BCBSM's ICD-10 Project

Dennis Winkler, Technical Program Director
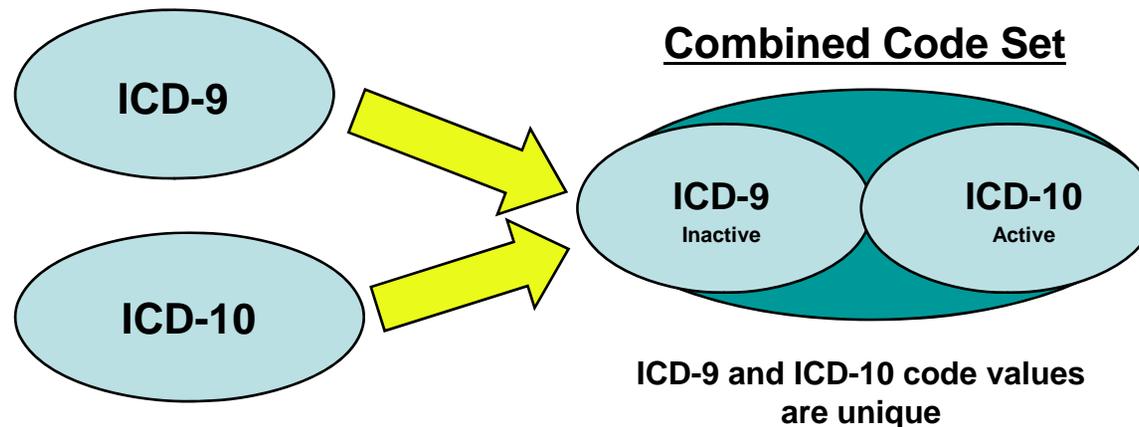## Blue Cross Blue Shield of Michigan

BCBSM Has Established Two Primary Guiding Principles for its ICD-10 Program

1. Maintain the status quo in all aspects of the business (including claims payout).

2. Position BCBSM to begin utilizing the ICD-10 data as it begins manifesting itself in our environment.

Making the ICD-10 Transition

BCBSM has selected a combined single field expansion solution (remediation) for ICD-10 compliance versus a crosswalk solution.

Combined Code Set

ICD-9

ICD-10

ICD-9
Inactive

ICD-10
Active

ICD-9 and ICD-10 code values are unique

ICD-9 and ICD-10 codes can be combined since:

• Approximately 40 duplicates exist between the two code sets

• The duplicates are not primary for payment

• ICD-10 nomenclature doesn't support creation of additional duplicates

A Closer Look at Remediation

Why this solution? →

- ICD-9 and ICD-10 data values are essentially separate and distinct
- Once the field expansion is accommodated, values can exist in the same physical location
- The solution represents the lowest total cost of ownership.

Implications of the solution →

- The annual update process (normal volume ≈ 500 codes) will be used to process 160,000 new ICD-10 codes
- Technical changes are limited to field expansion and update of applications currently using ICD-9 codes
- The ICD-10 core technical changes are large in number, low in complexity
- Most of the 'work' is on the business side

How Will BCBSM Maintain its Claims Payout Status Quo?

Two distinct processes are required to support financial neutrality:

- For facility claims, the ICD-10 codes must map to approximately the same DRGs. A three-phase methodology and approach is currently under development and being finalized.

- For professional claims, the ICD-10 codes are mapped to the appropriate diagnostic categories*. We refer to this as our mapping process and it began in April 2011.

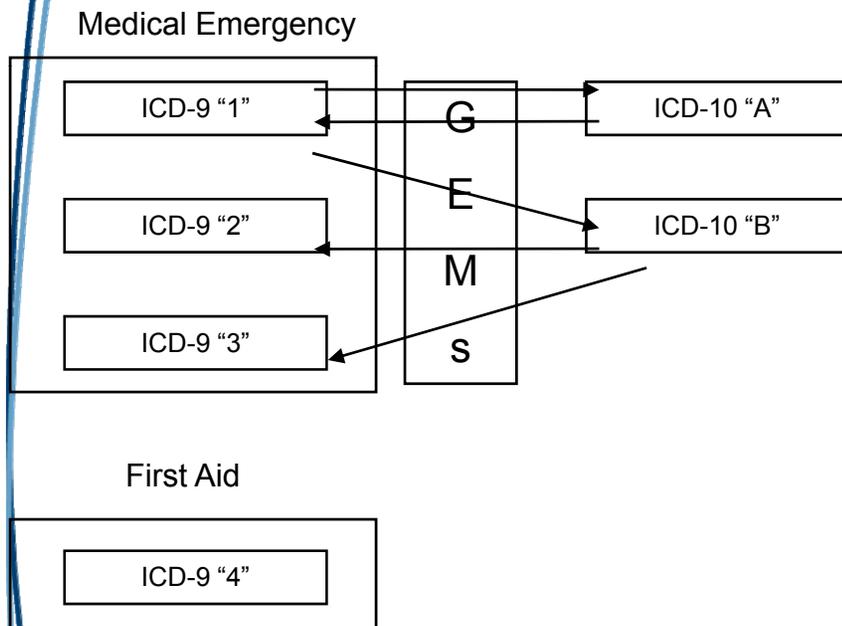*BCBSM organizes diagnostic codes into categories to determine benefits

Mapping Process Highlights

- The many-to-many nature of the CMS GEM files introduces potential discrepancies that must be resolved before codes can be assigned to the proper diagnostic categories.

- CMS GEM files will "get you in the neighborhood" and are extremely important to the process.

- Our mapping process ensures the proper placement of the codes within the BCBSM environment.
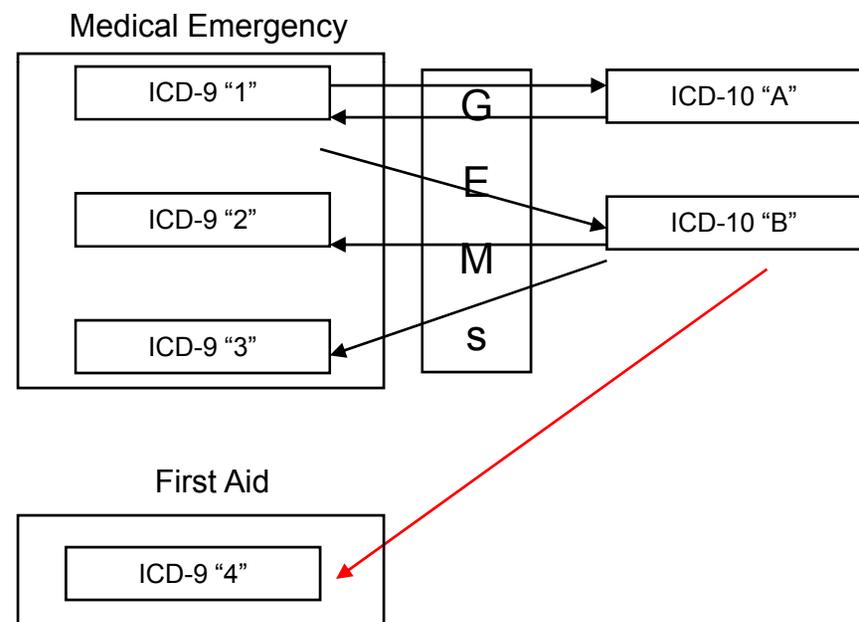
What is a Mapping Discrepancy?

No Discrepancy Exists

Discrepancy Exists

Medical Emergency

ICD-9 "1"	G	ICD-10 "A"
ICD-9 "2"	E	ICD-10 "B"
ICD-9 "3"	M
	S

First Aid

ICD-9 "4"

Medical Emergency

ICD-9 "1"	G	ICD-10 "A"
ICD-9 "2"	E	ICD-10 "B"
ICD-9 "3"	M
	S

First Aid

ICD-9 "4"

We will focus our mapping on discrepancies and high impact codes

What is Meant by High Impact Codes?

High impact codes are those that are high volume, high payout, specialized or specialty based. Such as:

S9031XA - Contusion of right foot, initial encounter

In contrast to other, less common codes…such as:

V91.07XA - Burn due to water-skis on fire

ICD-10 Risks

- The largest risk that we face as a plan is overall industry readiness.

- The question of readiness spans all stakeholders

- Lack of readiness from any stakeholder could lead to disruption in the system which could affect:
  - Cash flow
  - Member/patient benefits
  - Data integrity
  - Stakeholder relationships
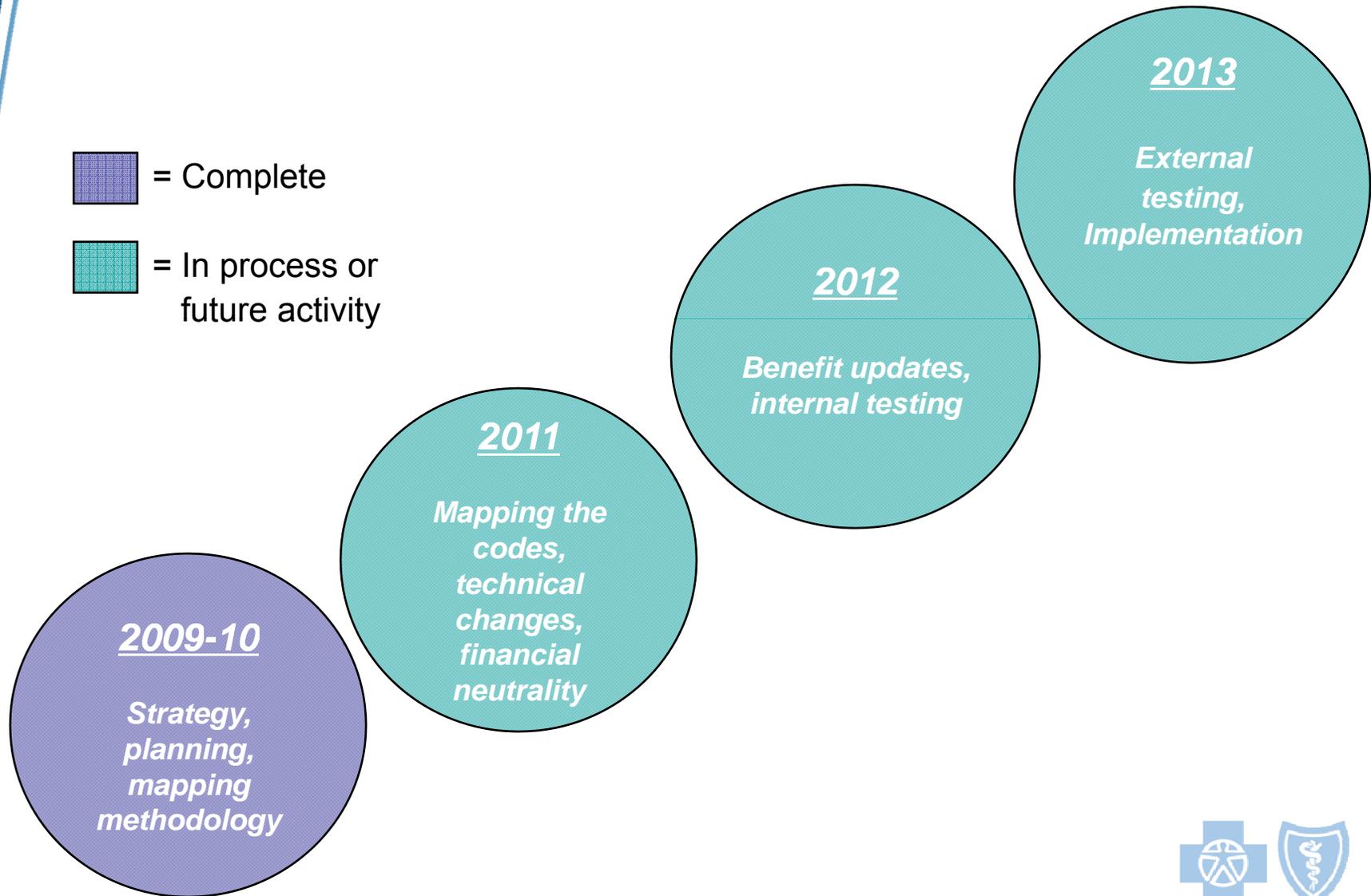
Different ways to address the risk

- Communications and outreach
  - Need to include standard channels of communications (newsletters, etc.) as well as face-to-face contact with stakeholders throughout the entire ICD-10 timeframe
  - This creates awareness of ICD-10, helping to support system readiness by sharing of information
- Partnering
  - Limited number of external critical partner practice entities
  - Look at the 'life of a code' from the medical record all the way through claim payment
  - Work together to define and validate financially neutral environment
- Planning for continuity of business operations
  - Define and address the multiple dimensions of contingencies
  - Helps to plan for all possible situations and avoid disruption

High-level ICD-10 timeline

= Complete

= In process or future activity

2009-10

Strategy, planning, mapping methodology

2011

Mapping the codes, technical changes, financial neutrality

2012

Benefit updates, internal testing

2013

External testing, Implementation

Rich Cullen Testimony

National Committee on Vital and Health Statistics

Subcommittee on Standards

On behalf of the Blue Cross and Blue Shield Association – a national federation of 39 independent, community-based and locally-operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for nearly 98 million members Americans – I am pleased to offer the following testimony on Blue Cross and Blue Shield Plans' readiness for the HIPAA 005010 (5010) Transactions and ICD-10 Code Sets

In addition to providing our state of readiness for 5010 and ICD-10, this testimony will address several other topics for which the subcommittee expressed an interest. We believe that our status report reflects the Blue system's commitment to achieving full compliance by the implementation dates specified in the regulations.

While the bulk of the work will be done by Plans, BCBSA is facilitating implementation by:

- Actively engaging with other industry stakeholders to promote industry awareness and readiness, supporting educational programs and developing standard messages.

- Working with Blue Plans to share best practices, identify and resolve issues in a timely manner, and monitor overall progress towards implementation.

- Participating in industry groups such as the Workgroup for Electronic Data Interchange (WEDI) and the Health Information Management Systems Society (HIMSS). This participation supports overall industry readiness and address common issues.

- Providing access to information and educational materials on our public website.

- Promoting best-of-breed tools through early evaluation, selection, and advantageous price negotiation.

- Responding in a timely way to requests for information or assistance from CMS.

- Updating the systems that support Blue inter-Plan and Federal Employee Health Benefits Plan (FEHBP) processing.

BCBSA surveys Plans quarterly and we used composite information from the most recent survey, which was compiled in April, in preparing our testimony. Additional

information was solicited from Plans to assist in formulating our responses to the questions and topics we were asked to address with our testimony.

5010 Readiness:

All Plans report that they not only expect to meet the January 1, 2012 compliance date for all transactions but also expect to be able to process both 5010 and 4010A1 claim status and eligibility transactions in a dual mode by July 1, 2011. In addition, while Plans will begin accepting 5010 transactions in limited production by July 1, 2011, they do not expect a very high volume at that time; with most indicating it will be less than 20 percent of total transactions. As most of the process change and system development work has been completed, Plans are now actively engaged in testing (as reported in our first quarter survey testing status results).

Impact Assessment and Strategy:

The typical project approach for a Plan was to conduct an analysis of the final rules, determine business process and system changes, develop project plans, determine resource requirements – including vendor needs -- develop communication plans for both providers and vendors, and develop testing plans and schedules for both internal and external testing. No unusual or special training requirements were noted or suggested.

Sense of Urgency:

We believe it is important for the 5010 requirements to be implemented on time. Our sense of urgency stems from two key factors: the need to remain compliant and the ability of Plans to free up resources to work on ICD-10, healthcare reform and other strategic initiatives. It also ensures a smoother national cutover to 5010 on January 1, 2012

Risk Management:

Plans have two primary risk management concerns regarding the 5010 project: (1) trading partner readiness and (2) having sufficient time to complete testing to implement on time and with minimal post-implementation issues. Plans indicated that lack of progress by trading partners, most notably the small provider community, poses the greatest risk to full implementation on January 1, 2012. Plans also mentioned that the 5010 errata changes, while relatively minor in nature, had a material impact on testing schedules because vendors delayed delivery of product modifications, and trading partners were reluctant to start testing until the errata changes were made. Plans are trying to determine how to remain customer-focused and retain current provider productivity while also being compliant.

Testing:

As indicated previously, Plans are in various stages of testing both internally and externally. Most are first testing with their high volume trading partners, such as clearinghouses and large volume providers that submit directly, then moving to lower volume partners as time permits. Having enough time to test both internally and externally is a critical success factor in terms of quality and productivity. While Plans can control their internal test schedules, external test schedules must be negotiated and coordinated carefully to avoid last minute issues and to allow time to correct any issues encountered during testing. If Plans go into full production and material issues are encountered, not only will productivity be diminished but resources scheduled for ICD-10 and other projects will need to be used to correct and resolve related operational issues that occur, therefore jeopardizing the timely completion of those projects as well.

Communications:

To help mitigate these two risks, Plans are actively engaged in communication and outreach programs with both providers and vendors. Plans communicate with their providers in several different ways including: provider workshops, newsletters, surveys, e-mail, hotlines, and webinars. While no one method is favored, the best approach seemed to be deploying several methods on a regular basis. Communication examples include but are not limited to; information sites like the CMS website, potential impacts to the providers such as reimbursement impacts after 1/1/2012 and how to establish testing with their direct trading partners as well as their payers.

Observations:

The Subcommittee may be interested in the following observations made by individual Plans relayed to us during a recent call to discuss 5010 readiness. First, if one compares where the industry was on January 1, 2011 to timelines established for recommended Level 1 and Level 2 testing, it would appear that the industry's overall status was somewhat behind where it should have been. Second, in communicating with providers and others, one Plan was hearing that several providers were relying on their vendors to obtain 5010 compliance but they had not gone out to verify that their vendors were planning to support the required changes. The Plan expressed concern that some providers may get caught short if at the last minute they find out that their vendor was not going to support changes to accommodate 5010 requirements.

For all aspects of readiness, including testing, communications and risk management, providers need to be considered as 3 unique groups, institutional, non-institutional and professional, each has a unique set of issues to be addressed.

In our view, CMS has done a very good job of promoting awareness and providing educational materials for the 5010 implementation project. Given the level of industry readiness, we encourage CMS to continue with these efforts over the next six months. BCBSA stands ready to work with CMS in this endeavor. We encourage focusing on the smaller provider offices.

ICD-10 Readiness:

All Blue Plans have initiated and are actively engaged in ICD-10 projects at this time. The most notable observation to date was breadth and depth of the work that will be required. Every area of the healthplan operations will be impacted. As reported in our April 2011 status report, as of the end of the first quarter:

- More than 90 percent of Plans had completed or nearly completed their impact assessments.

- More than 70 percent had completed or nearly completed development of their implementation strategies.

- More than 40 percent had completed or nearly completed their project plans.

- More than 90 percent have started process design and development.

- More than 90 percent had started system design and development.

Please note that work in several of the items listed above may proceed in parallel. In addition, Plans are actively engaged in identifying and filling staffing requirements and determining the need for external support for these projects.

While Plan projects have gained traction and are gaining momentum, it will be critical for CMS to immediately engage in aggressive provider education and outreach if we are to avoid losing those gains.

Impact Assessment and Implementation Strategies:

Our Plans' approach to impact assessment is to use both internal and external resources, to inventory all of the places ICD codes are received, processed, stored, and transmitted. This information is then used as the starting point for an analysis of the impact to the business process, practices, and systems. As indicated above, the size and complexity of the project was the most noticeable item identified during this process. Other issues or areas of significant work identified during the assessments included selection of a translation strategy, provider re-contracting, determination of

resource requirements both financial and human, identification of training needs, formulation of communication plans, and formulation of testing plans.

In general, translation strategies selected by Plans fall into one of three broad categories, with several Plans indicating they would use more than one strategy. The three base strategies are as follows:

- Remediation: where the business process or system will be changed to use either ICD-9 or ICD-10 codes starting October 1, 2013.

- Normalization: where ICD-10 codes received on or after October 1, 2013 will be converted back to ICD-9 for processing.

- Replacement: where the system to use ICD-10 codes will replace the system that uses ICD-9 but they will both run in parallel for a period of time.

Selection of a given strategy was largely based on each Plan's special circumstances, taking into account such factors as cost, time, and an assessment of financial risks. The majority of Plans selected the remediation strategy though some are using a combination of strategies.

Sense of Urgency:

There is considerable value in the more granular information that can be obtained from ICD-10 codes. With increased granularity, ICD-10 codes have the potential to reveal a good deal more about quality of care, enabling such improvements as better understanding of complications, better designing of clinical decision support, and better tracking of outcomes of care. However, because the full benefits of greater granularity require accurate and consistent use of the codes by all stakeholders, it will be critical for everyone including providers to be ready on time. Moreover, expeditious implementation of ICD-10 is essential to timely and efficient implementation of the many other Administrative Simplification provisions of the Affordable Care Act, as among them Health Plan Identifiers, Claims Attachments Standards, Health Plan Certification, EFT, and Operating Rules (which have yet to be fully defined).

Risk Management:

Plans have two primary risk management concerns regarding the 5010 project: (1) trading partner readiness and (2) having sufficient time to complete testing to implement on time and with minimal post-implementation issues. Plans indicated that lack of progress by trading partners, most notably the small provider community, poses the greatest risk to full implementation on January 1, 2012. Plans also mentioned that the

5010 errata changes, while relatively minor in nature, had a material impact on testing schedules because vendors delayed delivery of product modifications, and trading partners were reluctant to start testing until the errata changes were made. Plans are trying to determine how to remain customer-focused and retain current provider productivity while also being compliant.

Training:

All Plans have identified the need to train staff for this project. One third have started training for in-house coding staff and almost 30 percent have started training business staff. Of those not yet started, most expect to begin before the end of 2011. Training ranges from very comprehensive for coders to very general for those with indirect involvement.

Testing:

Most Plans expect to begin external trading partner testing no later than the first quarter of 2013. While many Plans will use internally developed testing tools, others are determining if they should build or buy the necessary tools. While external testing to make sure ICD-10 codes can be transmitted and are valid may be relatively simple, testing to make sure internal systems that will convert, process, store, and transmit those codes will be complex and will require large comprehensive test files to be constructed. The most challenging aspect of testing is the creation of realistic test data. Health plans have access to historical ICD-9 claims data that they will convert to ICD-10 based claims. However, the converted claims will reflect what the health plan expects to receive based on their own mapping and translation analysis. Those claims may not reflect what providers will actually send based on their mapping and translation analysis.

Use of General Equivalent Mappings (GEMs):

Member Plans view the GEMs as a starting point for any mapping activities. Plans leveraging purchased software tools to support mapping activities recognize that the GEMs are still the most advantageous starting place.

However, Plans also recognize that much additional work needs to occur before a final set of maps can be developed for use in systems remediation or for use on an operational basis for processing. The most significant issue that needs to be addressed and resolved is how to get from the starting place provided by the GEMS to a final place that will result in either the accurate remediation of systems and business processes or the accurate conversion of one code version to the other for purposes of processing. Great care is needed to make sure all the appropriate factors are incorporated into the business rules that will be used to complete the building of a comprehensive set of maps.

Given the number of individual maps that will be developed, there will be a high degree of risk that some of those maps will have errors or that inconsistencies in maps used by trading partners may occur. In some situations this may not be a problem, for example: code A was used instead of code B but the adjudication and pricing would be the same for either code. However, in other situations it may cause a significant problem, for example: code A would price at $10,000 while code B might price at $20,000, so if the incorrect code was selected or converted to an incorrect code, a material error would occur.

In our opinion, there are two primary ways to mitigate this risk. The first is comprehensive training for the people who will be involved in the construction of maps or business rules established for mapping purposes. The second is testing, not only to see if a valid code exists and that it can be transmitted but also to determine if it was assigned correctly, resulted in the correct adjudication and correct price, and that it resulted in appropriate processing wherever it was used post payment. This type of business testing will be complex and will require a substantial amount of time to do while requiring careful coordination between and among trading partners.

We expect numerous additional risk mitigation strategies to be developed as industry projects move forward. One option is to watch for differences in pricing between the 9 Vs 10, especially with regard to DRG pricing. Claims could be priced with an ICD10 code; then in an off-line mode, those same claims could be run against their ICD-9 pricing structure, and have a mathematical difference calculation done to assure that the pricing is same/close within a tolerance, or way off. Reports could be generated and reviewed daily with investigative and corrective action where a pricing code may go aberrant.

Dual Processing (both ICD-9 and ICD-10):

Assuming no changes to the current rule, the determination of the validity of a code will be based on discharge date or date of service (initial and interim claims) for institutional inpatient claims. Therefore, no matter which implementation strategy is selected, Plans are preparing to be able to accept both ICD-9 and ICD-10 for a considerable time. However, such dual processing where transactions would be accepted with ICD-9 or ICD-10 codes irrespective of dates would fall under the topic of a contingency plan and should not be used as a standard operating procedure for ensuring payment accuracy. In the event contingency options are both necessary and permitted; this may be the most practical option. However, at this time most Plans have not identified or evaluated contingency options in order to handle trading partners not able to implement on time. As was said under the 5010 project, Plans do not want to be faced with a choice between productivity and compliance.

Vendor Issues:

While vendor communication and outreach programs have started at several Plans, there is insufficient information available to us at this time to know if there are or are not material issues to be addressed. The general approach is to inventory and prioritize the vendors, and to use that information to reach out in order to determine their ICD-10 plans and or status. We know is that this will is a substantial work effort as the number of vendors for some Plans is in the thousands.

Communication and Outreach with Trading Partners:

All Plans will establish communication and outreach strategies with their providers: two-thirds have already launched outreach programs. As with the 5010 project, there are a wide variety of methods being used and or developed for ICD-10 education. These methods include: newsletters, on-site visits, educational workshops, online access to information and training materials, and presentations to professional organizations. The greatest challenge is to ensure that everyone recognizes the complexity of the process and the need to move forward. Plans indicate it will require a combination of methods to achieve the best results and that the best approaches may change as the industry moves through the various stages of implementation. Today awareness is still the primary focus; tomorrow it may be addressing specific issues or concerns.

Observations:

Once ICD-10 is implemented, it may be very difficult to easily recognize issues. If a claim is not coded correctly at the source, if a crosswalk is inaccurate or a benefit table is coded inaccurately, the resulting problem may not be readily apparent by looking at any one claim. It may take an unusual trend before a problem is recognized. All stakeholders will need to continue carefully monitoring claims and related data after implementation to identify and resolve issues quickly.

Due to time demands, providers may be reluctant to undergo the training necessary to understand how to assign valid and appropriate codes. Accurate coding at the source will be critical if the industry is to fully recognize the value of the new code sets.

National and state-level organizations such as professional societies can play a valuable role with respect to awareness and education.

CMS has already done a considerable amount of work regarding industry awareness and education but will need to do even more in the future. We encourage targeting the smaller provider, both professional and institutional. Again we are ready to assist CMS with these efforts.

Industry questions or requests for direction submitted to the Office of eHealth Standards and Services (OESS) need to be promptly addressed and responded to, even if only to clarify that the question or issue is beyond their authority to address or resolve. Industry stakeholders rely on CMS guidance in their own project planning and as such, any delay in responding to these questions or requests, tends to create reasons for industry delay or project stoppage. This has a ripple effect on the ability of stakeholders to meet compliance dates.

As with the 5010 observation all aspects of ICD 10 readiness, including testing, communications and risk management, providers need to be considered as 3 unique groups, institutional, non-institutional and professional, each has a unique set of issues to be addressed.

Lastly, BCBSA, our Plans and the industry need more information and guidance around compliance enforcement, monitoring and certification. Understanding future requirements is key to our planning implementation timelines and resource alloacations appropriately.

Testimony to National Committee on Vital and Health Statistics
Subcommittee on Standards

Testimony on Industry Implementation of X12 Version 5010, NCPDP Version D.0,
NCPDP Version 3.0 and ICD-10
June 17, 2011

Introductory Statement and Emdeon Overview

Good morning. My name is Debbi Meisner, and I serve as Vice President of Regulatory Compliance Strategy for Emdeon. Emdeon is pleased to offer the following comments to the Subcommittee regarding implementation of 5010 and ICD-10. Emdeon has been an early tester of the new transaction standards, so we hope that our experiences and observations will be helpful as you assess the industry's readiness to proceed with these critical initiatives.

Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions. Building on more than 25 years of government and commercial service, Emdeon provides powerful financial, administrative and clinical communication solutions that connect payers, providers and patients to improve healthcare efficiency. Emdeon processes over 5 billion healthcare transactions each year, and our industry-leading network connects 500,000 providers, 81,000 dentists, 60,000 pharmacies, 5,000 hospitals and 1,200 government and commercial payers. In effect, Emdeon can act as a representative sample of the entire U.S. commercial healthcare sector and a major portion of the U.S. government sector – giving us a unique, 360-degree view of the impact of these changes on the industry.

Today we would like to discuss our roadmap for implementing 5010 and D.0, the results of our early testing efforts and some important considerations for the industry as we look ahead to ICD-10.

5010 Implementation Roadmap

Emdeon's roadmap for 5010 follows a 5-step path towards implementation that includes: Analysis, Engagement, Design, Remediation and Testing.

Step 1: Analysis: In early 2009, Emdeon conducted an extensive Gap Analysis to determine the impact on all of our products and services. We then repeated the process in 2010 for the Errata. A thorough Gap Analysis – conducted internally or with help from an outside consultant – is critical in preparing for the impact of 5010.

Step 2: Engagement: Emdeon communicates early and often to trading partners and other stakeholders to keep them engaged and informed about the process. Our goal is to be transparent and ensure that information is easily accessible to those who need it. Through our website, www.hipaasimplified.com, Emdeon makes a wide range of resources available, including timelines, reference guides, webinars and tools for testing. By engaging with trading partners, we can support their compliance efforts and gather important feedback from their implementation and testing experiences.

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Step 3: Design: The next step was to conduct Design Decision meetings across the enterprise to coordinate efforts and determine how best to approach specific needs identified during the Gap Analysis. Examples include:
- Challenges faced when mapping up and down
- Need for new edits
- Content and timing of communications to stakeholders

Step 4: Remediation: Once the Gap Analysis and Design phases were complete and input was gathered from trading partners, Emdeon proceeded with remediation of our internal workflows. While the remediation effort had many components, a primary focus was a migration to a XML-based flexible structure.

Step 5: Testing: Emdeon was an early tester for 5010. We facilitated Level 2 Trading Partner Testing ahead of the HHS January 1, 2011 Guidance. Testing is currently underway with both submitters and payers for the 837 Professional, Institutional and Dental Claims, the 835 Electronic Remittance Advice, the 270/271 Eligibility transactions, the 276/277 Claims Status and for NCPDP D.0.Testing for the 278 Referral/Authorization is expected to be completed in the Second Quarter of this year.

By following this roadmap and applying a disciplined approach to testing, Emdeon has learned a great deal about the impact of 5010 and D.0 on the industry. Today we would like to share with you what we have learned and offer suggestions for mitigating the challenges that stakeholders are likely to face during the implementation process.

Lessons Learned from Early Testing

Emdeon's 5010 testing efforts shed light on a number of issues that could be avoided with proper preparation and planning. Here is an overview of our observations as a clearinghouse regarding the impact on providers, health plans and software vendors.

Providers: For providers, it is critical to understand the impact of the 5010 enhancements and to update business processes and procedures accordingly. Making these changes early will allow providers to begin collecting and entering incremental 5010 content leading up to the compliance deadline. In addition, we recommend that providers begin requesting 5010 updates from their software vendors – early and often – and proceed with installing, training and utilizing the updates with their EDI trading partners.

Health Plans: For health plans, our experience tells us that it is vital for health plans to understand that many providers will not be able to send full 5010 content, especially during the transition period leading up to the compliance date.. During the transition period (and possibly beyond), health plans who use translator products to translate inbound 5010 transactions into formats used by the adjudication system may need to relax or re-configure such translators to prevent claims from rejecting due to missing 5010 content. If health plans set their translator products to reject transactions that do not meet all 5010 content standards (but the transactions contain all content necessary for claim adjudication and payment within the health plan's business processes) Emdeon is concerned that:

- EDI penetration rates may fall as small providers revert to paper
- Health Plans may run afoul of State Prompt Pay regulations
- Provider payment and therefore cash flow may suffer

Software Vendors (POMIS; HIS): Finally, software vendors are strongly encouraged to complete and test 5010 product updates early in order to allow time to deploy and train their provider customer base. We are seeing a significant learning curve for 5010, so it will take time for billing clerks and other office staff to learn and understand the changes. Along similar lines, we recommend that vendors include 5010 updates for all transaction types in the initial deployment to avoid having to repeat the full release cycle – and staff training – transaction by transaction.

Sample Issues and Findings

In addition to the broader observations above, a number of very specific issues emerged during testing. I would like to provide some examples of these issues.

Billing Provider Address: The address on a claim can no longer be a PO Box, yet we continue to see extensive use of the PO Box in current claim volume. There could be several explanations, including the fact that it might be difficult for providers to change the address in desktop software tables. In addition, providers may be wary of changing the address for fear that it might result in rejections of the claim for provider enrollment. Thus, it is important for providers to contact their payer partners proactively regarding updating the address information to avoid any adverse affect on enrollment.

Zip Code: Under 5010, the zip code must be nine digits for the Billing Provider or Service Facility. Once again, it may be difficult for providers to make this change in desktop software tables. To address this problem, a clearinghouse could, at the trading partner's request, default to "9998"in the final four digits during the transition.

Release of Information Code: Under 5010, codes were deleted that do not specify consent to release information. During testing, we found that providers continue to submit claims with values that indicate lack of consent. It is important to continue to educate providers not to submit the claim if they do not have consent.

Accepts Assignment Indicator: The designation for assignment changed in 5010 and now represents the providers relationship with the health plan and is not restricted to Medicare only. In addition, we are still seeing some providers send in the value of "P" (Patient refuses to Assign Benefits) even though it is not a valid business reason for this data element today. Thus, we must continue to educate providers that they must no longer use "P" and should assign the value based on their arrangement with the destination health plan..

Transition Approach: Progression vs. Perfection

Now, I would like to come back to a point I raised earlier in my testimony. As an industry, it is extremely important that we recognize and plan for the fact that there will be a period of transition as we all move towards 5010 readiness and compliance. During this period, providers will need time to learn new rules for capturing data content. While this learning period is taking place, we recommend that:
- Providers and their vendors should work toward compliance.
- But at the same time, clearinghouses and health plans should process transactions based on business processes and applicable regulations – not strict enforcement of content that is not required as part of their business process.

In fact, the 5010 TR3 makes specific reference to this approach. Section 2.2.1.1 looks at transaction compliance in the context industry usage. In this section, the guide specifically states that when evaluating a transmitted transaction for compliance with industry usage, the guidelines are, "not intended to require or imply that the receiver must reject the non-compliant transactions. The receiver will handle the non-compliant transactions based on its businesses processes and any applicable regulations." As we work through the transition to 5010 compliance, we recommend that steps be taken to avoid rejection of transactions based on overzealous reading of the rules so that providers can make progress without impacting cash flow. Again, the emphasis should be on *progression vs. perfection*. We strongly encourage the Subcommittee and others at CMS to consider how this concept might be applied during the 5010 transition to minimize disruption for providers, payers and ultimately for patients.

Looking Ahead to ICD-10

For the remainder of my testimony, I would like to spend a little time looking ahead to ICD-10 and offering some observations from our early efforts to move our company and our customers to the new code sets that go into effect in 2013.

As we all understand, the ICD-9 code system is old and does not reflect advances in medical knowledge or technology. ICD-10 is already in use in many other countries, and there is considerable pressure from the World Health Organization for United States to convert. As our healthcare system continues to evolve, the current codes do not capture data relating to factors other than *disease* affecting health. This gap in information impacts quality reporting as new delivery models emerge. Increased specificity could generate better data on procedure and diagnosis trends resulting in improved patient care, as well as assisting with public health threats like pandemics or bio-terrorism.

To date, Emdeon has taken a series of important steps towards achieving ICD-10 readiness. We have convened a group of critical stakeholders and requested an initial impact assessment for each line of our business. We have also conducted reviews of the various "crosswalk" products, and we are currently assessing demand for crosswalks among our customer base and the ability for crosswalks to properly translate on behalf of these customers.. Again, our customers represent all major sectors of the healthcare industry, so it is critical that we invest in this due diligence process so we can offer solutions to meet the varying needs within each of these sectors.

These early efforts have led us to draw four important conclusions about ICD-10:
1. **It's BIG** - ICD-10 implementation has far greater impacts and is more complex than any other HIPAA initiatives
2. **It's High Impact** – No one should assume this is an IT project. It brings significant impacts to basic business processes and operations.
3. **It's still unknown** – as an industry, we still do not know the full impact of the transition to ICD-10
4. **And it's continuing to evolve** – so it is very important that all of us stay involved in the process and work hard to educate our own organizations and those of our partners

Conclusion

In closing, we would like to thank the members of the Subcommittee for their time and attention. The changes being discussed today represent a major transformation for our industry. We appreciate all of your efforts to

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bring clarity and consensus to the process. We hope this information will be useful to you. Should you have questions or need any further information, please do not hesitate to let us know.

Thank you.

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NCVHS Hearing

Industry Implementation of HIPAA Standards and Code Sets 5010, NCPDP and ICD-10

June 2011

Perspective

Impact Assessment Approach and Outputs	• Majority will be updating | remediating their systems not replacing them • Many are now evaluating business implications vs treating as a code translation exercise; requires balancing Business Rules, Policy changes with System updates; most started late and are behind • Most are surprised at work effort involved and costs
Implementation Strategies and Approaches	• Many are finalizing Level of Effort and Cost estimates • Urgency: many are performing 5010 and ICD-10 transition concurrently • Quantitative analysis: Predictive modeling to validate risk and cost neutrality assumptions; requires post-10/2013 ICD-10 claims data for accuracy • Focus on codes that drive revenue and volume
Risk Management | Contingency Planning	• Questionable Provider Readiness: smaller Providers more at risk • Impediments | challenges: "Assumptions" modeling will drive financial conservatism • Uncertain Code Mapping and testing dialog and planning • Impact from: Productivity; increased pended | rejected claims, denials; manual claims; record requests
Training	• Mostly internal Awareness; schedule Clinician, Nurse, Coders, PreCert Pros, Billing & Collections • Anatomy Surgical, Physiology, Documentation • Beginning to assemble Business | Process Impact Task Forces • Limited new System or Process Training | Communication to-date

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Perspectives Cont'd

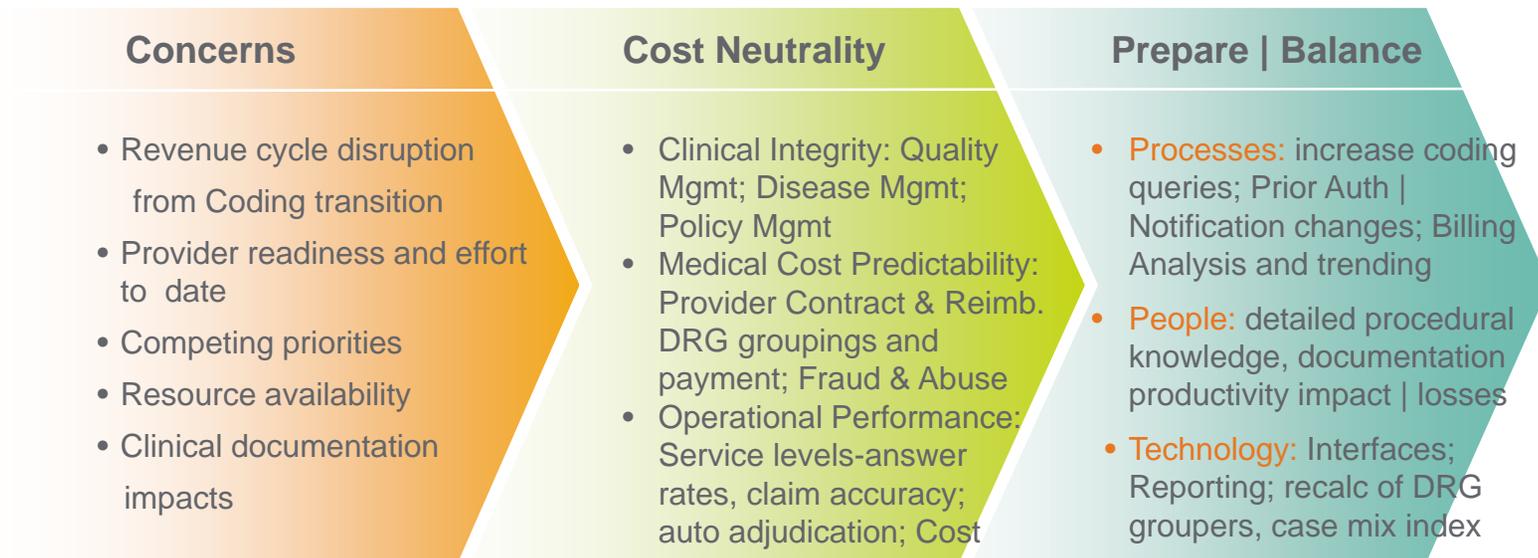|	
Testing Status and Strategy	• Many have completed 5010 Internal testing; External underway; ICD-10 likely in 2012 • Trading Partner | Delegated Entity testing schedule or underway • Limited Provider testing to-date
Transaction Processing Strategies	• Requires balanced approach of GEMs, Crosswalks, and Mapping Tool • Will require custom mapping • Most organizations are seeking outside resources and assistance
Dual Processing	• Will need dual datasets for testing • Test for mapping decisioning *and* impact • Beginning to budget for additional IT overhead: systems, people
Vendor and Trading Partner Communication	• Many are still validating Readiness for large % of Vendors and Trading Partners • Communication: Outreach, functional enhancements • Testing, Training Plans, expectations

Path Forward

Objective: Mitigate impact and risk; revenue predictability and accuracy

Concerns

- Revenue cycle disruption from Coding transition
- Provider readiness and effort to date
- Competing priorities
- Resource availability
- Clinical documentation impacts

Cost Neutrality

- Clinical Integrity: Quality Mgmt; Disease Mgmt; Policy Mgmt
- Medical Cost Predictability: Provider Contract & Reimb. DRG groupings and payment; Fraud & Abuse
- Operational Performance: Service levels-answer rates, claim accuracy; auto adjudication; Cost

Prepare | Balance

- Processes: increase coding queries; Prior Auth | Notification changes; Billing Analysis and trending
- People: detailed procedural knowledge, documentation productivity impact | losses
- Technology: Interfaces; Reporting; recalc of DRG groupers, case mix index

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Thank You.

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State of Tennessee
Bureau of TennCare

NCVHS Committee Testimony
June 17, 2011

Brent Antony, Chief Information Officer
Don Oaks, EDI Manager

TENNCARE

TennCare

- Managed Care Program
- 1.2 Million Tennesseans
- 12,000 Providers

5010 Status

- Internal testing with minor coding corrections
- Companion Guides have been posted
- External testing starts July 7, 2011
- Production implementation planned for October 28, 2011

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5010 Concerns

- Multiple conflicting priorities and system issues are impacting external partners
- Some content/business rule changes
- Just beginning external testing
- Provider readiness is unknown

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ICD-10 Status

- Gap analysis and policy review underway
- Code remediation to start after 5010
- Broad organizational impact
- ICD-9 to ICD-10 crosswalk considerations for longitudinal analysis
- Significant effort required to plan, remediate, communicate, educate and coordinate

TennCare

ICD-10 Concerns

- Conflicting projects and schedules
- Conflicting priorities and objectives
- Shortage of resources and expertise
- Industry focus on technology and administrative compliance
- Inconsistency in approach
- Extended data fog
- Unmanageable level of concurrent change

TennCare

Conclusion

- 5010
  - Industry testing is behind schedule
  - Many will be ready for 2012 implementation
  - Risk mitigation options exist
- ICD-10
  - 2013 implementation will be disruptive
  - Other priority initiatives will be impacted
  - Uncertain short-term benefit

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Recommendation

- Consider the interaction between clinical terminology or vocabulary and administrative coding or classification

- Recognize the need for robust clinical data capture to support coding/classification

- Support and leverage HIT initiatives

- Sequence priorities and schedules

- Reconsider ICD-10 schedule

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Industry Implementation of Updated and New HIPAA Standards and Code Sets
X12 Version 5010, NCPDP Version D.0, NCPDP Version 3.0 and ICD-10

Testimony Presented by: Linda McCardel, MPHI
ICD-10 Project Coordinator
On behalf of the Michigan Medicaid Program

Good morning –I am Linda McCardel, senior analyst with the Michigan Public Health Institute and the ICD-10 Project Coordinator for the Michigan Medicaid Program. I am presenting today on the behalf of Michigan Medicaid.   Thank you for the invitation to provide information on our implementation of the new HIPAA standards and code sets.

A little background - currently Michigan Medicaid has approximately 1.9 million beneficiaries. About 75% of the beneficiaries are enrolled in risk-based capitated managed care programs and the remainder is in fee for service. Michigan is also one of the few states that maintains its own Medicaid program – we do not use a fiscal agent. To frame my comments, I ask you to keep in mind a few events that have occurred in Michigan recently. Last year, the State offered an early retirement incentive starting in October and running through December. Many of the long-term employees with historical knowledge retired during that time frame – a few were extended and now they too have been leaving with the last few to be done by the end of June. In January of this year, Michigan had a change in State Administration – a new Republican governor replaced the term-limited Democratic governor and along with that, there was a turnover of all department heads and many key staff. The retirements created vacancies which in turn has caused a lot of staff movement within the Department of Community Health which houses the Medicaid program. We are operating at reduced capacity as many of the vacancies have not been filled and may not be due to budget constraints. The State also implemented a new MMIS – Medicaid Management Information System - in September 2009, and staff has been heavily involved with preparation for the certification of the system required by CMS. CMS spent a full week in Michigan the beginning of May to review the MMIS – staff worked over three months preparing the documentation required for that visit. To say the least, state Medicaid employees have been spread very thin.

In spite of this, the state is well on its way to 5010 compliance. Currently, we are conducting B2B (business to business or end-to-end) testing on 270/271, 276/277, and 837 transactions. Unfortunately, we have not been able to identify any trading partner willing to test with the 278. Two days ago, on June 15, 2011, Michigan Medicaid participated in the National Version 5010 Testing Day and reached out to trading partners to at a minimum, enroll and start their validator testing. We have focused on the higher volume trading partners initially – the large hospitals, provider practices and clearinghouses. The outreach has included a dedicated website, a traveling Outreach team that holds face-to-face meetings with providers, bulletins, email announcements, and a recent postcard effort that encouraged an additional 50 trading partners to enroll for testing. Staff has also been doing one to one phone calls to encourage providers to start the test process – transaction validation first, then B2B/end-to-end testing.

Michigan will not be implementing the 277CA due to the way we process – near real time. Providers will have to go to our provider portal where they can view their claim status online or submit a 276 and receive a 277 response. One of our outreach efforts is to alert providers that the current 277U will no longer be available after January 1, 2012 so they should be testing the 276/277 capability as part of their 5010 efforts. Under 4010, we only have 5 trading partners that currently submit a 276 transaction.

A key value to our outreach effort has been our collaboration with Blue Cross Blue Shield of Michigan and the Michigan Association of Health Plans. Combined, we cover about 75 to 80% of the covered lives in Michigan. We did this with 4010 as well – worked together on provider outreach participating in face-to-face meetings and webinars to provide implementation information in a consistent manner. While we are not implementing 5010 in the same fashion – BCBSM is doing a staged implementation and Michigan Medicaid will implement all on January 1, 2012 – we are continuing the collaboration and providers appreciate the single coordinated effort which saves them time.

We hear from some of our trading partners that they are ready to test – and they are enrolling to start validation testing. However, submitting an actual test file is another issue – we're simply not getting them in the volume we'd like. Our goal is to have over 80% of our trading partners finished with testing by November but we are concerned given the low response we're getting. For our managed care partners, we plan to provide them with outbound files – 824 and 820 - in mid-July and hope they will be fully engaged in the test process by then and providing us feedback.

We are concerned that the provider community seems to believe the 5010 implementation is something that can be handled by their vendors – many are not realizing the business impacts they need to be aware of - in fact some don't know what "5010" means.   Just last week our testing team received a call from a trading partner who wanted to know how they could look at the "test" that CMS was going to give them in the near future – they wanted to be prepared. Mainly we are finding that the attention of providers is focused elsewhere - on meaningful use and the EHR incentive program, and not on 5010 or ICD-10.

Regarding NCPDP D.0, the State's Pharmacy Benefit Manager will begin coordinated testing with pharmacy software vendors later this month with a target completion date of early July. They anticipate that interested pharmacy providers may begin to submit the NCPDP claim format at Point-of-Sale in the fall, as early as October, 2011.   We have no reason to believe that they will not be compliant on or before January 2012.

Michigan Medicaid is fully prepared to be compliant on January 1 2012 with the new 5010 transactions. Michigan would not be prepared to handle a delay and hope that there will be no change or contingency period for the 5010 implementation.

Michigan is confident that we will be able to meet the October 1, 2013 compliance date for ICD-10 implementation. There is a good sense of urgency to get on with the implementation.   We have had our struggles with kicking the ICD-10 project off. Last summer, Project Sponsors were named and we began initial planning meetings.   In September of 2010, we engaged the upper management in the Department of Community Health with a high level awareness presentation. We followed up with a presentation to Bureau Directors and asked them to begin informing their staff they would be contacted. We conducted a high level survey as a precursor to a detailed impact assessment. As a result of that we have a good handle on what business areas are impacted the most by ICD-10. Then everything came to a halt – the resources were devoted to 5010 and several other activities I will discuss in a bit; the retirements came in waves and the management staff changed; the MMIS certification took precedence. The end result – we are essentially starting over. We had to step back and reconsider Governance. We are now involved in a detailed impact assessment. Our strategy is to implement native ICD-10 – we will take ICD-10 codes in and adjudicate with ICD-10 codes. We will soon start to redefine

our medical policies and other business processes and will track future strategic opportunities as we go. We are planning to carry out tasks in a parallel manner to catch up.

We understand that this project will have a far heavier impact on clinical areas and business processes than on the IT side and will require more resources than originally estimated. In Michigan, there are many other departmental areas that interface with Medicaid and will be impacted by ICD-10 – we have to incorporate consideration of that in our planning and funding process. The funding for this project is another concern – while states receive federal matching funds we are very concerned about the amount of state match that might be required for this project. In talking to other Medicaid programs, the estimated cost of the ICD-10 implementation once a full assessment has been completed has exceeded preliminary estimates by four to five times or more. We don't have all the answers, but the industry has provided a lot of input – it almost is good to be a little behind as we have benefited from what others have learned and so may be saved from going down some misdirected paths.

Providers are not up to speed on ICD-10. In fact we hear from physicians that they don't think ICD-10 will impact them – they will continue to practice medicine as they have in the past and view ICD-10 as an administrative or vendor task and assume coders will handle the issues. We need a coordinated effort to get their attention – and that has to come from their peers. As with 5010, their focus is on meaningful use and the EHR incentive programs.

So what are the other challenges and barriers that we face? As everyone in the industry knows, there is a LOT going on in healthcare these days. In addition to 5010 and ICD-10, we have other mandates – operating rules, health plan certification and compliance with resulting penalties, meaningful use, health plan Identifiers, HIPAA standards and new effective dates, claims attachments, HIEs and interoperability, to name a few. In addition, State Medicaid programs have a plethora of other initiatives that are mandated for them - EHR incentive payments, National Correct Coding Initiative, new eligibility systems and health insurance exchanges, provider enrollment and certification criteria, policies to not pay for preventable health care acquired illnesses or injuries, Recovery Audit Contractors, and a number of other mandated policies and processes out of the Affordable Care Act that all take resources and staff. So we have many competing priorities – too many at once – too much to do in too short a time frame.

While we want to do a good job and be compliant, States face reduced resources both in terms of staff and funding. The current staff is burned out as the same resources are trying to cover all of these projects at the same time in addition to those that the state legislature may mandate. These are large initiatives and with the changes in Administration and staff turnover and loss of historical knowledge, it is extremely challenging to establish and maintain the vision and coordinated effort all of these projects require.

Our hope would be that we continue with 5010 and ICD-10 but take a look at what other initiatives can be put on hold and delayed. Michigan believes there needs to be prioritization of the major initiatives with thoughtful consideration of the resources – both funding and staff- that are required.

I thank the Committee again for the opportunity to provide comments today.