



NCHICA Comments on NPRM for 5010

The North Carolina Healthcare Information and Communications Alliance, Inc (NCHICA) is submitting the comments contained in this document on 45 CFR Part 162 *Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule*. NCHICA is a nonprofit consortium of nearly 200 organizations dedicated to improving health and care by accelerating the adoption of information technology and enabling policies. These comments were prepared by the NCHICA HIPAA Transactions, Code Sets and Identifiers (TCI) Workgroup and approved by the NCHICA Board of Directors. The workgroup is represented by health care providers, health plans and software vendors who support North Carolina covered entities.

Support for 5010. The NCHICA Transactions, Code Sets and Identifiers Workgroup supports the naming of the 5010 version of the ASC X12 transactions as the next HIPAA version. We see both technical and business benefits in moving forward with 5010:

- Tightened, clear situational rules reduce analysis time for everyone and the need for companion guides
- Improved eligibility responses and better search options improve efficiency for providers and reduced phone calls for both providers and payers
- Detailed clarifications of commonly misunderstood areas such as corrections and reversals, refund processing, and recoupments should result in a consistent implementation of the 835, which is not the case today. Incorrect implementations of the 835 have prevented providers from switching to electronic posting as widely as they might otherwise. Good 835s would reduce phone calls to payers, reduce appeals to payers due to more complete information, eliminate unnecessary customer support, and reduce the cost of sending and processing paper remittances.
- The greatly improved 278 referral and authorization transaction is expected to encourage wider implementation and save labor costs

However, we recommend the following modifications to the NPRM concerning implementation.

1. **Start of implementation period.** The implementation period needs to start with the effective date of the final rule for the following reasons:
 - Organizations need time to budget
 - Only high-level analysis was done during the NPRM comment period, not detailed systems analysis
 - Vendors want assurance that this is the version that will be implemented

2. **Staggering of compliance dates for HIT initiatives.** We support the staggering of compliance dates for 5010/D.0, claims attachments and ICD-10, but we strongly recommend longer implementation periods. The proposed compliance date is not reasonable. Instead, we support the NCVHS proposal of 2 years to get to Level 1 Compliancy (ready to test with trading partners) followed by a transition period. Discussion at the WEDI PAG offered 1 year as a transition period, making a total of 3 years, which we find reasonable. The healthcare industry cannot be ready for full compliance by April 1, 2010 for the following reasons:
- It is apparent that the timeline was based on HHS budgets and initiatives without taking the industry as a whole into consideration. Medicare has already been working on the 5010 project (budgeting, planning, detailed analysis) for more than a year. The rest of the industry has not started, other than high-level analysis for making comments.
 - It is unrealistic to begin the implementation period prior to publication of the final rule.
 - It took 4 years to implement 4010 and another 4 years to implement NPI, but in truth, neither is fully implemented within the healthcare industry.
 - It is true that the industry has more experience with HIPAA transactions now, but the success of HIPAA has resulted in more types of transactions being conducted with more trading partners, which offsets the gain in time due to experience because of the additional testing.
 - No pilot testing was conducted for 5010, so there is a risk that problems a pilot would have found will have to be addressed during implementation.
 - Moving to 5010 involves more than a minor version upgrade. It introduces some new technical features which will require a longer implementation period.
 - Competition for resources with other HIT initiatives.
3. **Establishment of a transition period.** We strongly recommend a transition period for the move from 4010A1 to 5010 for all trading partners, as outlined in the NCVHS recommendation. A single cutover date for the entire industry will not work. History has proven with the implementation of 4010A1 and NPI that transition periods are necessary to facilitate a smooth implementation for the industry. Too little time for implementation and transition will necessitate an extension, which is very costly to the industry. This would impact our ability to implement ICD-10, because the same IT resources will have to address the problems caused by a hasty implementation of 5010.
- Testing should be done with each trading partner. Every scenario cannot be covered in low-volume testing. Some problems are not detected until end-to-end testing with higher volumes.
 - A transition period is needed to ensure uninterrupted payments. Payment disruption could have an adverse effect on patient care. Conducting roll-outs trading partner by trading partner allows payment problems to be uncovered and addressed without impacting all partners at once and jeopardizing cash flow. We need the flexibility to use either 4010A1 or 5010 as we transition to full compliance. After using 5010 in production, a trading partner may need to switch back to 4010A1 while problems are resolved.
 - Fixing problems after conversion is more costly than good end-to-end testing and incremental roll-out of new versions of transactions.
 - Need a time period before final compliance date where it is compliant to use 5010 & D.0 between willing trading partners without a waiver. As the rule stands now, each entity would have to apply for a waiver to conduct any transaction in the next HIPAA version. Defining a transition period when either version is

compliant will save CMS and the industry time and effort. However, no one should be forced to conduct 5010 before the final compliance date.

- A more prudent approach will safeguard the ability of the healthcare industry to continue to serve patients effectively by ensuring that the reimbursement and the administrative transactions are there to support smooth operations.
- One implementation date means that every covered entity will be testing and going live with every trading partner at the same time. This will create tremendous stress on the industry and means that, if for no other reason than limited resources, the time it takes to resolve all issues will be extended. A transition period reduces that and allows for orderly planning of these activities.
- Converting trading partners over a period of time prevents lengthy system freezes while waiting for a single production cutover date, allowing daily business operation changes to occur as needed.

4. **Consideration of additional impacts on providers.** The providers in the NCHICA Transactions, Code Sets and Identifiers Workgroup disagree with the statement that for many providers, 5010 will be just a software upgrade from their vendors. Following are some other impacts to providers:

- Possible additional data collection to determine whether a patient is uniquely identified by a member id
- Revision of the way NPI was implemented. 5010 requires that the same subpart NPIs be used with all payers, and some providers chose to obtain NPIs for use with a single payer to ensure payment. It will be necessary to coordinate with all trading partners to resolve the issues and avoid reimbursement problems that required this type of NPI implementation.

5. **Adoption of streamlined process in future.** For future adoption of transactions under HIPAA, NCHICA supports the streamlining of the process as presented by the SDOs to NCVHS on September 26, 2006. This would shorten implementation periods and allow more frequent, regular version changes, so that the industry does not have to wait another 10 years to move to the next version. The industry needs regular version upgrades to support the constantly changing business needs.

6. **Monitoring of Progress.** CMS should maintain an updated Critical Path Method (CPM) schedule to track implementation progress with published updates every six months to advise the industry if there is any slippage on any component of the schedule that will affect the overall timeline. This might be similar to the NCHICA WEDI timeline that is published on the NCHICA web site at:
<http://www.nchica.org/HIPAAResources/timeline.htm>.