5010 – State of the Industry Lessons Learned

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About Emdeon

Simplifying the Business of Healthcare

Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. Emdeon’s offerings integrate and automate key business and administrative functions of its payer and provider customers throughout the patient encounter. Through the use of Emdeon’s comprehensive suite of solutions, which are designed to easily integrate with existing technology infrastructures, customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle and clinical information exchange processes.

Industry Leadership

Emdeon has connections to more payers, providers and vendors than any other healthcare business in the marketplace. Emdeon understands how to deliver solutions that best impact the flow of information for all parties to increase efficiency and maximize profitability. By connecting information intelligently and making key administrative processes easier, Emdeon simplifies the business of healthcare for everyone.

Emdeon’s network encompasses:
- 340,000 providers
- 1,200 government and commercial payers
- 5,000 hospitals
- 81,000 dentists
- 60,000 pharmacies
- 600 vendor partners
Emdeon

1,030,301,209 CLAIMS
- 4,483 Payer IDs
  - Institutional 1,824
  - Professional 2,659
- 296 Channel partners/vendors submitting claims
- 1,768,906 Provider sites submitting claims (distinct Tax/Site IDs, including dental)

383,473,597 PAYMENT ADVICE
- 440 Payer IDs sending ERAs
- 68,976 Provider TINs receiving ERAs

732,597,440 Real-Time Transactions
- 456 Payers
- 697,566,258 Eligibility inquiry transactions
- 43,704,982 Claim status inquiry transactions
- 463,212 Health services review transactions

Agenda

- Overview of Transaction Modification Final Rule
- State of the Industry
- Lessons Learned
HHS Guidance/Compliance Timeline

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Milestone</th>
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<tbody>
<tr>
<td>Jan 2009</td>
<td>Begin Level 1 activities (Gap analysis, design, and development, for 5010 &amp; D.0)</td>
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<td>Jan 2010</td>
<td>Begin internal testing for Versions 5010 &amp; D.0</td>
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<td>Dec 2010</td>
<td>Achieve Level 1 compliance (Covered entities have completed internal testing and can send and receive compliant transactions in 5010 and D.0)</td>
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| Jan 2011    | - Begin Level 2 testing period activities (external testing with Trading Partners and move into production; dual 4010A/5010 processing mode)  
- Begin initial ICD-10 compliance activities (Gap analysis, design, and development) |
| Jan 1, 2012 | 5010/D.0 Compliance Date for all covered entities. |
| March 31, 2012 | CMS extended the enforcement date of 5010 |
| July 1, 2012 | CMS ended the extension |
| Oct 1, 2013 | The Compliance date for ICD-10-CM and ICD-10-PCS is October 1, 2013 for all covered entities. |

Emdeon’s View as of July 1, 2012
By Transaction Type

- **Inbound Claims**
  - 91% of inbound claims by volume were received in the 5010 format.
  - 82% of submitter organizations by count sent claims in the 5010 format.

- **Outbound Claims**
  - 96% of outbound claims by volume were sent in the 5010 format.
  - 64% of receiver LOBs by count received claims in the 5010 format.

- **ERA**
  - 72% of remits by volume were received in the 5010 format.
  - 67% of remits by LOB count were received in the 5010 format.

- **Real-time**
  - 94% of overall real-time payer volume was sent in the 5010 format.
  - 62% of real-time payer LOBs by count received real-time transactions in the 5010 format.
Emdeon’s View as of July 1, 2012
By Payer Model

- **Medicare:**
  - P&I claim LOBs 100%
  - Eligibility 100%
  - ERA 68% LOBs fully completed, 32% partially completed.
- **Medicaid:**
  - P&I claim LOBs – 94% of volume, 96% by LOB count completed.
  - ERA – 86% by volume, 79% by LOB count.
- **BCBS:**
  - P&I claim LOBs 100%
  - ERA – 43% by volume, 23% by LOB count.
- **Commercial:**
  - P&I claim LOBs – 94% of volume, 62% by LOB count
  - ERA – 74% by volume, 46% by LOB count.

wedionline.org

WEDI Collaborated with Centers for Medicare & Medicaid Services (CMS) and Other Industry Partners to Launch Education Initiative on ASC X12 5010 Issues
Claims Issues

- **NPI Compliance**
  - Address can no longer be a PO Box
- **Zip Code must be 9 digits**
  - Billing Provider/Service Facility
- **Rules Changes**
  - Release of Information Code
  - Medicare Accepts Assignment Indicator
  - Principal/Other Procedure Codes
  - Diagnosis Code Changes
  - AMT Segments

Payment Advice Issues

- **Testing is smoother and less disruptive than claims – shorter testing cycle**
- **Balancing the transaction is critical as it feeds the COB Claims that must be balanced.**
- **TAX ID is required on Payment Advice except for Pharmacy claims.**
Real-Time Issues

- NPI on the 270 Eligibility Request and 276 Claim Status Request for the first time causing some confusion
- Some payers still not supporting Service Types
- Each payer has a different transition approach

Industry Perspective

On June 20, 2012 NCVHS held hearing on Standards

- Need for Transition Period
- One Thing at a time
- Policy Changes
- Acknowledgments
- Issues with MACs
- Industry Calls
Need for Transition Period

- **Asynchronous implementation**
  - Large providers and health plans ready early
  - Smaller providers rely on vendors and are often late in the game
- **Difficulties**
  - New, modified or deleted elements/codes
- **Clearinghouses account for ~50% of the healthcare transactions**
  - Challenges with upward/downward compatibility

Direct Submission/Dual Path

- Both submitter and receiver keep both versions running
- Submitter must know which version the receiver is on
Intermediary Submission

- Submitter sends only one version – old or new
- Clearinghouse up/down converts based on health plan
- Health Plan receives only one version – old or new
- Allows for asynchronous implementation

Recommendation

- Allow for a staggered approach
- SDO’s consider date driven changes to help with the transition
  - New content/codes would state “required on or after the compliance date of this TR3 when…”
  - Deleted content/codes “required prior to the compliance date of this TR3, if not required do not send”
- Translator products should build the edits using the dates to avoid early rejections
- This concept is under consideration with ASC X12N Management
One thing at a time

- **Formatting** – ensure that the files are syntactically correct and that content is placed in the transaction according to the implementation guidelines.
- **Content** – based on business needs, ensure that new content and codes are supported in the application systems and placed according to the implementation guidelines.
- **Edits/Logic** - as the industry moved closer to the compliance date, trading partners began to enforce rules to align with the requirements outlined in the implementation guidelines. In many cases, edits were based on business needs rather than strict enforcement.

Recommendation

*Establish milestones for new initiatives that allow the industry to stagger the implementation over a transition period focusing on one piece of the project at time.*

1. Focus first on syntax – did you get it right
2. Next focus on rules for existing content – experience shows not all products are equal
3. Finally focus on the new content when business use is applicable – not all content is needed by all users
Policy Changes

Policy Changes happen between versions

- NPI and Privacy regulations came out between 4010 and 5010 but TR3’s were not modified to support the regulations
- State regulations occur on a different schedule requiring work-arounds in some cases
- Health Plan policies change over time to support their customer needs

Recommendation

Coordinate the policy changes and standards to avoid confusion

1. Update implementation guides at the same time as the policy changes whenever possible
2. Avoid confusion on whether to follow policy change or the implementation guide
3. About to see this again with HPID
Acknowledgments

Acknowledgments were new to many with 5010

- Inconsistent use of 999 vs. 277CA
- Were not planned as part of the testing cycle for change
- Vendors were not consistent in the way the implemented

Recommendation

To avoid delays in future releases a consistent approach to acknowledgements is needed:

1. Adopt a standard approach to acknowledgments
2. Consider translator products in the certification rule
3. Provide guidance on the need for including testing of the acknowledgements as part of any transactions implementation
Testing Day/Week

*Provided important feedback.*

*Required tremendous amount of prep time to get ready:*
  - Provider approval (two weeks)
  - Added to staff duties
  - On top of current testing schedule

*No true end-to-end Testing with payers.*

*Recommendation:*
  - Longer testing window needed

Issues with MACs

*There were inconsistencies with MAC’s:*
  - Some accepting dual versions of 4010/5010, some not;
  - Some accepting only 4010 or 5010;
  - Different acceptance date;

*Inconsistent enrollment requirements:*
  - PTAN number.
Recommendation

Work with the Centers for Medicare and Medicaid to provide more consistent approach to testing

1. Medicare Fee-for-Service should do more to manage the MACs.
2. CMS/OESS and the Central Medicaid Office should do more to manage the state Medicaid agencies and more quickly address issues that were identified with the states and hold them accountable for non-compliance.
3. Establishing better communications with trading partners in providing their acknowledgement of the issue, timeline for resolution as well as any interim work arounds if available until the issue is resolved.
4. Clearinghouses are willing to work on a manageable escalation process.

Questions