ICD-10

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NCVHS June 17th, 2011

AAPC Strategies and Approaches

- Implementation Strategies
  - Comprehensive two-day boot camp trainings
  - Documentation Readiness Assessments
  - Anatomy and Pathophysiology

Dual Processing

- Potentially large hurdle for providers
  - Ongoing need for technology, training and resources

Provider Use of Crosswalks

- Actual provider use of the GEMS files should be limited
  - Were not designed for a coding solution
  - Many vendor solutions may cause unanticipated side effects

Communication and Outreach

- 474 Local Chapters
- Stakeholders meetings
- CMS
- Speaking Engagements

Testimony Before

National Committee on Vital and Health Statistics
Standards and Security Subcommittee

5010 and ICD-10 Update

Presented By:

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Co-Chair
HBMA ICD-10 Committee

JUNE 17, 2011
Washington, DC

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Mr. Chairman and members of the National Committee on Vital and Health Statistics (NCVHS). My name is Holly Louie and I am the co-chair of the ICD-10 Committee of the Healthcare Billing and Management Association (HBMA). On behalf of HBMA and the more than 600 companies that belong to our association, I want to thank you for this opportunity to give you an industry update on readiness for implementation of both 5010 and ICD-10 CM. Our members process an estimated 350 million claims per year, making us uniquely qualified to address these issues.

HBMA has been and continues to be a strong supporter of the move to more advanced and comprehensive electronic claim transactions. We also support the CMS position that the implementation dates are firm. However, we believe a much more organized and aggressive universal approach must be undertaken at once for a successful transition to 5010 and subsequently ICD-10 to occur.

As requested, I will go through the questions you have asked us to address.

HBMA PREPARATION FOR THE IMPACT OF 5010 and ICD-10

The transition to ICD-10 is the most far-reaching change our industry has seen in most of our professional lifetimes, touching every facet of healthcare delivery: documentation, operations and reimbursement.

In reviewing how resources have been allocated, it is our view that a disproportionate amount of time has been directed towards educating providers about the effective dates and too little time and too few resources have been directed towards educating providers about the operational and financial issues that will likely occur as a result of this transition. We are concerned that the emphasis on dates rather than the need for process change has caused many providers to conclude that this transition is largely a series of technical changes that will have little direct impact on their practice.

HBMA has continuously encouraged billing companies and their clients to prepare for both the 5010 and ICD-10 transition for several years. Beginning in 2009, we have conducted numerous educational programs at our semi-annual meetings, published articles in our monthly journal, “BILLING”, conducted webinars on these topics, and established a dedicated ICD-10 website with links to authoritative citations and industry stakeholder resources. These efforts will continue through 2013 and beyond.

In 2009, HBMA created our ICD-10 Committee as a means to bring together various entities involved in the healthcare transaction chain. The purpose of the Committee is to address the myriad issues involved in moving from both 4010 to 5010 and ICD-9 to ICD-10. Our committee is a multi-disciplinary group of billing companies, software vendors, health plans, physicians, coding experts, clearinghouse representatives and other entities involved in claims submissions and processing.

As you know, individuals representing software vendors and clearinghouses have testified before NCVHS during the past year on HBMA's behalf so that this committee could have the benefit of their insight and perspectives. In preparation for this testimony, we consulted with several software vendors and clearinghouses, as well as our members and various industry stakeholders.

Although we are confident that most billing companies and their vendors are as prepared as they can be for the transition to 5010, there are some troubling signs on the horizon that bear notice.

A. We remain concerned that many physicians (and billing companies) are relying upon their software vendors and clearinghouses to be 5010 compliant. While it is true that vendors and clearinghouses will be responsible for compliant claim submission, the perception appears to be that 5010 is a solely a technical issue that does not impact them and that no actions are required. It also appears physicians and billing companies may not fully appreciate the need for individual testing by client and specialty, in addition to the work their vendor and clearinghouse are doing with payors. We are concerned that provider-specific information in vendor and clearinghouse databases is not up-to-date (consistent with PECOS) because physicians are unaware of the potential issues, have not budgeted the time and labor required, and/or some physician practice management systems are unable to accommodate the required modifications. This situation will lead to claims rejections – not because the claim is out of compliance with the technical standards for 5010, but because the information in the payor database is not identical to information in the vendor/clearinghouse database. New 5010 requirements for data consistency will, we believe, cause claims payment delays and disruptions, seriously impairing physician cash flow. Our primary concern is that testing will not expose these discrepancies and only when live claims are processed will providers and payors learn that the claims have failed.

B. Further, we are concerned that there is a disconnect between what vendors, clearinghouses and health plans mean when they say they are "5010 ready" and how those words are being interpreted by physicians and billing companies. We have learned that "5010 ready" may mean only internal testing is complete, external testing is in process, external testing is scheduled, external testing has been successfully completed with a (or some number) of payors, or external testing has been successfully completed with all payors.

We are also concerned that "5010 ready" appears to apply almost exclusively to claim submission and does not include other functionality available with 5010 implementation. In 2009, we testified before this committee on this issue.

As 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 payors. 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 payor 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 payor. Additionally, the Cooperative Exchange members do not have direct connections with every possible payor; therefore this analysis is only applicable for those payors 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 payors will, once again, find ways to circumvent the law. This cannot be allowed to continue to happen.

C. Very few health plans (published averages range from 8–12% to <15%) have successfully completed testing with providers, billing companies, software vendors or clearinghouses. There are approximately 134 business days to complete 5010 readiness. We are very concerned that given the large number of health plans that have planned but not yet begun testing, the number that have no estimated date for testing and the amount of time it takes (typically 2 – 3 days) to conduct and complete the testing process (with no guarantee it will be successful), we are out of time to complete the testing by the January 1, 2012 go-live date. We are also concerned about conflicting testing information. For example, we have been advised

by our clearinghouses and vendors that some MACS have instructed them to test once and some have instructed one test per provider or group, a potentially enormous difference.

Given past experience and the current industry lack of readiness, we anticipate significant delays with the processing of claims during the initial phase of implementation and beyond. We also anticipate some payors that are unable to meet the January 1, 2012 deadline will reverse map 5010 to 4010 as an interim solution. As these payors complete programming and system changes and are able to process 5010 claims in 2012, we believe we will see additional issues arise.

The lack of readiness is further complicated by the inefficiencies, costs and delayed payments associated with the necessity to support 4010 and 5010, to accommodate payors that are HIPAA exempt and do not update to 5010, and for payors with disparate implementation schedules. If a primary payor is 5010 compliant on January 1, 2012 and a secondary payor is not (a typical Medicare/Medicaid scenario), manual processes, paper claims and other costly interventions will be required. The bottom line for the physician or provider is additional increased costs and delayed payments for the foreseeable future.

D. IMPLEMENTATION STRATEGIES AND SENSE OF URGENCY

In all candor we are concerned that the sense of urgency amongst physicians and health plans is nowhere near where it should be. As I mentioned earlier, we believe there is a major disconnect between what "being ready" means and how these words are interpreted by physicians and some billing companies.

We are concerned that the level of testing between clearinghouses and health plans and vendors and health plans is nowhere near where it should be 134 days from the "go-live" date for 5010. In addition, there appears to be a less than optimal level of testing between physicians and their clearinghouses and vendors and an even more suboptimal level of testing with payors.

Based on our communications with the vendors supporting our members, we believe that by and large, most software vendors and clearinghouses long ago completed their internal testing and have been ready, willing and able to test with health plans for several months, and many since last year. Unfortunately, these vendors and clearinghouses have not had anyone with whom to test. Billing companies, software vendors and clearinghouses are very concerned with the slow pace with which health plan testing is moving.

At the rate things are going, we are concerned that it will be impossible to complete all of the testing that will be required by the January 1, 2012 go-live date.

E . WHAT'S MISSING?

The testing process between health plans and vendors and clearinghouses must be accelerated. At the current pace, there will be insufficient time to complete all of the testing required between now and the January 1, 2012 go-live date.

We strongly urge the Office of E-Health Standards to assess the readiness for health plans to test – now and determine why so few – as a percentage of the health plan industry – have successfully completed or are able to offer live testing with their partner?

In addition, we urge the office of E-Health Standards to seek from the plans their own internal assessment of readiness for both testing and compliance.

Finally, we believe the Office of E-Health Standards should obtain from plans that will be unable to meet the 1/1/2012 deadline a contingency plan in the event the plan is unable to accept a 5010 compliant claim.

Frankly, the need for providers, vendors, clearinghouses and payors to internally convert 4010 to 5010 or 5010 to 4010 to allow claim processing should be prevented, as much as possible, and should not be as prevalent as it appears it might be. There should be a compliance contingency plan that would extend for a short and specified period of time after January 1, 2012.

Assuming all the current readiness data and statistics are accurate, completing the 5010 conversion will continue well into, and perhaps beyond 2012. Considering this is relatively simple, compared to the ICD-10 conversion, we are deeply concerned about the negative impacts on physicians and the healthcare industry and the lack of credible contingency planning.

F . WHAT DOES 5010 READY MEAN?

We (that's all of us) need to better explain to providers what it means when a vendor, clearinghouse or health plan attests to being "5010 ready."

We must educate physicians that an attestation from their software vendor or clearinghouse that they are 5010 compliant does not mean 5010 claims will process seamlessly.

We are very concerned that through the use of the 5010 format, health plans will adopt new edits which will cause claims to be rejected. Although technically these rejection notices will not be directly related to the 5010 standards, the provider will not see things that way.

This is why we think we need to redouble our educational efforts to avoid these cases of mistaken blame. Along these lines, HBMA has arranged for a free webinar for next Tuesday, June 23rd to address these issues and work with our billing company colleagues to get their cooperation in quickly addressing these concerns.

G. COLLATERAL IMPACT ISSUES

For almost a decade, the Sustainable Growth Rate (SGR) has calculated a negative adjustment in the payments to physicians. Because the SGR formula is cumulative, the projected payment adjustment for 2012 will be –30%. Almost every year, Congress intervenes – mostly, but not always at the last minute (sometimes retroactively) – and neutralizes the reduction or implements a nominal increase. The legislative brinkmanship that has always accompanied this annual event (three times in 2010!) wreaks havoc with the Medicare contractors who must program last-second changes to their claims processing systems.
Six months later, the chaos that followed the 2010/2011 changes are not yet fully resolved. Many of the after-the-fact adjustments and "fixes" that resulted from the legislative process have required multiple, highly complex reprocessing of already submitted, already processed and/or already paid claims.

We are concerned that yet another SGR crisis on December 31, 2011 will add another dimension to the "perfect storm" of a 4010A1 – 5010 transition. We are well aware that NCVHS, CMS and others responsible for the transition to 5010 are unable to affect this issue. However, we wish to point out that this transition is not occurring in a vacuum and there are many other economic factors impinging on physician practices. Even a minor "glitch" or "meltdown" in the 5010 transition, if coupled with another nearly inevitable SGR crisis may cause more physicians to abandon the Medicare program, as well as other payors that stumble out of the 5010 gate.

In addition, there is a well-known active federal initiative to promote adoption of electronic medical records. While adoption may or may not be as brisk as hoped or predicted, practices are actively engaged in EMR adoption and many of the practices are just now beginning to work with, or about to begin working with a new product offered by a vendor in its own infancy, as many of the hundreds of EMR products are offered by start-up companies with little or no prior experience in health care transaction.

H. STRATEGY FOR PROCESSING TRANSACTIONS WITH ICD-10 CODES – THE USE OF CROSSWALKS, ICD MAPPING TOOLS AND GEMS.

ICD-10 does not appear to be a priority or have a sense of urgency for most physicians at this time. Although some facilities have begun work on ICD-10, it is not universal and does not have widespread physician participation. Numerous stakeholders have addressed the competing issues facing physicians and providers that require prioritization and allocation of

resources. While there is no disputing the criticality of planning for ICD-10, the fact is there is simply not enough money, staff and time to tackle all of the competing requirements at once.

HBMA believes a major factor in the lack of urgency is the unknown reimbursement impact. Yes, there are crosswalks, GEMS, and various mapping tools. Yes, CMS has analyzed the payment impact using GEMS, but only on inpatient claims. However, the key question is one of payment, not coding. This key question, which neither CMS, nor the commercial payor community has definitively answered is, "Will unspecified diagnosis codes be reimbursed under ICD-10?" Similar to 5010 communications, the message to physicians has been that this conversion will be easy, they do not need to modify behavior, an EHR or mapping software will be the solution to any issues and there are still unlisted codes.

As anyone who deals with physician documentation on a regular basis can attest, many medical records lack the details necessary to support the specificity in ICD-9 CM, much less ICD-10 CM! If payors intend to require the most specific diagnosis code ***for payment***, significant time will be required to educate physicians and assist them in accurately and completely documenting their services. We believe until such time as the payment effects are known, physicians will not have any sense of urgency or believe any modifications or actions on their part are required. Again, they will look to vendors for the solution to any issues that may arise.

We also understand that many payors will rely upon internal, proprietary mapping to adjudicate claims. An ICD-10 CM code will be mapped to an ICD-9 CM code, a payment determination will be made based on the ICD-9 CM code but the ICD-10 CM code will be reported with the payment or denial. The effect is that the plan adjudicates a claim based upon a completely different code than the one intended – or submitted – by the provider. This can result in the denial of a claim that should have been paid by the plan or a payment from the plan that is different from the amount expected by the provider. Of equal, or greater concern, is that the patient will be "labeled" with a diagnosis that may be inaccurate and which might, in the future, affect their treatment by another provider, their ability to purchase life insurance, or be granted a security clearance.

HBMA learned at a recent HIMMS meeting that some commercial payors anticipate a minimum of two years, and potentially five years, of this internal mapping will be required to rebuild risk and claims databases. It was also stressed that payment delays, increased denials, increased operational work and costs to practices and the need for practices to have increased cash reserves should be expected. HBMA has been warning of this eventuality for the past two years. However, we do not believe most physicians, providers and their billing companies have planned for two to five years of additional costs, staffing, and operational challenges after the October 2013 implementation date.

As discussed above with 5010, we are also concerned that HIPAA exempt payors will choose not to implement ICD-10. Given current experience, the fact that ICD-9 will not be maintained is not a deterrent. In fact, one might speculate that HIPAA-exempt payors will appreciate that

ICD-9 CM is "frozen," allowing them to streamline their claims process with more stability! Two coding protocols will require maintenance of parallel systems, or the purchase of a new system, that supports both ICD-9 and ICD-10, an additional cost with no end date.

Based on our current experience with 5010, we are very concerned the industry will not be ready for the conversion to ICD-10. Preparation for much of the industry is in the infantile stages or has not begun, no coordinated testing is on the horizon, no payment policies have been announced, variable unknown mapping programs will be relied upon, and no published study has fully examined the financial and payment impact for physicians and no known contingency plans exist. Given the literally hundreds of payors and thousands of plans, this is a monumental undertaking.

We strongly urge CMS and other health plans to clearly publish their policies with respect to the level of coding that will be expected and more importantly – ***reimbursed*** – by the health plans. While some flexibility with the use of the unspecified codes may be necessary in the early stages of the transition, CMS and health plans should seek to ***gradually*** raise the bar in terms of the expectation for accurate coding by the providers and/or their staffs.

While we are obviously concerned about whether these claims will be paid, our larger concern is that the answer to this question will by-and-large dictate the sense of urgency a provider feels in terms of appropriately using the ICD-10 codes. If a provider knows that health plans will continue to process and pay claims using the unspecified codes, then he/she or the provider's staff have little or no incentive to document services more thoroughly or to really learn and apply the specificity available with ICD-10.

Equally important, we lose the one reason for moving to the ICD-10 system – the ability to have greater detail and information about what is occurring in the provider-patient encounter.

In essence, if the current widespread use, acceptance and payment of the unspecified codes allows the provider to be technically compliant with the HIPAA requirements but functionally, continue to use minimum, generic codes, we will have spent millions – possibly billions – to adopt and implement a coding system that in the end, will be no better than the current coding system.

I. DUAL PROCESSING OF CLAIMS

This phrase has two meanings:

a. Dealing with payors that will accept ICD-10 CM or ICD-9 CM, but not both;

b. Dealing with claims submitted to more than one payor for a single service, one that only accepts ICD-10 CM and one that only accepts ICD-9 CM.

NOTE: A variant of this are the so-called "cross-over" claims, where the initial payor – most commonly Medicare – forwards the claim information to a secondary insurer ("Medi-Gap" plans). If Medicare accepts ICD-10 CM codes and passes those code(s) to a secondary insurer that can only process an ICD-9 CM code, chaos will result.

This will mean that providers, vendors, clearinghouses and health plans will need to maintain due capability – submit and process both ICD-10 CM claims, as well as ICD-9 CM claims.

We fully expect that there will be some plans that will be unable to process an ICD-10 claim after the deadline but more importantly, there are some third-party payors who are not subject to the HIPAA standards – most notably, workers compensation, auto insurance and tort liability plans. Therefore, it is inevitable that providers and billing companies will have to maintain both an ICD-9 CM capability as well as an ICD-10 CM capability, for at least a year, and perhaps indefinitely-a significant and costly problem.

Clearly, the Office of E-Health Standards can address the non-compliant health plan concern through their enforcement authority. We intend to work closely with OESS to identify, work with and if necessary, seek penalties against health plans that fail to comply with the HIPAA standards.

The issue of non-covered plans is entirely different. OESS can encourage these plans to become ICD-10 compliant but because they technically have no jurisdiction over these HIPAA exempt plans, there is little they can do from an enforcement standpoint. Clearly the underlying HIPAA law needs to be re-examined and a concerted effort by the provider, vendor, clearinghouse and health plan communities to seek uniform application of the HIPAA standards to all third-party payors.

SUMMARY OF KEY CONCERNS

In conclusion, I want to reiterate HBMA's key concerns:

1. Testing is going too slowly and only focuses on successful claim submission, not complete adjudication, eligibility and benefit verification, claim status, claim query, etc. Providers are overly reliant upon assurances by vendors and clearinghouses to ensure the successful submission of claims post-2011.

2. Providers unaware of and are not taking the necessary steps to monitor and work with their vendors and clearinghouses to ensure that the information on file with their vendors and clearinghouses is up-to-date and consistent with information in the health plans database.

3. The level of testing between health plans and providers, vendors and clearinghouses is severely behind schedule. Testing schedules must accelerate their plans or we will not meet the January 1, 2012 "go-live" date. HBMA also wants to emphasize that we are not in favor of a postponement of the January 1 date; instead, we believe that the industry must intensify its efforts and CMS must become more aggressive in monitoring the industry's progress.

4. Reliance on crosswalks and intermediaries to convert to required standards – 5010 or ICD-10 – will cause unforeseen but predictable problems in payments, resulting in unnecessary delays or inappropriate payments for legitimate services rendered by providers.

5. The convergence and nearly simultaneous need for providers to make numerous technological and administrative changes will place a tremendous financial and human resource burden on providers. Uncertainty about future payments due to projected Medicare cuts causes providers to be reluctant to make the types of financial commitments necessary to comply with the 5010 and ICD-10 standards.

6. The 5010 transition is too often viewed as a technical endeavor; the technical advancement of administrative simplification, a programmers' delight and job security for technicians. It is not. This is about the life-blood of providers – cash flow – and 99% of all efforts should be focused on protecting and sustaining the cash flow of all providers during this transition. Medical practices, in particular, have been beset by a vast array of industry and economic changes that have undermined their income and their ability to sustain their businesses. If the 5010 and/or ICD-10 CM transitions fail them, many will be forced to shun the patients whose insurers are problematic, affecting the individuals our health care system is designed to serve – the patients.

HBMA will continue to aggressively educate our membership – and our members' clients – about the need to engage in testing and updating with vendors and clearinghouses. In addition, we urge CMS and the health plan community to do more outreach with providers educating them on ALL of the steps they must engage in to ensure little to no disruption in claims payments after January 1, 2012.

On behalf of the Healthcare Billing and Management Association, our member companies and the hundreds of thousands of physicians we bill for, I want to thank you for this opportunity to present our views and concerns and I look forward to answering your questions.

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	0	-
11	2	0.1%
10	0	-
9	0	-
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%

LeadingAge Written Testimony to the NCVHS Standards Subcommittee:

Nursing Homes and Home Health Agencies Experience With the Implementation of Version 5010 and ICD-10

LeadingAge appreciates the opportunity to provide written testimony on the experience that LeadingAge members have had thus far with the transition and implementation of the new HIPPA standards and code sets Version 5010 and ICD-10. LeadingAge (www.LeadingAge.org) is an association of 5,500 not-for-profit organizations dedicated to the future of aging services through quality people can trust. We advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age. The members of LeadingAge serve millions of people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. LeadingAge members offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes.

LeadingAge commends the work of the NCVHS Standards Subcommittee to better understand the readiness of the industry and challenges ahead. LeadingAge continues our commitment to provide our members with the latest information and CMS resources on the transition to Version 5010 and ICD-10 through our LeadingAge website, newsletters, list-serves, annual conference sessions, and webinars. LeadingAge is also considering opportunities to partner with leading health information management associations to provide training covering ICD-10 coding. As we continue with these efforts, below are comments based on our members' experience that may help the Subcommittee identify challenges as we approach the final Oct. 1, 2013 implementation deadline.

1. Readiness of LeadingAge members

Many facilities are aware of the ICD-10 and Version 5010, and preparation for the transition is under way. Some have already purchased and used some training resources (ex: ICD-10-CM Mapping, Medicare Correct Coding Guide, ICD-10-CM, the ICD-10 Draft Code Set for 2011, GEMs) and attended webinars on the topic. We are increasingly hearing from members who are in the beginning stages of learning about the new system and the need for training. Many have reported that they will engage in staff training at least 6 months before ICD-10 implementation.

There are, however, a relatively large number of nursing homes and home health agencies members that are less prepared for the implementation of Version 5010 and ICD-10, despite LeadingAge's and the Centers of Medicare and Medicaid Services' (CMS) efforts to raise awareness of the impending compliance deadlines. This may in part be a result of an over-reliance on vendor preparedness and major recent policy changes in the industry's reporting tools, which has in itself consumed most of the facilities' time and resources for training and compliance.

Of those facilities, some do not understand the relevance of the new system or how it could potentially affect their billing and claims processing. As a result, many member facilities have not yet identified staff who would need to be trained or talked to their vendors about their readiness and

implementation plans. Many have just now started internal and external testing of Version 5010 in preparation for the first January 1, 2012 Version 5010 compliance deadline. There seems to be a general misunderstanding that the vendors alone will need to comply with the changes, and despite of some awareness, facilities may be relying too much on vendors to learn and prepare for the transition.

As facilities continue to prepare for implementation, we would like to emphasize the need for additional CMS resources that are more specific to the different provider types. Nursing home and home health providers are finding it challenging to process the information currently available and distinguish what applies to them. In partnership with CMS, LeadingAge has recently given a webinar addressing which nursing home and home health staff will need to be trained and involved in the transition, coding changes as it relates to their particular reporting practices and tools, and other topics specific to these industries. Since then, we have received feedback on the need for more provider-specific resources.

2. Vendor issues

The most notable challenge that LeadingAge members are expressing is the readiness of their software vendors. Most facilities that are aware and making plans to prepare for the transition are waiting for their vendors to roll out the updates, including product installation for internal and external testing of the 5010 version (to be implemented January 1, 2012). In these cases, facilities are not able to test until vendors comply with the first of many recommended compliance dates proposed by CMS (i.e. January 1, 2011 for external Version 5010 testing). Some facilities that are working with their software vendors on the implementation deadlines have reported that only in the beginning of this coming fall will their vendors finalize the groundwork for testing. In addition, there seems to be a lack of communication between vendors and facilities about contingency plans to handle obstacles and delays.

3. LeadingAge training plans

LeadingAge will continue to raise awareness of important implementation dates and CMS resources on a regular basis. We have noticed an increased interest and attentiveness to the topic since we began frequent announcements of CMS and in-house webinars. LeadingAge is committed to improving our messaging and providing regular updates of CMS resources to our membership. We will continue to actively work with CMS on special projects, such as frequent webinars with specific focus on the skilled nursing home and home health industries. We are also working on finalizing plans to partner with health information associations to provide our members with the resources they need to prepare for a successful transition.

Finally, to ensure minimal disruption in claims processing and other potential hold-ups beyond the control of facilities and vendors, it is important to assure that all systems be tested ahead of time and work properly come the October 1, 2013 last compliance date.
We thank you for reaching out to LeadingAge and we look forward to continued discussion in these and future issues to streamline the transition to this new system.

Sincerely,

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National Committee on Vital and Health Statistics
Subcommittee on Standards

HIPAA Standard and Code Sets for X12 Version 5010 and ICD-10

Workers' Compensation

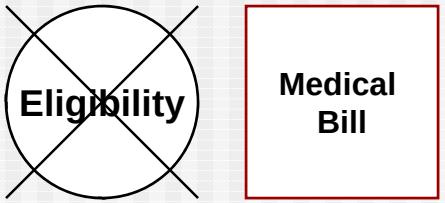
June 17, 2011

Lisa Wichterman

HIPAA X12 Version 5010

MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY

HIPAA X12 Version 5010



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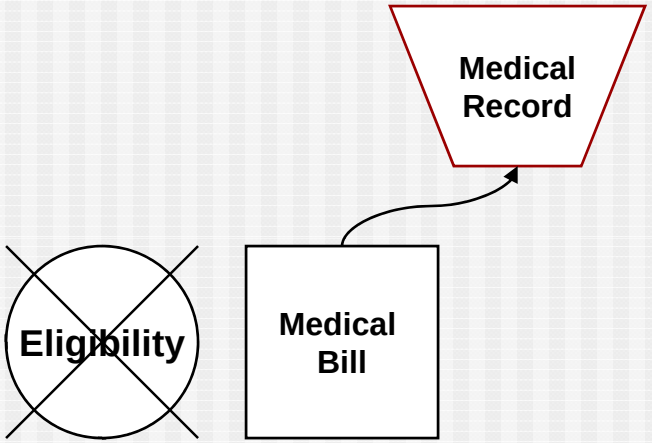
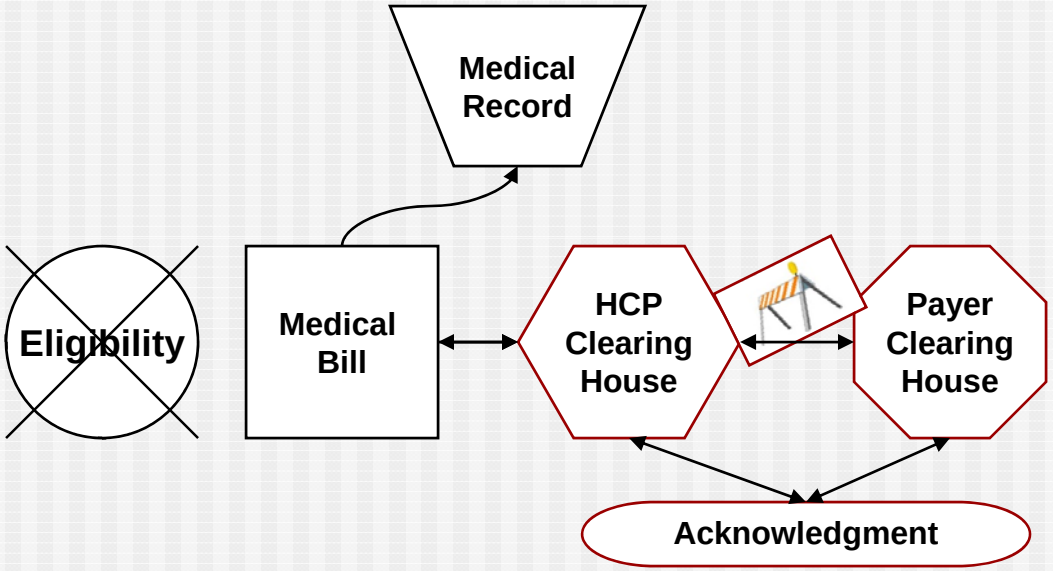
HIPAA X12 Version 5010



MINNESOTA DEPARTMENT OF LABOR & INDUSTRY

HIPAA X12 Version 5010



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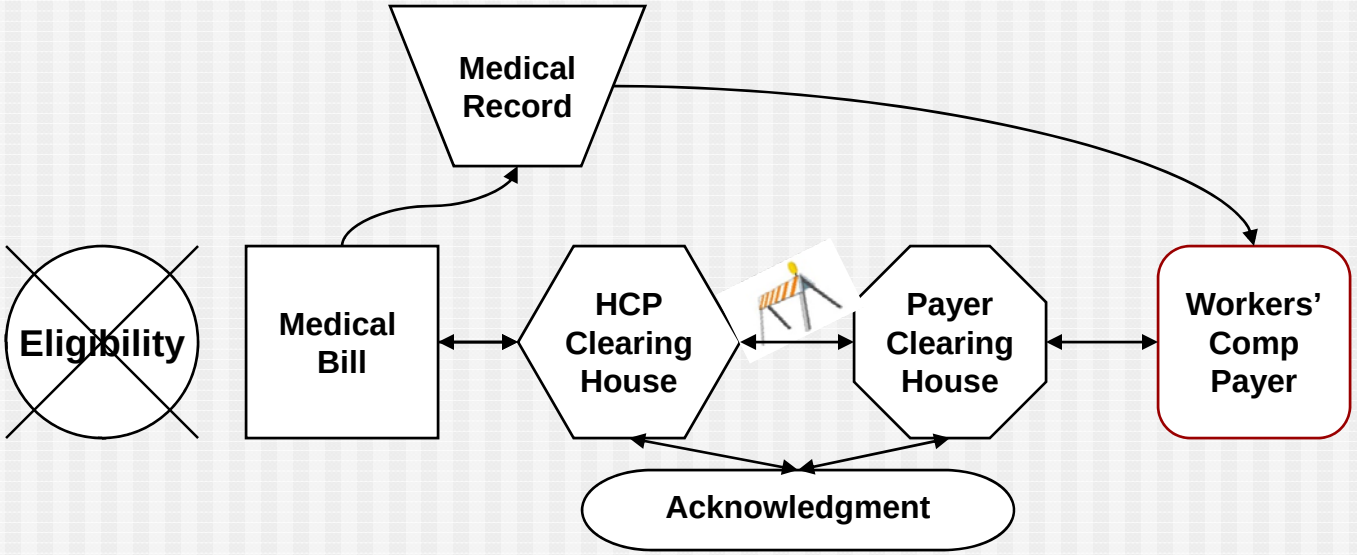
HIPAA X12 Version 5010



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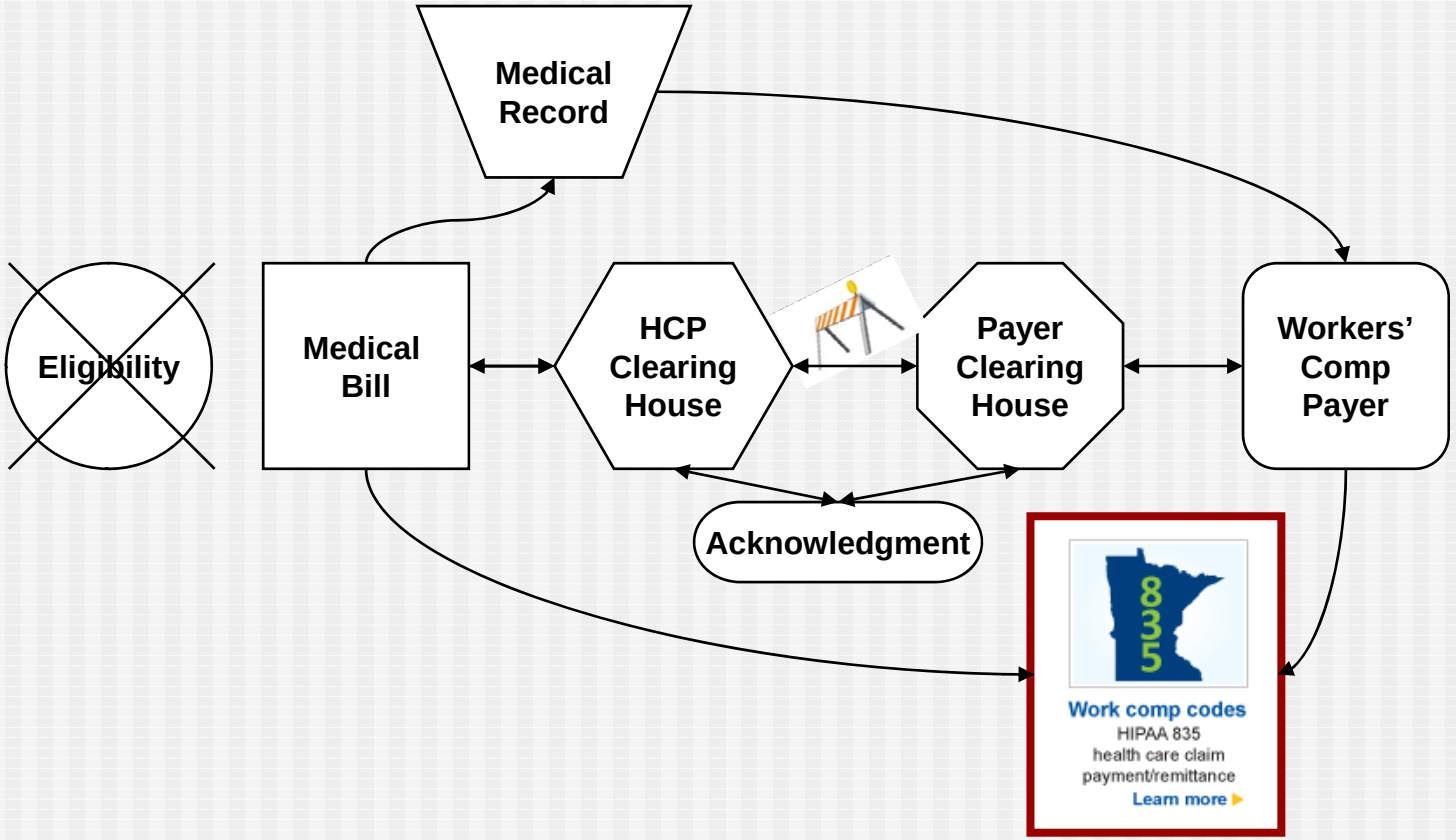

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ICD-10 Assessment and Strategies

- Review existing statutes and rules for ICD-references—fee schedule, treatment parameters, permanent partial disability ratings and forms.
- Changes to statutes or rules must be made
- Mapping – using online sources such as CMS, WHO and AACP translators.
- Health care providers are on track for the 10-1-2013 date.
- Payers are relying on vendors.

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Communication

- Work with associations such as MN AUC, MN Dept of Health, and IAIABC
- E-mail blasts to stakeholders
- Twitter tweets from MN Department of Labor and Industry
- Providing updates at industry meetings

MINNESOTA DEPARTMENT OF LABOR & INDUSTRY


American Insurance Association

American Insurance Association Presentation to National Committee on Vital and Health Statistics

Subcommittee on Standards
June 17, 2011

American Insurance Association

American Insurance Association

- AIA is the leading property/casualty insurance trade organization, representing approximately 300 insurers that write nearly $100 billion in premiums each year. AIA member companies offer all types of property/casualty insurance, including personal and commercial auto insurance, commercial property and liability coverage for businesses, workers' compensation, homeowners' insurance, medical liability coverage and product liability insurance.

American Insurance Association

- Historically property/casualty (p/c) insurance has been regulated on a state-by-state basis. However, ever increasing federal initiatives continue to raise issues for carriers. Having a staff based in Washington, D.C., the AIA is especially well positioned to tackle any federal issues facing insurers and deal with federal government agencies.

American Insurance Association

Summary

- Until enactment of Section 111 of the SCHIPS extension bill of 2007, the p/c industry did not have any reason to collect ICD-9 codes in their claims systems.
- At that time, the p/c industry was required to begin to report claims information to Medicare (CMS) under the Medicare Secondary Payer Act.
- We are the recipients, not the creators of the correct determination of an ICD-9 or ICD-10 code.

American Insurance Association

P/C Claims

- P/C insurers pay claims for injuries sustained on the job (workers' compensation) and as the result of an accident (personal & commercial).
- For p/c insurers a single bill from a provider does not constitute a claim. A claim is the collection of all bills arising from the same event.
- A p/c claim may involve multiple parties from a single incident, therefore the claims files can be quite large.
- The p/c industry processes over 40 million claims a year. The exact number is unknown since no single data base exists.

American Insurance Association

History of use of ICD codes by P/C Insurers

- The p/c insurance industry never captured ICD-9 codes except in some medical bill re-pricing systems used in workers' compensation and no-fault insurance by the largest carriers.
- These codes were not relevant to the industry's claim process.
- Therefore the basic p/c claim systems record layouts were never designed to capture ICD-9 codes, let alone ICD-10 codes or multiple codes.

American Insurance Association

History (cont'd)

- The passage of the MMSEA Section 111 reporting requirements in late 2007 set up a reporting system for the p/c industry to collect and report claims data to Medicare (CMS).
- One of the 170+ fields in the record layout is for ICD codes.
- Initially they are CMS' approved ICD-9 codes.

American Insurance Association

Reporting of ICD-9 Codes under Section 111

- P/C industry only began reporting for workers' compensation and claims under CMS' no-fault definition as of January 1, 2011.
- We are finding that most of the reporting errors are stemming from the rejection of files for incorrect ICD-9 codes.
- The industry thought that these claims would have the most reliable ICD-9 information as we pay the providers directly.
- However, when checking on these errors we have found that the ICD-9 code submitted is what was received from the vendor of the service or the bill re-pricing system, but is rejected by CMS.

American Insurance Association

Reporting Penalties

- Under MMSEA Section 111 reporting requirements, p/c insurers are subject to very onerous fines -- $1,000/day/claim for reporting errors.
- Since we only report once a quarter, this could establish a base fine for a single claim of $90,000.
- Therefore, a major issue we face is getting correct ICD-9 information.

American Insurance Association

Conversion to the use of ICD-10 codes

- Extensive programming of p/c insurers claims systems was required in order to comply with Section 111 reporting.
- The record layout allows for use of ICD-10 codes, therefore much of the programming has been done except for liability claims that will not be reported until January 1, 2012.

American Insurance Association

Issues facing the p/c industry in using ICD-10 codes

- The collection of ICD-10 codes for reporting purposes is only as good as the data received.
- Presents particular problems when dealing with liability claims.
- Liability insurance provides protection from claims arising from injuries or damage to other people or property.
- A liability claim is when an entity or person claims another has breached a duty owed under a regulation, administrative, common or statutory law.

American Insurance Association

Issues (cont'd)

- The person or entity the p/c insurer is dealing with is usually not their customer and has no prior relationship with the insurer.
- One concern with the change to ICD-10 codes is the receipt of medical information in claims without any codes which is common on third-party liability claims.
- In many p/c claims, the insurer only receives the medical reports.

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Issues (cont'd)

- This will require p/c insurers to determine the codes themselves, outsource the function, or include it in certain medical bill re-pricing contracts, all of which will increase costs.
- Determination of correct ICD-10 codes, which will be more difficult than we are now facing with ICD-9 codes, is of significance because the reason we are collecting ICD-10 codes is to comply with the Section 111 reporting requirements.

American Insurance Association

Conclusion

- The p/c insurance industry has not had any reason to collect ICD-9 codes until we were required to collect them for Section 111 reporting purposes.
- Transitioning to ICD-10 codes will be problematic for the industry because:
  - Requires providers of services to correctly code the medical reports.
  - May require p/c insurers to “code” injuries/procedures from medical reports that do not include codes.
  - Exposure to large fines if incorrectly reported.

American Insurance Association

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American Insurance Association

INDUSTRY IMPLEMENTATION of ICD-10

WEDI Testimony to NCVHS Subcommittee on Standards June 17, 2011

Presented by
Jim Daley
BlueCross BlueShield of South Carolina
WEDI Chair-elect
Co-chair, WEDI ICD-10 Work Group

wedi™
Partnering for Electronic Delivery of Information in Healthcare

What is WEDI?

- Workgroup for Electronic Data Interchange
  - Established 1993
  - Named advisor to HHS under HIPAA
  - Represents broad cross-section of healthcare industry
  - Objective collaborative approach to addressing issues

WEDI ICD-10 Surveys

- Four ICD-10 readiness surveys
- Survey respondents:

SURVEY	Vendor/CH	Health Plan	Provider
November 2009	72	102	187
January 2010	37	87	41
June 2010	23	66	61
January 2011	16	72	27

WEDI Surveys (continued)

- Survey results
  - November 2009 high-level
    - Work beginning but slow
    - Other initiatives delaying efforts
    - Vendor products – half in 2010/2011; half in 2012/2013
  - January 2010
    - Little progress – understandable
    - Vendor products – 20% in 2010/2011; 80% in 2012/2013
    - Executives aware of ICD-10

WEDI Surveys (continued)

- Survey results (continued)
  - June 2010
    - Slight progress
    - Impact assessments not completed
    - Shift toward native ICD-10 processing
    - Communication limited, but starting
    - Providers concerned about health plans; health plans concerned about providers
  - January 2011
    - Making progress on impact assessments
    - Vendor product test and delivery dates unclear
    - Communication increasing slowly

WEDI-NCHICA Timeline Comparison

REVISED TIMELINE PROJECTIONS

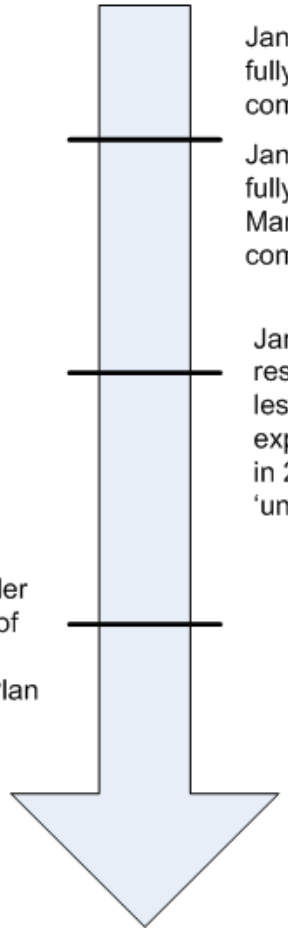
January 2011: Health Plan Assessment Completion

January 2011: Provider High-level Assessment Completion

October 2011: Vendor product customer review and beta testing begins

January 2012 – January 2013: Provider and Health Plan Deployment/Testing of Vendor Software

January 2013: Provider and Health Plan Internal Testing Completion



SURVEY RESPONSES

January 2011: About one third of health plans were fully complete, one fifth were three quarters complete, and one fifth were 25% or less complete.

January 2011: Almost one half of providers were fully complete or would finish assessment by end of March, most of remaining providers expect completion by December 2011.

January 2011: About two thirds of vendors responded that they hadn't started or were 25% or less complete with solution development. One fifth expected to begin customer review and beta testing in 2011, one half in 2012 and almost one third replied 'unknown.'

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WEDI Survey Interpretation

- High awareness, slow progress
- Falling behind revised timeline
- Communication growing
- Test and delivery dates unclear
- Some products won't support both code sets

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Considerations and Concerns

- Competing priorities
- Vendor product delivery
- Understanding impacts
- Testing
- Health plan / provider communication
- GEM usage
- Post-implementation monitoring

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Suggested Industry Actions

- Continue outreach / education
- Continue surveys
- Understand impacts of work delays
- Encourage collaboration
- Emphasize compliance date
- Publicize available resources
- Understand crosswalking and GEM's
- Develop testing process
- Clarify 'dual processing'
- Consider risks
- Resolve outstanding questions

Closing

- Thank you for the opportunity to testify
- WEDI offers our support
- WEDI web site: www.wedi.org
- My contact info: jim.daley@bcbssc.com