN 2009 FOR THE 2013 DEADLINE. WE ARE, HOWEVER, CONCERNED, THAT MANY BILLING COMPANIES, PHYSICIAN PRACTICES AND THIRD PARTY PAYERS, MAY RELY UPON COMPUTER CROSSWALKS – RATHER THAN INTENSIVE EDUCATION AND TRAINING – TO COMPLY WITH THE ICD-10 STANDARDS.

2. <u>HOW ARE OTHER HIGH PRIORITY INITIATIVES AND THE CURRENT STATE OF THE ECONOMY AFFECTING YOUR PLANNING AND IMPLEMENTATION EFFORTS?</u>

ALTHOUGH HEALTHCARE IS SOMETIMES DESCRIBED AS A "RECESSION-PROOF" SECTOR OF THE ECONOMY, THE STAFFING BUDGETS AND FINANCIAL RESOURCES OF MOST HEALTH CARE ORGANIZATIONS HAVE RECEDED NOTICEABLY SINCE Q3 2008. PAST EXPERIENCE HAS SHOWN THAT SUCH BELT-TIGHTENING IS IMPLEMENTED QUICKLY AND RELEASED SLOWLY – OFTEN OVER A PERIOD OF 36 – 60 MONTHS.

CONCURRENTLY, HEALTH CARE ORGANIZATIONS HAVE ALSO PARED BACK ON THEIR INFORMATION TECHNOLOGY RELATED PROJECTS, IN PART DUE TO BUDGETARY AND CREDIT-RELATED CHALLENGES. HOSPITALS, MEDICAL SCHOOLS, PRACTICES AND NEARLY EVERY OTHER

PART OF THE HEALTH CARE INDUSTRY HAVE FOCUSED ON “MUST-DO” PROJECTS IN ORDER TO BALANCE THEIR RESOURCE AND FINANCIAL LIMITATIONS.

EVEN IN THE BEST OF TIMES, THE TRANSITION TO 5010 AND ICD-10 WOULD BE BOTH A FUNCTIONAL AND ECONOMIC CHALLENGE. UNDERTAKING THIS TRANSITION AT A TIME WHEN THE ECONOMY IS IN THE WORST SHAPE IN SEVERAL DECADES, NEW FEDERAL INCENTIVES FOR EHR AND LATER MANDATES FOR “MEANINGFUL USE” AND THE FACT THAT CONGRESS IS CONSIDERING MAJOR CHANGES TO OUR NATION’S HEALTHCARE DELIVERY SYSTEM COULD AMOUNT TO THE “PERFECT STORM” IN AMERICAN HEALTHCARE.

WE ARE FINDING THAT MANY PHYSICIANS SIMPLY DO NOT HAVE THE FINANCIAL RESOURCES TO UNDERTAKE THE TYPES OF CHANGES THEY ARE FACING. PHYSICIAN PAYMENTS UNDER MEDICARE HAVE NOT KEPT PACE WITH INFLATION AND EVEN AS WE MEET TODAY, PHYSICIANS ARE LOOKING AT THE PROSPECT OF A 21% REDUCTION IN THEIR MEDICARE PAYMENTS IN 2010. AND WHILE WE REMAIN CONFIDENT THAT CONGRESS WILL ULTIMATELY INTERVENE TO PREVENT THAT CUT FROM TAKING PLACE, THE MOST LIKELY SCENARIO IS THAT IT WILL BE ANOTHER TEMPORARY FIX WITH PHYSICIANS SEEING A .5% INCREASE IN THE MEDICARE CONVERSION FACTOR IN 2010. WHILE A SMALL INCREASE IS

BETTER THAN A HUGE CUT IN PAYMENTS, WHEN COSTS IN MOST OTHER AREAS ARE CONTINUING TO RISE, PROVIDING SUCH A SMALL INCREASE IN MEDICARE PAYMENTS WILL MAKE PRACTICING MEDICINE LESS PROFITABLE IN 2010 THAN IT WAS IN 2009 – AND 2009 WAS NOT A VERY PROFITABLE YEAR FOR MOST PHYSICIANS.

WE PROJECT LITTLE TO NO GROWTH IN PHYSICIAN PAYMENTS FOR THE NEXT FEW YEARS. CONSEQUENTLY, BUDGETS WILL BECOME TIGHTER AND TIGHTER AND PHYSICIANS WILL BE LOOKING FOR WAYS TO REDUCE OVERHEAD COSTS. AS ONE MIGHT EXPECT, THIS HAS CREATED NEW INTEREST AMONG MANY OFFICE-BASED PHYSICIANS IN USING BILLING COMPANIES TO TAKE OVER THE HANDLING AND PROCESSING OF CLAIMS. WITHIN THE PAST FEW YEARS, WE HAVE SEEN A DRAMATIC INCREASE IN THE NUMBER OF OFFICE-BASED PHYSICIANS (AS OPPOSED TO HOSPITAL-BASED) WHO ARE TURNING TO THIRD PARTY MEDICAL BILLING COMPANIES TO MEET THEIR CLAIMS PROCESSING AND BUSINESS OPERATION NEEDS.

AS BUSINESSES WHOSE BUSINESS IS THE PROCESSING OF MEDICAL CLAIMS, WE ARE ABLE TO REDUCE THE COST OF CLAIMS PROCESSING BY ACHIEVING CERTAIN ECONOMIES OF SCALE THAT A SOLO OR SMALL GROUP PRACTICE IS UNABLE TO ACHIEVE INDIVIDUALLY. THE VALUE AND EFFICIENCIES WE ACHIEVED WITH HOSPITAL-BASED PHYSICIANS

WHO TYPICALLY HAVE NO OFFICE STAFF IS NOW BEING BROUGHT TO BEAR FOR OFFICE-BASED PHYSICIAN PRACTICES.

BILLING COMPANIES, LIKE MOST OTHER BUSINESSES, ARE NOT IMMUNE FROM THE ECONOMIC PROBLEMS CONFRONTING OUR NATION. AS I NOTED EARLIER, MOST BILLING COMPANIES ARE SMALL BUSINESS, EMPLOYING FEWER THAN 25 EMPLOYEES. THE CREDIT CRISIS AND DEPRESSED BUSINESS CYCLE HAVE AFFECTED OUR MEMBERS AS WELL. ALTHOUGH HBMA AS AN ASSOCIATION CONTINUES TO GROW, WE CONTINUE TO SEE CONTRACTION IN THE INDUSTRY. VERY SMALL (1 – 5 EMPLOYEES) BILLING COMPANIES ARE EITHER GOING OUT OF BUSINESS OR MERGING TOGETHER WITH OTHER SMALL BILLING COMPANIES. MEDIUM SIZED BILLING COMPANIES (20 – 50 EMPLOYEES) ARE MERGING TO FORM LARGER BILLING COMPANIES AND LARGE BILLING COMPANIES ARE BUYING UP SMALL BILLING COMPANIES. ALL OF THIS IS OCCURRING TO CREATE GREATER EFFICIENCIES AND ECONOMIES OF SCALE. BUSINESSES HAVE ONLY TWO WAYS TO IMPROVE THEIR PROFITABILITY – RAISE PRICES OR REDUCE COSTS. GIVEN THAT RAISING PRICES IN THE CURRENT ECONOMY IS UNREALISTIC, AN EMPHASIS IS PLACED ON REDUCING COSTS. THAT IS TRUE FOR PHYSICIANS AS WELL AS BILLING COMPANIES.

SHOULD THE CONFLUENCE OF VARIOUS EVENTS COME TO PASS: 5010 ADOPTION; ICD-10 CONVERSION; HEALTHCARE REFORM; MANDATORY USE OF EHRS BY PHYSICIANS AND A WIDELY RECOGNIZED NATIONAL SHORTAGE OF PHYSICIANS, WE ARE CONCERNED THAT MANY PHYSICIANS WILL SIMPLY THROW UP THEIR HANDS IN FRUSTRATION AND LEAVE THE PRACTICE OF MEDICINE, OR AGGRESSIVELY ELIMINATE OR RESTRICT THE MOST OPERATIONALLY PROBLEMATIC INSURED PATIENTS. WE HAVE ALREADY BEGUN TO OBSERVE MORE AND MORE PRACTICES RATIONING OR ELIMINATING MEDICARE PATIENTS FROM THEIR PRACTICES.

QUITE HONESTLY, IF IT WERE NOT FOR THE POOR PERFORMANCE OF MANY 401K PLANS OVER THE PAST 18 MONTHS, WE BELIEVE THE EXODUS OF PHYSICIANS FROM THE ACTIVE PRACTICE OF MEDICINE MIGHT ALREADY HAVE BEGUN TO OCCUR. AS IT IS, MANY PHYSICIANS SIMPLY CANNOT AFFORD TO LEAVE MEDICINE AT THIS TIME. BUT SHOULD THE MARKET REBOUND AND RETIREMENT PLANS PERFORM ON A LEVEL COMPARABLE TO WHAT WE SAW IN THE LATE ‘90S AND EARLIER THIS DECADE, THERE COULD BE AN UNPRECEDENTED NUMBER OF RETIREMENTS AMONG THE PHYSICIAN COMMUNITY.

BILLING COMPANIES WILL CONTINUE TO PLAN AND OUR TASK FORCE WILL CONTINUE TO MEET. HBMA WILL CONTINUE TO PROVIDE

EDUCATIONAL PROGRAMMING THROUGH ALL OF ITS FORUMS (CONFERENCES, MEETINGS, WEBINARS AND JOURNAL ARTICLES). HBMA BROADCASTS A WEEKLY NEWS DIGEST AND A MONTHLY REGULATORY AND LEGISLATIVE REPORT PREPARED BY OUR WASHINGTON OFFICE, PUBLISHES A MONTHLY MAGAZINE AND MAINTAINS A VERY ACTIVE MESSAGE BOARD (LISTSERV) ALL TO KEEP OUR MEMBERS INFORMED OF ALL NATIONAL AND LOCAL CHANGES AND DEVELOPMENTS. WE ARE COMMITTED TO PROVIDING BILLING COMPANIES AND THEIR PHYSICIAN CLIENTS WITH THE MOST COST-EFFECTIVE SOLUTIONS FOR MEETING THE 5010 AND ICD-10 CHALLENGES.

3. WHAT ISSUES OR CONCERNS HAVE YOU IDENTIFIED FOR YOUR INDUSTRY REGARDING THE TRANSITION TO THE UPDATED STANDARDS, AND HOW HAVE THEY AFFECTED YOUR PROGRESS OR EFFORTS? HOW DO THE ISSUES COMPARE TO THOSE DURING THE INITIAL IMPLEMENTATION OF THE HIPAA STANDARDS AND CODE SETS?

AS YOU MAY RECALL, MR. CHAIRMAN, IN 2007, MY COLLEAGUE BING HERALD TESTIFIED ON BEHALF OF HBMA BEFORE THE NCVHS STANDARDS AND SECURITY SUBCOMMITTEE. WE WERE ASKED TO ADDRESS VARIOUS ISSUES ASSOCIATED WITH THE TRANSITION TO THE 5010 STANDARDS.

THIS IS WHAT HBMA HAD TO SAY TO THE COMMITTEE AT THAT TIME:

WHEN THE 4010 STANDARDS WERE ANNOUNCED SEVERAL YEARS AGO, THEY `WERE INITIALLY GREETED BY THE INDUSTRY WITH GREAT FANFARE. FINALLY, WE WOULD BE CREATING A UNIFORM PLATFORM FOR HEALTH CARE CLAIMS (837), HEALTHCARE CLAIM PAYMENT (EOB/ERA- 835), HEALTH CARE CLAIM STATUS (276/277), AND HEALTH CARE CLAIM SERVICE REVIEW (278), THESE VISIONARY STANDARDS WOULD ELIMINATE THE NUMEROUS CLAIM FORMS OF THE INDIVIDUAL THIRD PARTY PAYERS. GONE WOULD BE THE NSF (NATIONAL SIMILAR FORMAT) OF WAYS PAYERS ASKED FOR INFORMATION AND TRANSMITTED REMITTANCE ADVICE TO PHYSICIANS.

UNFORTUNATELY, OUR EUPHORIA OVER THE ADOPTION OF THE 4010 STANDARDS WAS SHORT-LIVED AS A NEW TERM ENTERED THE MEDICAL BILLING LEXICON – COMPANION GUIDES. SOON, EVERY THIRD PARTY PAYER – INCLUDING MEDICARE – ANNOUNCED THE DEVELOPMENT OF COMPANION GUIDES TO ACCOMPANY THE 837 4010A1. THE DIFFERENT WAYS THIRD PARTY PAYERS WANTED YOU TO ORGANIZE THE INFORMATION ON THE 835 WERE AS NUMEROUS AS THERE WERE COMPANIES. FOR EXAMPLE THE 4010A1 SET THE

STANDARD OF 50 LINE ITEMS PER CLAIM BUT A COMPANION GUIDE WOULD LIMIT YOU TO ONLY 6 LINE ITEMS PER CLAIM.

AT ONE POINT, IT WAS ESTIMATED THAT THERE WERE MORE THAN 1,200 COMPANION GUIDES PUBLISHED BY THE VARIOUS THIRD PARTY PAYERS. AS YOGI BERRA WOULD SAY, "IT WAS DÉJÀ VU ALL OVER AGAIN."

SO WHAT HAS CHANGED SINCE THOSE CONCERNS WERE RAISED NEARLY 2 ½ YEARS AGO? WELL, WE STILL HAVE COMPANION GUIDES BUT INSTEAD OF 1,200 COMPANION GUIDES, IT HAS BEEN ESTIMATED THAT THERE ARE NOW 1,400 COMPANION GUIDES.

THE FACT IS, THE TERM, "STANDARD TRANSACTION SETS" IS A MISNOMER. COMPANION GUIDES CIRCUMVENT STANDARDIZATION AND IMPOSE REQUIREMENTS FOR WIDESPREAD, HIGHLY IDIOSYNCRATIC ELECTRONIC CLAIM SUBMISSION REQUIREMENTS. WITHOUT RESTRICTIONS ON COMPANION GUIDES, THIS PERPETUATES EXTREMELY ONEROUS PROGRAMMING AND GREATLY INCREASES THE COMPLEXITY, CHALLENGES AND COSTS FOR SUCCESSFUL 5010 TESTING AND IMPLEMENTATION.

WE UNDERSTAND THAT COMPANION GUIDES MAY BE NECESSARY TO SOME SPECIALTIES, SUCH AS DME, BUT THESE GUIDES SHOULD BE LIMITED TO A FINITE NUMBER AND A NATIONALLY APPROVED SET.

TODAY, WE ASK THE SAME QUESTION WE ASKED IN 2007 – WILL THE ADOPTION OF THE 5010 STANDARDS ELIMINATE THE USE OF COMPANION GUIDES? UNFORTUNATELY, THE ANSWER TODAY IS THE SAME ONE WE RECEIVED THEN – NO.

WHEN A BUSINESS – AND THE PRACTICE OF MEDICINE IS A BUSINESS - CONSIDERS A SYSTEM CHANGE, IT MUST LOOK AT WHAT IT CAN EXPECT AS A RETURN ON ITS INVESTMENT? WILL THIS CHANGE MAKE THE BUSINESS MORE EFFICIENT? WILL IT REDUCE OVERHEAD? WILL IT MAKE THE STAFF MORE PRODUCTIVE? FOR A MEDICAL PRACTICE OR A BILLING COMPANY, THE QUESTIONS ARE WILL THESE CHANGES RESULT IN LOWER CLAIM PROCESSING COSTS, LESS PAPER, FEWER MISTAKES, TIMELIER FILING, ETC.?

EVEN IN A TIGHT ECONOMY, A BUSINESS CAN JUSTIFY AN INVESTMENT IN TECHNOLOGY IF THE BUSINESS CAN DEMONSTRATE THAT THE COST OF THE INVESTMENT WILL BE RECOUPED IN A REASONABLE AMOUNT OF TIME THROUGH GREATER EFFICIENCY (I.E. LOWERING OF COSTS).

WE REMAIN CONCERNED, MR. CHAIRMAN, THAT ADOPTION OF THE 5010 STANDARDS WILL RESULT IN HIGHER COSTS TO BOTH BILLING COMPANIES AND MEDICAL PRACTICES, WITH LITTLE IMPROVEMENT IN PRACTICE EFFICIENCY. GIVEN THAT THERE IS LITTLE LIKELIHOOD THAT THE PROVIDER OR BILLING COMPANIES WILL BE ABLE TO INCREASE THEIR INCOME TO PAY FOR THE INVESTMENT, THE PRACTICE AND BILLING COMPANY WILL HAVE TO "EAT" THE COST. THE END RESULT IS THAT THE MEDICAL PRACTICE WILL BE LESS PROFITABLE, WHICH LOGICALLY LEADS PRACTICES TO REEVALUATE THEIR CONSTITUENCY.

IRONICALLY, THE NET RESULT MAY BE THAT MORE PHYSICIAN PRACTICES ARE DRIVEN TO RETAIN THIRD PARTY MEDICAL BILLING COMPANIES TO HANDLE THEIR MEDICAL CLAIMS PROCESSING BECAUSE CONTINUING TO PERFORM THIS FUNCTION IN HOUSE WILL BECOME COST PROHIBITIVE.

SIMILAR QUESTIONS MUST ALSO BE ASKED OF THE TRANSITION TO THE USE OF ICD-10 CODES.

BEFORE GETTING INTO THE BUSINESS ISSUES INVOLVED IN USING THE ICD-10 CODES, I DO WANT TO TAKE THIS OPPORTUNITY TO ENCOURAGE THE NCVHS TO SUPPORT A TEMPORARY FREEZE IN THE ISSUANCE OF NEW ICD-9 CODES. HBMA, ALONG WITH MOST OTHER HEALTHCARE

ORGANIZATIONS, HAS ENDORSED A TEMPORARY FREEZE IN THE ISSUANCE OF NEW ICD-9 AND ICD-10 CODES.

IN A LETTER TO CMS THIS PAST SEPTEMBER, HBMA RECOMMENDED THAT BOTH ICD-9 CM AND ICD-10 CM CODES SHOULD BE FROZEN IN OCTOBER 2010 IN ORDER TO ALLOW SUFFICIENT TIME FOR PROVIDERS, CODERS, SOFTWARE DEVELOPERS, PUBLISHERS, TRAINING ORGANIZATIONS AND A HOST OF OTHERS TO PREPARE FOR THE TRANSITION TO ICD-10 CM IN OCTOBER 2013 WITHOUT THE DISTRACTION OF UPDATES IN 2011 AND 2012.

OUR RATIONALE FOR THIS RECOMMENDATION IS THAT IN ORDER TO FACILITATE THE USE OF ICD-10 CM CODES IN ELECTRONIC CLAIMS, THE EXISTING 4010 HIPAA TRANSACTION CODE SET (TCS) MUST BE REPLACED WITH THE MORE ADVANCED AND COMPLEX 5010 TCS. THE IMPLEMENTATION DATE FOR THE 5010 TCS IS SCHEDULED FOR JANUARY 1, 2012, WITH EXTERNAL – PROVIDER TO PAYER – TESTING RECOMMENDED TO BEGIN NO LATER THAN EARLY 2011. IF BEGUN ON TIME, TESTING WILL THEN CONTINUE THROUGHOUT 2011 IN ORDER TO ASSURE A SUCCESSFUL TRANSITION FROM THE 4010 TCS TO THE 5010 TCS.

HBMA BELIEVES THERE ARE SEVERAL CHALLENGES TO CONSIDER:

a. BASED ON INFORMATION FROM WEDI AND MEETINGS WE HAVE HAD WITH AHIP, IT APPEARS THE COMMERCIAL PAYERS ARE ON A SCHEDULE THAT IS NOT AS AGGRESSIVE AS THE CMS STATED READINESS. MANY PAYERS HAVE REPORTED EXTERNAL TESTING WILL NOT BE READY UNTIL JULY 2011 OR LATER. THE REQUIREMENT TO UPDATE CODE SETS IN THE MIDDLE OF THIS TESTING PERIOD WILL ADD ADDITIONAL BURDENS TO PROVIDERS, PHYSICIANS AND PAYERS AT WHAT IS LITERALLY THE ELEVENTH HOUR.

b. THE SYSTEMS, PROGRAMMING AND OTHER INFORMATION TECHNOLOGY STAFF RESPONSIBLE FOR TESTING, ADJUSTING, RE-TESTING, RE-ADJUSTING, RE-TESTING AND PERFECTING PROVIDERS' ABILITY TO SUCCESSFULLY SUBMIT COMPLIANT 5010 TRANSACTIONS TO DOZENS OF ELECTRONIC CLAIM RECIPIENTS, ARE ALSO THE SAME STAFF THAT WILL BE RESPONSIBLE FOR PROGRAMMING, LOADING, TESTING AND LAUNCHING ANY CHANGES IN ICD-9 CM AND/OR ICD-10 CM CODES, IF THEY ARE UPDATED IN OCTOBER 2011.

FINALLY, WE ARE VERY CONCERNED ABOUT REPORTS WE HAVE RECEIVED THAT MANY PAYERS DO NOT INTEND TO MODIFY OR UPDATE THEIR CLAIMS PROCESSING AND CLAIMS ADJUDICATION STANDARDS TO REFLECT ICD-10 CODING. INSTEAD, WE ARE BEING TOLD, PLANS WILL USE

CROSSWALK SOFTWARE TO CONVERT THE ICD-10 CODED CLAIMS TO ICD-9 CODES, APPLY EXISTING ICD-9 ADJUDICATION STANDARDS, PAY THE CLAIM BASED UPON THESE OLD STANDARDS, CONVERT THE CLAIM BACK TO ICD-10 AND TRANSMIT THE PAYMENT TO THE PROVIDER. IF THIS IS TRUE, THE PROBLEMS WITH THIS APPROACH BY THE PAYERS ARE MONUMENTAL.

WHILE WE UNDERSTAND THE BUSINESS REASONS BEHIND THIS DECISION BY HEALTH PLANS, IT DOES NOT CHANGE THE FACT THAT DISRUPTIONS WILL OCCUR.

FOR EXAMPLE, PROVIDERS HAVE NO WAY OF KNOWING HOW A THIRD PARTY PAYER WILL CROSSWALK THE ICD-10 CODE BACK TO AN ICD-9 CODE. A PROVIDER WILL SUBMIT A CLAIM USING THE APPROPRIATE ICD-10 CODE – ASSUMING THE THIRD PARTY PAYER WILL PAY THE CLAIM EXACTLY THE WAY THE CLAIM WOULD HAVE BEEN PAID USING AN ICD-9 CODE. HOWEVER, WHEN THE PROVIDER RECEIVES THE REMITTANCE ADVICE, HE OR SHE COULD FIND THAT THE CLAIM IS PAID DIFFERENTLY (OR NOT PAID AT ALL) BECAUSE THE PLAN CROSS-WALKED THE CLAIM TO A DIFFERENT ICD-9 CODE THAN THE ONE THE PROVIDER WOULD HAVE USED HAD THE PROVIDER SUBMITTED THE CLAIM USING AN ICD-9 CODE.

WE BELIEVE IT IS LIKELY THAT DURING THE TRANSITION, PROVIDERS WILL USE SOME TYPE OF COMPUTER SOFTWARE OR OTHER METHOD FOR ENGAGING IN ICD-9 TO ICD-10 CROSSWALKS. SOME TYPE OF DECISION TREE LOGIC WILL BE EMPLOYED TO IDENTIFY THE MOST APPROPRIATE ICD-10 CODE BUT AT THE OUTSET, THE PROVIDER WILL LIKELY BEGIN THE CODING PROCESS USING AN ESTABLISHED ICD-9 CODE. IF, AS HAS BEEN REPORTED, THE HEALTH PLAN REVERSE CROSSWALKS THAT ICD-10 CODE TO AN ICD-9 CODE, HOW DO WE KNOW THAT THEY ARE BOTH ENDING UP AT THE SAME POINT?

WE BELIEVE CONSIDERATION SHOULD BE GIVEN TO ESTABLISHING CROSSWALK STANDARDS SO THAT WHEN A PROVIDER SUBMITS AN ICD-10 CODE WITH THE EXPECTATION THAT IT IS ROUGHLY EQUIVALENT TO AN OLD ICD-9 CODE, THE HEALTH PLAN, IN APPLYING THEIR CROSSWALK, WOULD ARRIVE AT THE SAME CONCLUSION.

4. <u>WHAT ARE THE KEY PRIORITIES FOR PROVIDERS WHILE PLANNING FOR, AND IMPLEMENTING THE TRANSACTION STANDARDS AND ICD-10 CODE SET?</u>

FIRST AND FOREMOST, TRYING TO DETERMINE HOW TO PAY FOR THE COSTS ASSOCIATED WITH BOTH THE 5010 AND ICD-10 THE TRANSITIONS. WHERE DOES THE PROVIDER FIND THE MONEY TO DO THE STAFF

TRAINING REQUIRED? WHERE DOES THE PROVIDER FIND THE MONEY TO PAY FOR THE NEW SOFTWARE THAT WILL BE REQUIRED? AS I NOTED EARLIER, HOW DOES THE PROVIDER CONTINUE TO SURVIVE FINANCIALLY IN THE EVENT THERE ARE CASH FLOW DISRUPTIONS ASSOCIATED WITH EITHER THE 5010 OR ICD-10 TRANSITIONS?

SECOND, TESTING, TESTING AND MORE TESTING. WE CAN HAVE ALL OF THE ASSURANCES FROM VENDORS, BILLING COMPANIES AND CLEARINGHOUSES, BUT UNTIL WE CAN ACTUALLY START TESTING WITH HEALTH PLANS, WE HAVE NO IDEA HOW MANY PROBLEMS WE WILL HAVE TO WORK OUT.

IF YOU GO ONTO THE INTERNET, MR. CHAIRMAN, YOU WILL SEE VARIOUS SOFTWARE VENDORS WHO HAVE ANNOUNCED WITHIN THE PAST FEW MONTHS THAT THEY ARE READY TO TEST. WE WOULD ASK, TEST WHAT AND WITH WHOM? MOST THIRD PARTY PAYERS HAVE SAID THEY WILL NOT BE READY TO ACCEPT TEST CLAIMS UNTIL SOMETIME IN LATE 2011 – IF THEN. I CAN TEST ALL I WANT TO SEE THAT THE NEW SOFTWARE WILL GENERATE A 5010 COMPLIANT CLAIM, BUT UNTIL I CAN ACTUALLY SUBMIT A TEST CLAIM TO A THIRD PARTY PAYER, IT IS VIRTUALLY MEANINGLESS.

THIRD, AS MENTIONED ABOVE, FREEZING THE ISSUANCE OF NEW ICD-9 AND ICD-10 CODES AND DEVELOPING CROSSWALK PROTOCOLS SO THAT WHEN A PROVIDER SUBMITS A CLAIM USING AN ICD-10 CODE, THE PROVIDER HAS A REASONABLE EXPECTATION OF HOW THAT CLAIM WILL BE PROCESSED AND PAID BY THE THIRD PARTY PAYER.

FINALLY, MR. CHAIRMAN, WE CANNOT OVERLOOK THE FACT THAT NOT ALL PAYERS ARE COVERED BY THE HIPAA STANDARDS. LIABILITY INSURERS, SUCH AS WORKERS COMPENSATION, AUTO INSURANCE AND TORT LIABILITY PLANS ARE EXEMPT FROM THE HIPAA STANDARDS. MANY OF THESE PLANS HAVE ALREADY SAID THAT THEY HAVE NO INTENTION OF VOLUNTARILY COMPLYING WITH EITHER THE 5010 OR ICD-10 STANDARDS. ONE ORGANIZATION HAS GONE SO FAR AS TO DESCRIBE THIS FACT AS A MYTH, BUT I CAN ASSURE YOU THAT A BUSINESS THAT IS NOT REQUIRED TO INCUR THOSE SIGNIFICANT NEW COSTS WILL NOT DO SO, OR AT LEAST, WILL FEEL NO URGENCY TO COMPLY WITH A DEADLINE TO WHICH THEY ARE NOT SUBJECT.

THIS MEANS THAT PHYSICIANS AND/OR BILLING COMPANIES WILL HAVE TO MAINTAIN REDUNDANT SYSTEMS IN ORDER TO BE ABLE TO CONTINUE TO SUBMIT CLAIMS TO HIPAA EXEMPT ENTITIES. IF A WORKERS' COMPENSATION PLAN WILL NOT ACCEPT AN ICD-10 CODED CLAIM, THEN

THE PROVIDER WILL HAVE TO SUBMIT THAT CLAIM USING ICD-9 CODES AND WILL HAVE TO MAINTAIN THAT DUAL CAPABILITY – INDEFINITELY.

SIMILARLY, IF THE WORKERS' COMPENSATION PLAN IS INCAPABLE OF PROCESSING A CLAIM USING THE 5010 STANDARDS AND INSTEAD, INDICATES IT WILL ONLY ACCEPT 4010 CODED CLAIMS, THEN THE PROVIDER WILL HAVE TO MAINTAIN THEIR 4010 CAPABILITY AS WELL.

THUS, MR. CHAIRMAN, INSTEAD OF 5010 REPLACING 4010 AND ICD-10 REPLACING ICD-9, THEY WILL BECOME ADDITIONAL COSTS, NOT REPLACEMENT COSTS.

5. <u>WHAT PLANS ARE BUSINESS ASSOCIATES AND VENDORS MAKING TO ASSURE THE COMPLIANCE OF THEIR CLIENTS? WHAT ARE THE BARRIERS?</u>

IN MANY RESPECTS, MR. CHAIRMAN, BILLING COMPANIES AND PHYSICIANS ARE THE PROVERBIAL "MEN (OR WOMEN) IN THE MIDDLE." WE ARE LARGELY AT THE MERCY OF SOFTWARE VENDORS AND THIRD PARTY PAYERS.

HBMA CAN DO EVERYTHING AT ITS DISPOSAL IN TERMS OF PRODDING, URGING AND RECOMMENDING THAT BILLING COMPANIES AND THEIR PHYSICIAN CLIENTS UNDERTAKE ALL OF THE STEPS NECESSARY TO BE COMPLIANT. BUT IF THE VENDORS FAIL TO MEET THEIR OBLIGATIONS OR THE HEALTH PLANS FAIL TO FULFILL THEIR OBLIGATIONS, THEN NO AMOUNT OF TRAINING, EDUCATION OR PREPARATION BY PHYSICIANS OR BILLING COMPANIES CAN MAKE THE SYSTEM WORK SMOOTHLY.

IF TESTING WITH HEALTH PLANS WERE MADE AVAILABLE, WE'D DO IT IMMEDIATELY. IT ISN'T AND THEREFORE WE CAN'T.

WE DO BELIEVE THIS PROCESS MUST BE DONE IN A MORE ORGANIZED AND RATIONAL FASHION TO AVOID SOME OF THE PROBLEMS WITH PREVIOUS IMPLEMENTATION EFFORTS.

IN OUR 2007 TESTIMONY, WE MADE THE FOLLOWING RECOMMENDATION WHICH WE REITERATE TODAY. I QUOTE FROM OUR 2007 TESTIMONY:

> *"… BILLING COMPANIES AND PHYSICIANS WILL BE ASKED TO INVEST THOUSANDS OF DOLLARS AND HUNDREDS OF PERSON-HOURS INTO A SYSTEM THAT WILL SLOW DOWN PAYMENTS AND COMPLICATE THE SYSTEM.*

AS BILLING COMPANIES, WE ARE ONE LINK IN THE CLAIMS PAYMENT CHAIN. WE WILL COMPLY WITH WHATEVER STANDARDS AND REQUIREMENTS THE GOVERNMENT MAY IMPOSE. BUT WE IMPLORE YOU TO MAKE RECOMMENDATIONS THAT DEMONSTRATE THAT WE HAVE LEARNED FROM PAST MISTAKES.

THE ROLLOUT OF THESE CHANGES, IN WHICH NUMEROUS ENTITIES ARE INVOLVED, SHOULD BE STRUCTURED AS A RELAY RACE, NOT AS A COMMON SPRINT TO THE FINISH LINE. WITH NPI, WHAT SHOULD HAVE BEEN A RELAY WAS A SPRINT TO A COMMON FINISH LINE FOR EVERYONE INVOLVED.

FOR THE 5010, WE RECOMMEND THE ROLLOUT BE STRUCTURED WITH HEALTH PLANS BEING REQUIRED TO ADOPT THE 5010 STANDARDS BY A TIME CERTAIN. PRIOR TO MOVING TO THE NEXT PHASE IN THE ROLLOUT, THERE SHOULD BE ADEQUATE TESTING AS PART OF THE DEMONSTRATION BY THAT PARTICULAR ENTITY THAT IT IS COMPLIANT. ONCE THE HEALTH PLANS HAVE COMPLETED TESTING AND DEMONSTRATED COMPLIANCE, THEN CLEARINGHOUSES SHOULD BE REQUIRED TO ADOPT THE 5010 STANDARDS BY A SECOND TIME CERTAIN. AGAIN, THERE SHOULD BE PILOT TESTING AS PART OF THIS PROCESS.

FINALLY, ONCE CLEARINGHOUSES AND HEALTH PLANS HAVE DEMONSTRATED COMPLIANCE, THEN PROVIDERS (INCLUDING THEIR BUSINESS PARTNERS) SHOULD BE GIVEN A TIME-CERTAIN DEADLINE FOR INCORPORATION OF THE 5010 STANDARDS IN THEIR OPERATIONS. AGAIN, PILOT TESTING SHOULD BE BUILT INTO THIS PROCESS BEFORE MOVING TO FINALIZATION OF THE PROCESS.

BY SEQUENCING THE ROLLOUT AND INCORPORATING PILOT TESTING AT EACH PHASE, WE WILL MINIMIZE DISRUPTION AND THE LIKELIHOOD THAT THERE WILL BE SIGNIFICANT DELAYS IN CLAIMS PAYMENT.

WE BESEECH YOU TO GET IT ALL WORKED OUT, AND THEN BRING US THE FINAL – FINAL PRODUCT. LET US MAKE ONE CHANGE THAT MOVES US TO THE NEXT – AND FINAL – LEVEL. DON'T ASK US TO INCUR UNRECOVERABLE COSTS THAT ONLY SOLVE PART OF THE PROBLEM.

ADOPTING 5010 WON'T GET US TO THE FINISH LINE ANY FASTER, IT WON'T ACCELERATE ANY SAVINGS PROVIDERS MIGHT REALIZE AS A RESULT OF IMPROVED EFFICIENCIES. ADOPTING 5010 WILL RAISE COSTS, SLOW DOWN WORKFLOW AND MAKE IT MORE COSTLY FOR

HEALTHCARE TO BE DELIVERED. PLEASE DO NOT ALLOW EVERYONE TO KEEP DROPPING THE BATON."

6. WHAT ARE THE KEY RISK AREAS FOR 5010 AND ICD-10 (FINANCIAL, PERSONNEL, ETC).

AS WE HAVE PREVIOUSLY MENTIONED, ONE OF THE MAJOR RISK AREAS IS FINANCIAL. WHERE DO PROVIDERS AND BILLING COMPANIES FIND THE CAPITAL NECESSARY TO UNDERTAKE BOTH THE 5010 AND ICD-10 CHANGES THAT ARE BEING REQUIRED?

IN ALL LIKELIHOOD, PRACTICES WILL HAVE TO BORROW MONEY (WHICH IN THE CURRENT ENVIRONMENT CAN PRESENT ITS OWN PROBLEMS) TO PAY FOR BOTH THE SOFTWARE AND THE STAFF TRAINING NECESSARY TO BECOME COMPLIANT.

BUT WHO WILL LEND THE MONEY TO THE PROVIDER, EVEN IF THERE IS MONEY TO LEND? A BANK IS GOING TO ASK THE MEDICAL PRACTICE TO PROVIDE A PLAN FOR HOW THE LOAN WILL BE REPAID. GIVEN THE SLIM PROSPECT THAT HEALTH PLAN PAYMENTS WILL INCREASE AS A RESULT OF EITHER 5010 OR ICD-10 AND THE DISINCENTIVE TO INCREASE VOLUME (THAT'S WHY WE HAVE THE SGR) AND NO ABILITY TO DEMONSTRATE THAT EITHER 5010 OR ICD-10 WILL LOWER PRACTICE COSTS, BANKS WILL CONCLUDE THAT SUCH LOANS ARE HIGH RISK. THESE HIGH RISK LOANS

– AGAIN ASSUMING YOU CAN FIND A BANK THAT WILL LEND THE PRACTICE MONEY – WILL COME WITH VERY HIGH INTEREST RATES REFLECTIVE OF THE HIGH RISK.

WE ARE FAR LESS CONCERNED ABOUT THE ABILITY OF PHYSICIANS AND/OR BILLING COMPANIES TO OBTAIN THE TRAINING NECESSARY TO APPROPRIATELY USE ICD-10 CODES. NUMEROUS ORGANIZATIONS, SUCH AS THE AMERICAN ACADEMY OF PROFESSIONAL CODERS (AAPC), THE AMERICAN COLLEGE OF MEDICAL CODING SPECIALISTS (ACMCS) AND THE AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION (AHIMA) ALL HAVE UNDERTAKEN AGGRESSIVE PROGRAMS TO ENSURE AN ADEQUATE SUPPLY OF HIGHLY TRAINED CODERS. OF COURSE, PHYSICIANS AND/OR BILLING COMPANIES WILL STILL NEED TO FIND THE CASH TO PAY FOR THE NECESSARY TRAINING AND THIS COULD BE A PROBLEM. BUT WE BELIEVE THAT THE AVAILABILITY OF A WELL-TRAINED CADRE OF PROFESSIONAL CODERS IS THE LEAST OF OUR WORRIES.

IT IS IMPORTANT TO NOTE THAT, FOR MEDICAL PRACTICES IN PARTICULAR, THE KNOWLEDGE AND SKILL LEVEL REQUIRED TO LEARN AND USE ICD-10 CM CODES IS SIGNIFICANTLY HIGHER THAN FOR ICD-9 CM. AND, DESPITE CMS ASSURANCES TO THE CONTRARY, PHYSICIANS WILL HAVE TO SIGNIFICANTLY ALTER THEIR DOCUMENTATION AND

CHARTING HABITS IF THE MOST SPECIFIC ICD-10 CM CODES ARE TO BE CHOSEN.

THERE IS ALSO THE RISK THAT PRACTICE CASH-FLOW WILL BE ADVERSELY AFFECTED BY THESE TRANSITIONS. MEDICAL PRACTICES OFTEN LIVE FROM BILLING CYCLE TO BILLING CYCLE. A DELAY IN PAYMENTS OF A FEW WEEKS TO A FEW MONTHS DUE TO INAPPROPRIATE DENIALS OR ELECTRONIC COMMUNICATION PROBLEMS COULD PUT MANY MEDICAL PRACTICES AT SIGNIFICANT FINANCIAL RISK. AS WE HAVE LEARNED OVER THE PAST 24 MONTHS DURING VARIOUS MAC TRANSITIONS, PAYMENT INTERRUPTIONS HAVE LED TO PRACTICE BANKRUPTCIES, PERSONAL BANKRUPTCIES AND DRAMATIC CONSEQUENCES FOR SOME PATIENT POPULATIONS.

FOR MEDICAL PRACTICES THAT USE BILLING COMPANIES, THERE ARE NO ACCEPTABLE EXPLANATIONS FOR WHY A CLAIM WAS NOT PAID OR WAS PAID INCORRECTLY. OUR JOB IS TO GET THE CLAIM PAID ACCURATELY THE FIRST TIME. WE ANTICIPATE THAT MANY BILLING COMPANIES WILL BE WORKING OVERTIME TO RESOLVE PROBLEMS WITH SOFTWARE VENDORS, HEALTH PLANS AND CLEARINGHOUSES. OUR JOB IS TO GET THE JOB DONE. IT IS SOMETHING BILLING COMPANIES TAKE SERIOUSLY AND SOMETHING WE STRIVE TO ACHIEVE. WE ANTICIPATE THAT MANY BILLING COMPANIES WILL SEE THEIR MARGINS DECLINE AS THEY WILL

HAVE TO HIRE ADDITIONAL STAFF TO RESOLVE ANY PROBLEMS. THESE ARE COSTS THAT WILL NOT EASILY BE PASSED THROUGH TO THEIR PHYSICIAN CLIENTS AND WE HARDLY EXPECT HEALTH PLANS TO REIMBURSE COSTS WE OR PHYSICIANS EXPERIENCE DUE TO CLAIMS FILING PROBLEMS.

FINALLY, MR. CHAIRMAN, AS YOU MAY KNOW, A FEW WEEKS AGO, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES PUBLISHED A "REQUEST FOR INFORMATION" ASKING A SERIES OF QUESTIONS ABOUT HIPAA ENFORCEMENT. HBMA RESPONDED TO THIS REQUEST AND SUBMITTED OUR OBSERVATIONS ABOUT THE CURRENT STATE OF HIPAA ENFORCEMENT.

AS WE CONSIDERED CMS' RFI, WE SOUGHT TO DETERMINE THE FULL SCOPE OF INSURERS' COMPLIANCE WITH THE ACCEPTED HIPAA TRANSACTIONS. WE SOUGHT INPUT FROM THE COOPERATIVE EXCHANGE, THE CLEARINGHOUSE INDUSTRY TRADE ASSOCIATION. THEY WERE ABLE TO PROVIDE A VERY DETAILED "MAP" OF NEARLY 1,700 INSURERS AND WHICH HIPAA TRANSACTIONS THEY SUPPORTED. IF YOU WOULD LIKE, WE WOULD BE HAPPY TO PROVIDE THE COMMITTEE WITH THE COMPLETE SET OF SPREADSHEETS BUT IN THE INTERIM, THE SUMMARY STATISTICS ARE PROVIDED IN TABLE 1. THIS TABLE IDENTIFIES ALL 12 VARIANTS OF

HIPAA TRANSACTIONS AND HOW MANY OF EACH VARIANT ARE SUPPORTED BY THIRD PARTY PAYERS.

IT SHOULD BE NOTED THAT THIS LIST SHOULD NOT BE CONSTRUED AS ABSOLUTE, WHICH IS TO SAY THAT THERE IS A POSSIBILITY THAT THE COOPERATIVE EXCHANGE SURVEY MAY INDICATE THAT A PAYER DOES NOT SUPPORT A CERTAIN TRANSACTION SET; HOWEVER, THIS COULD BE A RESULT OF CLEARINGHOUSES NOT HAVING A NEED TO DEVELOP THE TRANSACTION SET WITH THE PAYER. ADDITIONALLY, THE COOPERATIVE EXCHANGE MEMBERS DO NOT HAVE DIRECT CONNECTIONS WITH EVERY POSSIBLE PAYER; THEREFORE THIS ANALYSIS IS ONLY APPLICABLE FOR THOSE PAYERS FOR WHICH THEY HAVE DIRECT CONNECTIONS.

EVEN WITH THESE CAVEATS, WE BELIEVE THE ABOVE DATA CONFIRMS WHAT HBMA'S MEMBERS HAVE OBSERVED SINCE HIPAA TCS WAS IMPLEMENTED: THAT INSURERS SUPPORT THE TRANSACTIONS THAT LOWER THEIR OWN OPERATING EXPENSES – RECEIVING CLAIMS VIA THE "837" TRANSACTIONS, BUT LARGELY FAIL TO SUPPORT THE TRANSACTIONS THAT LOWER PROVIDERS' OPERATING EXPENSES.

THE OVERALL CONCLUSION IS THAT ACTIVE SUPPORT OF HIPAA TRANSACTION CODES IS FAR FROM WIDESPREAD DESPITE YEARS OF OPPORTUNITY FOR INSURERS TO IMPLEMENT THEM.

TABLE 2 SHOWS THE NUMBER OF INSURERS THAT SUPPORT A GIVEN TOTAL NUMBER OF TRANSACTION TYPES. VIRTUALLY NONE SUPPORT EVERY FORM OF HIPAA TRANSACTION (AGAIN, PLEASE NOTE THE EXPLANATION PROVIDED ABOVE) AND "ONE" IS THE MOST PREVALENT NUMBER OF TRANSACTION TYPES SUPPORTED! FURTHER, 88.2% OF INSURERS SUPPORT NO MORE THAN 3 HIPAA TRANSACTION TYPES. IT IS NOTEWORTHY THAT ONLY 14 INSURERS DO NOT SUPPORT EVEN 1 HIPAA TRANSACTION TYPE; ONE MIGHT CONCLUDE FROM THIS THAT ALMOST EVERY INSURER HAS MADE A DETERMINED EFFORT TO BE ABLE TO REPORT THAT THEY "SUPPORT HIPAA TRANSACTIONS," ALTHOUGH THAT CLAIM WOULD HAVE TO OMIT THE EXTENT OF THAT SUPPORT.

HBMA BELIEVES THE INFORMATION GARNERED FROM THE COOPERATIVE EXCHANGE SURVEY IS EXTREMELY RELEVANT TO THE WORK OF THIS COMMITTEE. THOSE OF US WHO ARE IN THE BUSINESS OF HANDLING AND PROCESSING MEDICAL CLAIMS ARE CONCERNED THAT THE SAME LEVEL OF SUPPORT AND COMPLIANCE WE ARE SEEING WITH THE CURRENT STANDARDS WILL BE REFLECTED IN THE NEW STANDARDS. IN OTHER WORDS, THE PHYSICIANS AND BILLING COMPANIES WILL DO EVERYTHING TO COMPLY WITH THE 5010 AND ICD-10 STANDARDS – AT CONSIDERABLE EXPENSE TO THE PROVIDER. BUT THE PAYERS WILL

ONCE-AGAIN FIND WAYS TO CIRCUMVENT THE LAW. THIS CANNOT BE ALLOWED TO CONTNIUE TO HAPPEN.

ON BEHALF OF THE HEALTHCARE BILLING AND MANAGEMENT ASSOCIATION, WE APPRECIATE THIS OPPORTUNITY TO SHARE OUR VIEWS WITH THE NCVHS AND I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

TABLE 1

TRANSACTION CODES	**837**			**835**		**270 – 271**			**276 – 277**		**278**		**TOTAL**
	P	**I**	**D**	**P**	**I**	**P**	**I**	**D**	**P**	**I**	**P**	**I**	
# OF INSURERS = 1,689	**784**	**783**	**266**	**301**	**306**	**347**	**27**	**47**	**84**	**94**	**18**	**8**	**3,065**
PERCENT SUPPORTED	**46.4**	**46.4**	**15.7**	**17.8**	**18.1**	**20.5**	**1.6**	**2.8**	**5.0**	**5.6**	**1.1**	**0.5**	**15.1**
TOTAL NUMBER OF POSSIBLE MATCHES = 1,689 INSURERS X 12 CODES = **20,268**													

TABLE 2		
TRANSACTIONS	**COUNT**	**PERCENTAGE**
12	**–**	–
11	**2**	**0.1%**
10	**–**	**–**
9	**–**	**–**
8	**3**	**0.2%**
7	**5**	**0.3%**
6	**22**	**1.3%**
5	**39**	**2.3%**
4	**114**	**6.7%**
3	**173**	**10.2%**
2	**365**	**21.6%**
1	**952**	**56.4%**
0	**14**	**0.8%**
TOTAL	**1,689**	**100.0%**