Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

REGARDING: ICD-10 Implementation Beyond Covered Entities

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Sub-workgroup

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Members of the Subcommittee, I am Sherry Wilson, Co-Chair of the Property and Casualty Electronic Medical Bill (eBill) Sub-workgroup for the Workgroup for Electronic Data Interchange (WEDI) and the Executive Vice President/Chief Compliance Officer of Jopari Solutions. With me today, is Tina Greene, who is also a Co-Chair of the sub-workgroup along with Tammy Banks, Optum Cloud. Tina Greene is the Senior Regulatory Affairs Consultant with Mitchell International. We would like to thank you for the opportunity to present testimony today on behalf of WEDI concerning the matter of ICD-10 Implementations Beyond Covered Entities.

WEDI represents a broad industry perspective of providers, clearinghouses, payers, vendors and other public and private organizations that partner together to collaborate on industry issues. WEDI is named as an advisor to HHS under the HIPAA regulation and we take an objective approach to resolving issues.

This testimony will respond to the following two questions:

- What is the current status of P&C ICD-10 state readiness?
- What are the key issues with non-covered entities not adopting ICD-10 after October 1, 2014?

Background

The Patient Protection and Affordable Care Act (PPACA) of 2010, in addition to the 1996 Health Insurance Portability and Accountability Act (HIPAA), have been the major drivers in establishing requirements for effectively exchanging medical information through standardized electronic transactions and reducing administrative costs for all stakeholders. Under the HIPAA regulations, the Property and Casualty (P&C) industry has been exempt from these mandates as they are governed by state law rather than federal HIPAA regulations. However, more and more states are adopting Electronic Data Interchange by enacting electronic medical billing (eBilling) and payment requirements in their regulations that align with the HIPAA standard transactions and operating rules, as appropriate, to gain the benefits of administration simplification and stakeholder adoption realized by commercial and governmental payers.

WEDI has worked collaboratively with the International Association of Industrial Accidents Boards and Commissions (IAIABC) other National Standard Organizations (ASCX12, CAQH CORE, and NCPDP), additional Designated Standards Maintenance Organizations (NUCC, NUBC), the American Medical Association and the states adopting eBilling to address and resolve P&C-specific business needs.

This collaborative effort led to the formation of the WEDI P&C Electronic Medical Bill (eBill) subworkgroup (SWG) in 2008 that was renamed the WEDI P&C eBilling SWG. This SWG continues to be made up of stakeholder representatives from numerous state workers' compensation agencies, P&C payers, providers, clearinghouses and vendors

The purpose of the SWG is to collaborate with the P&C stakeholders to review and propose implementation strategies and solutions to meet the requirements of the states as regulations are passed regarding Electronic Data Interchange (EDI) or electronic billing.

The goal of the SWG is to work toward a national implementation model that facilitates successful implementation within the framework of the HIPAA transactions and code sets where possible and to reduce the administrative impact to participating stakeholders.

At the May 2008 WEDI Annual Conference, the SWG presented a P&C eBilling national implementation model based on the HIPAA transaction and code set rule that allows for state-based P&C exceptions. This national implementation model included the use of ICD-9-CM.

The P&C industry realizes that the adoption of national standard transactions across all lines of health care will increase adoption and enable all stakeholders to realize the benefits of administrative simplification. That is why the P&C industry is increasingly aligning with the national standards while taking into account state-specific requirements as it is the only way for HIPAA Covered and Non-Covered entities (Industry) to gain administrative simplification efficiencies and increase stakeholder adoption that was intended to be delivered by HIPAA and the PPACA.

This is evident by the 19 states that have adopted ICD-10 to align with the federally mandated deadline of October 1, 2014, showing it is possible for this industry to adopt ICD-10. Additional outreach is imperative for the 31 remaining states to raise awareness of the effect of not moving to ICD-10.

HIPAA covered and non-covered industry differences

While the P&C industry is increasingly aligning with HIPAA Transaction and Code Set (TCS) rule, there are differences that need to be recognized: Property & Casualty industry is:

- Exempt from the HIPAA regulations
- Governed by state law rather than federal regulations
- Required to follow rule making requirements, as appropriate, in order to adoption new code sets, such as ICD10.

These differences result in state-specific requirements, making it difficult for national/regional payers, providers, vendors and others to comply with these varying regulations.

HIPAA covered and non-covered industry similarities:

- Many Providers are the **same** providers that process government and commercial claims today leading to increased provider adoption of electronic billing. This isn't limited to just providers, as many payers and vendors process and/or pay P&C claims as well as government and commercial claims.
- Collaborates with the national standard setting organizations to accommodate specific industry business needs.
- Property and casualty uses the **same HIPAA standard transaction sets that** are used for government and or commercial claims processing. These transaction sets include the HIPAA claims, electronic remittance advice and electronic funds transfer standard transactions, code sets, as well as the ASC X12 acknowledgements and attachments.
- Many states are enacting regulations like eBill to align with HIPAA standard transactions, code sets and operating rules to gain administrative simplification cost savings and efficiencies.

What is the current state of adoption of ICD-10 by property/casualty carriers and other HIPAA non-covered entities?

In an effort to access the ICD-10 state of readiness and potential impact to P&C stakeholders, the IAIABC has conducted annual surveys of state workers' compensation agencies. The 2013 results were updated with the 2014 responses (as of 2/13/14[1]). The IAIABC surveys only looked at how state workers' compensation agencies are planning for the transition to ICD-10. 21 states responded, revealing the following results (answered more than one question).

- 1 State was not aware of the ICD-10 October 1, 2014 Effective Date
- 7 states have not formally evaluated how this transition will impact their workers' compensation agency.
- 4 states indicated that they had not evaluated how ICD-10 would impact their Administrative Rules.
- 12 states reported there was no engagement with stakeholders ICD-10 discussions

As of February 1, 2014, confirmed through the 2014 IAIABC survey results collected as of 2/13/14 and the review of published information on the hyperlinked state websites the Department of Labor as well as the following 19 states have aligned and/or are aligning

[1] Note all of the 2014 survey responses have not yet been collected.

ICD-10 with the CMS October 1, 2014 effective date:

California	Colorado	Florida	Georgia
Idaho	Illinois	Louisiana	Michigan
Maryland	Minnesota	New Mexico[2]	New York[3]
North Carolina	Ohio*	Oregon	South Dakota
Tennessee	Texas	Washington	

Source: IAIABC Survey 2014 (as of 2/13/14) and the review of published information on the listed state websites. Reprinted with permission.
* Monopolistic State: The state government provides the workers compensation insurance through a state insurance fund.

There is an industry need to better understand the remaining states' plans to continue with ICD-9 or move to ICD-10. This leaves less than eight months for effective transition planning, especially since stakeholders will either need to transition fully to ICD-10 or to reporting of both ICD-9 and ICD-10 in order to comply with federal and state requirements simultaneously.

What are the key benefits when non-covered entities adopt ICD-10 after October 1, 2014?

As we mentioned previously, 19 states have aligned with the ICD-10 mandate. There are several reasons why states should align P&C with this mandate and most significantly, the adoption of national standard transactions across all lines of business will enable all stakeholders to realize the benefits of administrative simplification. Some of these benefits include:

- Eliminates conflicting diagnosis and procedure coding requirements;
- Eliminates the need to maintain and store two different code sets by all stakeholders;
- Aligns with the national standard implementation approach adopted by states that have enacted eBilling regulations;
- Allows for much greater specificity and accuracy in diagnosis;
- Data standardization enables the ability to compare data within and across industries—providing quality and efficiency measurements that may lead to higher quality medical care;
- Decrease administrative costs;
- Streamline patient care;
- Gain administrative simplification efficiencies; and

[2] State Web site: http://www.nmcpr.state.nm.us/nmac/parts/title11/11.004.0007.htm
[3] State Web site: http://www.wcb.ny.gov/content/main/SubjectNos/sn046_560.jsp

- Increase stakeholder adoption.

What are the key issues with non-covered entities not adopting ICD-10 after October 1, 2014?

State requirements

The federal ICD-10 mandate requiring virtually all hospitals, physician practices, and other healthcare providers to start using ICD-10 diagnosis (and inpatient procedure) codes in place of the ICD-9 codes has been a debated issue within the property and casualty industry, since the final rule was released. Unless states transition property and casualty to ICD-10, providers, payers, and vendors will be required to meet two sets of conflicting standards after October 1, 2014.

For example, providers have raised concerns that ICD-10 coding is intrinsic to clinical documentation and administrative reporting processes, and systems are not designed to capture and maintain both ICD-9 and ICD-10 versions simultaneously. The result could be catastrophic and cause a significant increase in manual effort and re-work to process property and casualty bills, if both ICD-9 and ICD-10 coded bills are required to be submitted after October 1, 2014. As providers are required to transition to ICD-10, they are raising important concerns that their states' legacy ICD-9 coding requirements, applicable to property and casualty payers, will impose unnecessary burdens, costs, and possible delays or compromises of patient care.

Federal requirements

Additionally, Property and Casualty payers (and other non-group health plans) have been reporting to CMS for the Medicare's Mandatory Insurer Reporting for Non Group Health Plans contain reporting requirements [4] for claims that may have impacted Medicare beneficiaries. This reporting requirement was recently updated to adopt ICD-10 for claims paid after October 1, 2014, with such reporting made mandatory as of April 1, 2015.

ICD-9 codes cannot readily be converted to ICD-10; the only way to ensure clinically defensible reporting will be for the payers to capture the diagnoses created at the point of care. As of October 1, 2014, these diagnoses will be recorded in ICD-10.

State action is required, otherwise hospitals and physician practices will be faced with conflicting requirements to report both ICD-9 and ICD-10 on different types of bills.

1http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/New-Downloads/Alert-%E2%80%93-Testing-ICD-10-CM-Diagnosis-Codes.pdf,

Payers will be forced to use one set of codes to satisfy state billing requirements and a different set of codes to meet federal reporting requirements.

While there are many issues with non-covered entities not adopting ICD-10, the two mandatory reporting requirements are the most significant as they will require many stakeholders to perform dual processing - report, store and respond with both ICD-9 and ICD-10 code sets on transactions. This may be the perfect storm that will negate all the positive movement toward electronic billing and bring the industry back to the labor-ridden, manual process of the past.

In summary, Potential non-alignment of state and federal mandates will have a significant impact on the industry at large. Unless states transition, P&C (workers' compensation and auto) to ICD-10, all stakeholders will be required to meet two sets of conflicting standards after October 1, 2014.

- Some systems may not be designed to capture and maintain both ICD-9 and ICD-10 versions simultaneously.
- Medicare's Mandatory Insurer Reporting for Non Group- Health that requires Non-Group Health to report ICD-10 on claims paid after October 1, 2014, with such reporting made mandatory as of April 1, 2015 may conflict with state reporting requirements.
- Only way for stakeholders to remain compliant with state and federal requirements is dual processing that may lead to dropping bills and claims to paper.

<u>Impact on injured workers</u>

The greatest impact that needs to be considered and addressed is the negative impact to the injured workers and the potential for reduced provider participation to care for these injured workers. This could result in additional burdens to the already injured worker that may include:

- longer drives to see a physicians
- longer wait time for authorizations
- longer lost time from work

Unknown ICD-10 Readiness: Stakeholder Contingency Impacts

There remain numerous unanswered questions that stakeholders need to adequately prepare for a transition to ICD-10. States that are not ICD-10 ready result in the lack of continuity and impact stakeholders' contingency plans. Many states have not yet widely

distributed this critical information to their stakeholders. Some of these questions that need answers are listed below:

- Will a state require new rule making to adopt ICD-10?
    - If so, what is the expected timeline and **state contingency plan** to assist stakeholders in **maintaining business continuity** during this transition period?
- If ICD-10 is not adopted, what is the state's stakeholder contingency plan for business continuity?
- If ICD-10 is adopted, what is the state's contingency plan for stakeholders that will not be ICD-10 ready?
    - Will stakeholders be allowed to process ICD-9 during the transition period and still be compliant?
- Will states align with the CMS requirement to split bills that span the ICD-10 implementation date?
- Will states include regulatory language that will allow bills submitted after 10-1-2014 that includes dates of service prior to the 10-1-2014 ICD-10 federal effective date to contain ICD-9 codes?
- Will states ICD-10 rules have a specified cutoff date for ICD-9?
- Will state rules include the adopting the Version 1.1 06/13 02/12 1500 CMS 1500 paper form to accommodate the reporting of ICD-10?

WEDI P&C ICD-10 Education State Awareness Outreach Initiative

Most recently, WEDI has written a letter that includes ICD-10 survey questions to send to the state Workers' Compensation Insurance Commissioners and the Department of Insurance (auto) to escalate ICD-10 awareness that is under review.

Upon WEDI approval, the results of the ICD-10 state readiness survey will be posted on the WEDI website that will serve as an industry ICD-10 central repository resource tool.

States will be encouraged to use this tool as an additional stakeholder ICD-10 communication vehicle to provide educational support for their regional and national stakeholders.

WEDI has **waived membership fees for states** in an effort to collaborate with the states to provide industry support and resources to enable the transition from paper bills

to eBills to align with the HIPAA standard transactions and code sets and operating rules, as appropriate.

CONCLUSION

Property and Casualty eBilling has been around for a number of years and provides providers one automated workflow for all lines of business, since eBilling utilizes the same electronic transactions used in the governmental and commercial claims submission, processing and reconciliation. This process has been proven to increase efficiency and reduce costs for all partners in the eBill process. Since practice management systems are currently non-covered HIPAA entities, they do not have a mandate to be a partner in ensuring providers send and receive the ICD-9 and/or ICD-10 information that is mandated to be sent from commercial and governmental payers, let alone store both ICD-9 and ICD-10 codes. While workers' compensation payers are not covered entities or subject to the HIPAA transaction and code set rule, this is also a real issue to address that impacts all stakeholders, both HIPAA covered and non-covered entities.

WEDI urges the NCVHS Subcommittee on Standards to recommend to the Secretary of HHS to:

- Partner with WEDI to **assess the status of the state's ICD-10 readiness** in order to help all stakeholders determine an appropriate contingency action plan to comply with both state and federal implementation timelines.
- To make a **strong statement to the states regarding the urgency to the industry at large to move to ICD-10**, regardless if organizations are HIPAA covered entities. Ensuring that all entities are implementing ICD-10 will help further industry's movement towards streamlining and automating end-to-end workflow process in order to improve efficiency and lower cost for all stakeholders.

WEDI's strength is bringing together all types of stakeholders to discuss opportunities and challenges in an open and collaborative environment on issues that truly need to be addressed. We look forward to the opportunity to be able to share the Property and Casualty Industry concerns regarding emerging regulations in the future. WEDI in its advisory role offers our support to the Secretary of HHS stands ready to assist in look forward to partner with HHS achieve these goals and stands ready to assist as needed.

Members of the Subcommittee, we thank you for the opportunity to testify.