

WHITE PAPER

Will Opportunities be Leveraged or Squandered?

Why Organizations Should Approach 5010, ICD-10 and HITECH Act Compliance with a Single Strategy

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Will the Industry Take Advantage of the Changes that Lay Ahead?

Will the health care industry squander the opportunities that lay ahead? The industry's history is littered with squandered opportunities, particularly when those opportunities come through legislation and regulation. Why should anyone expect new opportunities to result in different outcomes? Consider the following:

- The 4010A1 transaction standards adopted under HIPAA were never fully implemented, leveraged or used to their full extent, despite the clear advantages of doing so.
- ICD-10 provides a higher level of specificity, yet the industry rarely uses the current ICD-9 codes to their highest level of specificity.
- There are numerous health care-specific technology standards (e.g., HL7, DICOM, SNOMED, lab orders/results, pharmacy orders/refills, care quality measurements, etc.), yet it's still quite difficult for disparate information systems to exchange data.

Perhaps the most frustrating among these squandered opportunities is the 4010A1 transaction standards originally mandated by HIPAA that were supposed to simplify electronic transactions between providers and payers. Payers balked at the costs associated with upgrading their electronic data interchange (EDI) and claims adjudication systems to comply with the standard. Instead of retooling their systems, many payers implemented workarounds and over-simplified

transaction translation capabilities. The result, which the industry is currently using, is anything but standardized electronic communications or administrative simplification. Now, more than 1,000 payer companion guides exist, which is essentially the equivalent of 1,000 different proprietary communication standards.

However, payers shouldn't take all the blame. Providers didn't demand that payers implement the full functionality of the 4010A1 standards, which would have enabled providers to seamlessly handle eligibility inquiries, claims status inquiries, manage referrals and receive remittance advice electronically. Instead, many providers continued to use labor-intensive, manual methods for these tasks.

In large part, the real "blame" for squandered opportunities lies not with any particular type of health care organization, but rather with the inability for those opportunities to solve core problems. For example, the lack of standardization of 4010A1 – its intended purpose – greatly reduced its advantage to providers. Then, when providers did not step up to implement the transactions, payers did not benefit from the large-scale automation 4010A1 was supposed to bring. In other words, there was mutual dependency for true benefits to occur, and neither payers nor providers stepped up.

Deadlines Approaching

ICD-10 Deadline — The Department of Health and Human Services (HHS) is mandating the transition to ICD-10 for coding and adjudicating of health care claims. The deadline for the transition is October 1, 2013.

5010 Deadlines — There are two deadlines for the 5010 transaction standard for health care claims, and version D.O. for pharmacy claims. Trading partners are expected to be able to exchange test 5010 transactions as of December 31, 2010, and can only exchange 5010 transactions starting January 1, 2012.

HITECH Act Deadline — The HITECH Act within the American Reinvestment and Recovery Act (ARRA) of 2009, makes more than \$19 billion available to physician practices and hospitals that implement a certified EHR system by 2011, and can demonstrate "meaningful use" of the technology. Physician practices can earn up to \$44,000 in funding between 2011 and 2015.

ICD-10 and 5010 Benefits for Providers and Payers

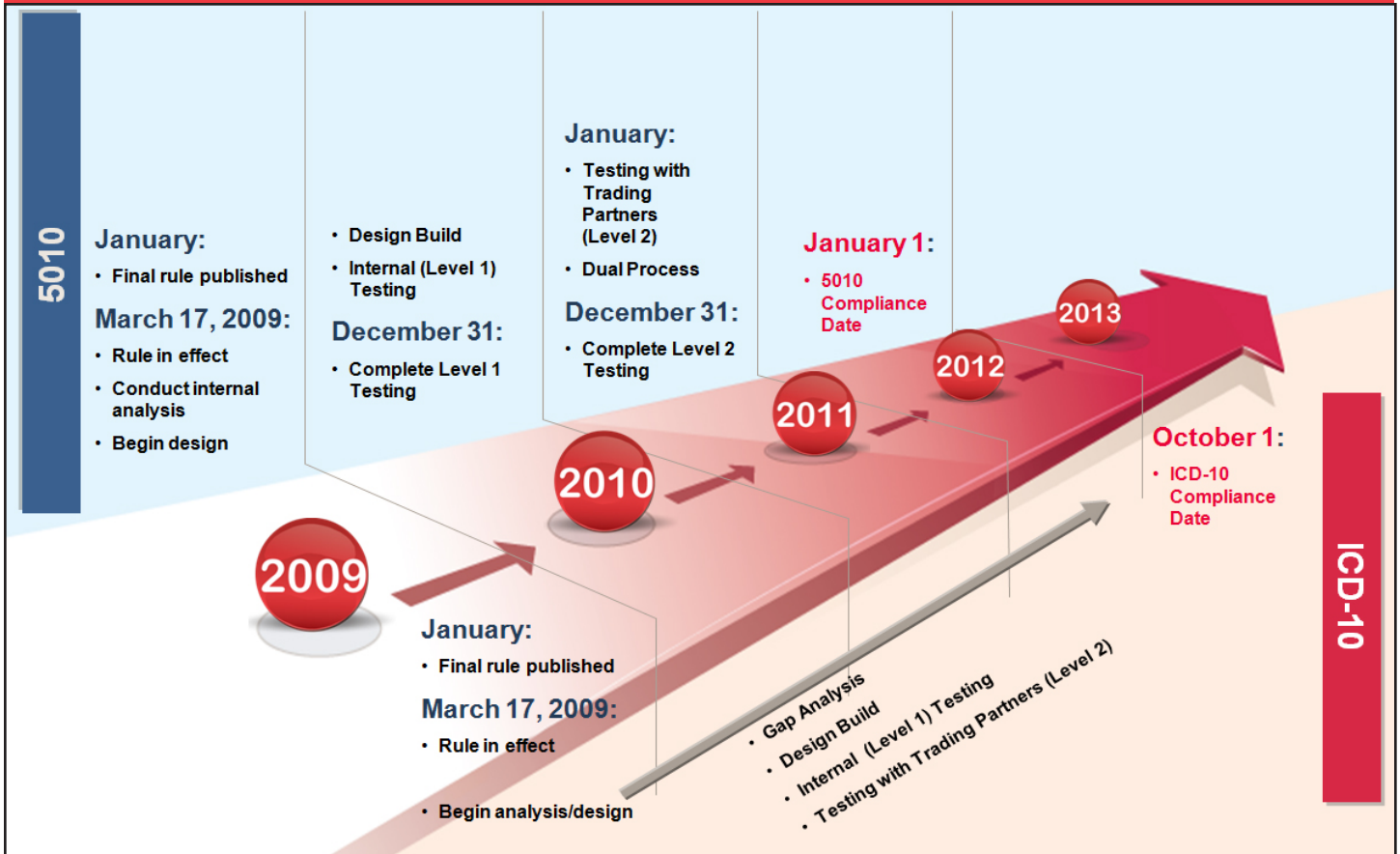
The 5010 and ICD-10 standards -- if properly implemented -- provide the industry with substantial opportunities. In fact, many of the benefits that these standards provide are precisely what the industry has been asking for, such as:

	ICD-10 Benefits	5010 Benefits
Providers	<ul style="list-style-type: none"> • More accurately defined patient services • More specific diagnosis and treatment information • Improve clinical documentation to support ICD-10 and meaningful use criteria • More comprehensive reporting of quality data • More accurate payments for new procedures with fewer rejected claims • Improve clinical analytics by leveraging ICD-10's greater specificity 	<ul style="list-style-type: none"> • Mandates the return of key eligibility information from payers • Enables and mandates the reporting of service-level eligibility • Create and submit clean claims that get processed and paid faster • Reduce need for supplemental data submissions • Clarifies rules and improves balancing for electronic remittances • Simplifies reporting of key data on claims — provider information, diagnosis, patient/subscriber information, etc. • Provides necessary detail on claims status to make transaction usable • Clarifies and eliminates inconsistencies from payer to payer on all transactions • Removes redundant and unnecessary information from transactions
Payers	<ul style="list-style-type: none"> • Better actuarial analysis • Improved benefits design • New product development • Care management facilitation • Extract treatment data and decrease reliance on provider reporting of supplemental data • More details for provider contracting 	<ul style="list-style-type: none"> • Simplifies and clarifies transactions • Enables reporting of key information for eligibility and payments that will result in increased electronic transaction use • Provides improvements to claims status and authorization transactions that will result in increased electronic transaction use • Reduce administrative costs by decreasing the need for manual intervention in the handling of claims and other transactions

Specific to the 5010 standard is the opportunity to disintermediate, meaning that organizations can reduce their reliance on clearinghouses and other third parties. With HIPAA 5010, standardization of critical transactions will be enhanced, promoting greater consistency, accuracy and efficiency. This will also reduce the use of proprietary companion guides and enhance consistent data flow across various implementation guides. This simplification will enable organizations to exchange the more standard

data directly. This is in contrast to the current usage of the 4010A1 standards, where a substantial number of providers are reliant on clearinghouses to translate their EDI transactions, due to the complexity caused by requirements and rules in each payer's unique companion guide. This resulting complexity increased transaction costs, added ambiguity among common data elements, and increased the prevalence of unnecessary and redundant data elements.

Overview: The 5010 and ICD-10 Timelines



Timing is Everything

It's unprecedented to simultaneously have so many opportunities available to the industry. The timing, however, might encourage organizations to focus on some opportunities and neglect others. Perhaps the bigger problem is that the majority of health care organizations are approaching these changes as isolated initiatives, rather than with an integrated strategy.

Both 5010 and ICD-10 are opportunities for the industry to embrace standards that lay the groundwork for other initiatives. For example, the 5010 transaction standard provides the structure to accommodate the ICD-10 code set. Also, an improved communications approach for 5010 would provide the framework for better utilizing the health information exchanges (HIEs) that are being developed by government and private initiatives.

Likewise, the increased specificity of ICD-10 helps organizations comply with proposed EHR meaningful use

criteria, such as documenting patient progress and clinical summaries, as well as providing immunization and lab data to public health registries. In addition, ICD-10 provides the increased detail that will drive the next generation of value-based purchasing and pay-for-performance (P4P) initiatives.

Considering the relationship between 5010, ICD-10 and the requirements to qualify for HITECH funding, approaching them with an integrated strategy makes sense for multiple reasons. First, each of the implementations can leverage shared processes, testing and workflow realignments. It's an opportunity to do the job once, do it right and apply it to all the initiatives, rather than repeat the process for each effort. Combining these efforts reduces operational costs and decreases implementation timelines. Second, an integrated approach allows organizations to visualize how all the initiatives fit together, and how they can be aligned with core business strategies. This macro view of the efforts can help transform organizations into efficient operations with streamlined processes.

Most importantly, health care organizations cannot afford any further delays in their preparations to address these issues, nor can they continue to blame other stakeholders for stalling implementation. In short, providers and payers must be aggressive and proactive with their software vendors and IT departments to update systems, and need to start their planning even if their trading partners have yet to communicate their readiness. Only this level of activity across the industry will create the momentum for large-scale implementation needed for all entities to benefit.

The following information explores the benefits of addressing these issues with an integrated approach, examines the current state of industry preparations, and offers timelines for organizations to complete their work to meet deadlines.

Benefits of Taking an Integrated Approach

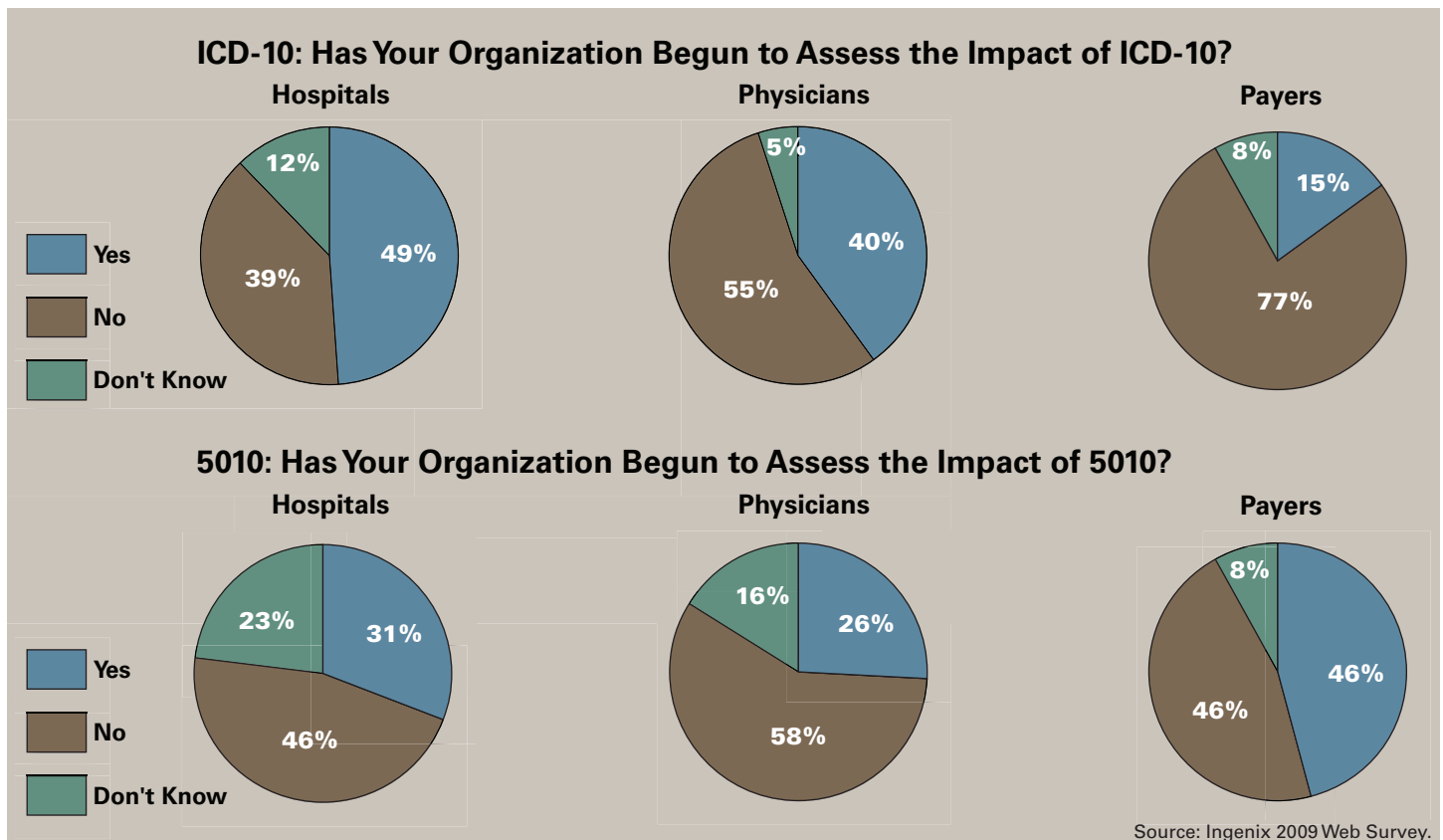
Besides becoming compliant with 5010 and ICD-10 utilization, organizations that sync their efforts with an integrated approach have an opportunity to gain a competitive advantage in the marketplace in terms of reduced operational

costs and increased performance. With an integrated approach, organizations can improve efficiency by:

- Leveraging a single business process assessment
- Strengthening providers' and payers' abilities to better understand the health care utilization or their patients and enrollees.
- Considering process and workflow changes together to eliminate rework
- Utilizing a single implementation methodology

State of the Industry – Current Preparations

The planning and implementation of ICD-10 alone is estimated to take 1,287 days for provider and payer organizations, with the implementation phase itself expected to take 966 days, according to research conducted by the North Carolina Healthcare Information and Communications Alliance (NCHICA) and the Workgroup for Electronic Data Interchange (WEDI). Under this timeline, organizations need to start their ICD-10 planning and implementation efforts by January 18, 2010 if they want to be ready by the October 1, 2013 deadline mandated by the Centers for Medicare & Medicaid Services (CMS).



The NCHICA/WEDI timeline is an indicator that many organizations are already behind in their preparations. By comparison, the 5010 deadline of January 1, 2012 is 19 months in advance of the ICD-10 deadline, which means that organizations should be well into their 5010 preparations.

CMS has stated firmly that it does not intend to extend the 5010 or ICD-10 deadlines, and will offer no contingency period. Related to Medicare, the largest payer in the country, CMS has indicated that it will reject all non-5010 claims starting on the December 1, 2012 deadline, and all claims with ICD-9 codes starting on the October 1, 2013 deadline. Medicare is ahead of most of the industry in its preparations for both 5010 and ICD-10, which is a strong indication that they are taking the deadlines seriously.

Furthermore, the industry and politicians are increasing their focus on the creation and use of health information exchanges (HIEs), evidenced by the inclusion of HIE verbiage in current health reform bills. HIE participants that have taken the time to fully implement 5010, and understand the intricacies of ICD-10, will benefit most from these exchanges.

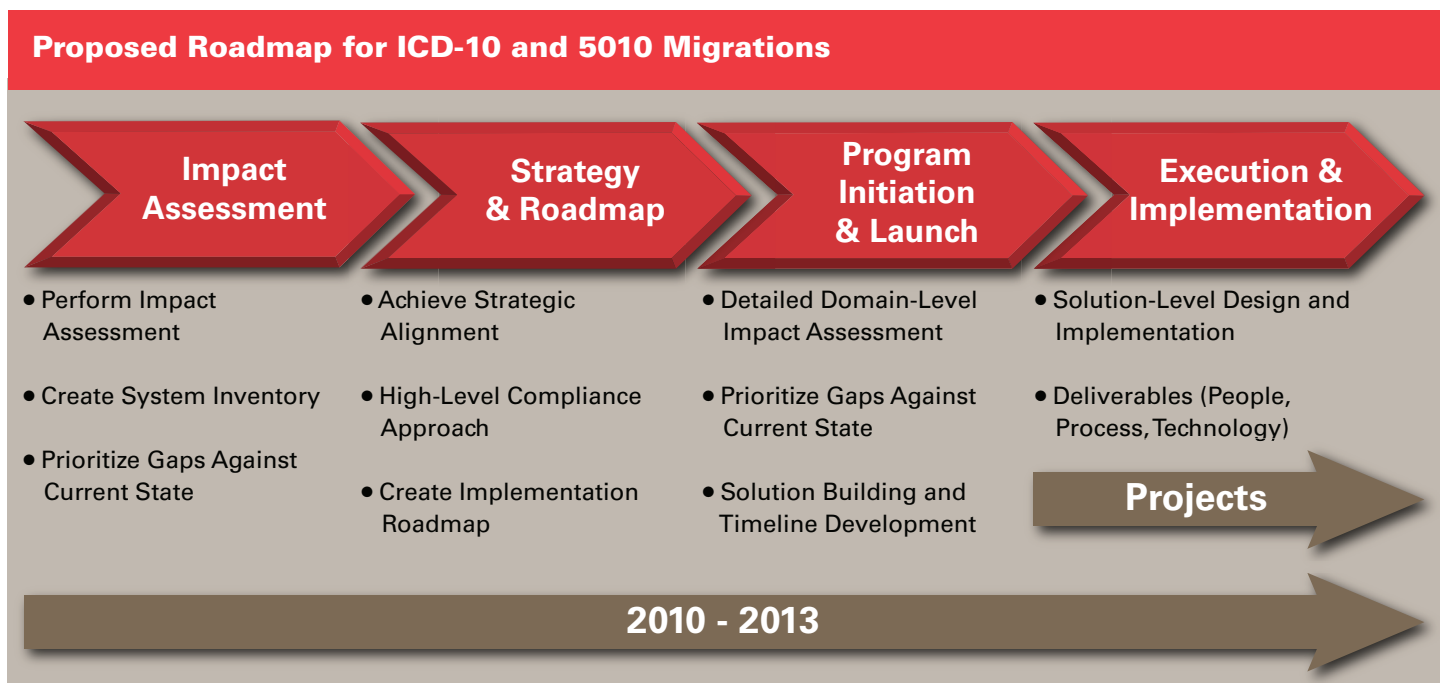
Despite the deadlines, however, an informal Web-based survey of hospitals, payers and physician practices conducted by Ingenix shows that many organizations are behind in their preparations. The survey provides a snapshot of the industry, although the respondents did not represent a statistically accurate cross-section of the industry.

Developing an Integrated Approach

How organizations approach these issues will impact long-term costs, efficiency and results. The chosen strategy is vital to the outcomes. Although 5010, ICD-10 and achieving meaningful use under the HITECH Act are all somewhat dependent upon technology, significant business process change and strategic opportunities will result from all three initiatives. Organizations need to address these issues from a strategic standpoint of which technology is a component, rather than focus on technological issues alone. To help achieve this, organizations need to create a cross-functional strategy committee to coordinate 5010, ICD-10 and HITECH Act compliance. This committee should focus on creating and utilizing similar planning and implementation methodologies for all three issues. Coordinating these efforts will maximize resources through co-related timelines, as well as conserve the use of tools and consulting resources.

Timeline development should initially focus on combining 5010 and ICD-10 planning and implementation efforts. As meaningful use criteria for the HITECH Act becomes finalized by CMS, steps related to these processes can be incorporated into the 5010 and ICD-10 timeline. Below is a proposed implementation roadmap that organizations can use as a starting point and later customize to fit their specific needs.

Timeline development needs to account for the strategy and tactics listed below. During the assessment phase, it's important for organizations to determine the elements that they can handle in house, versus the elements that they'll need to outsource to



accomplish, and budget accordingly. In particular, the testing phase is an ideal component to outsource to a third party that can independently certify transaction compliance for an organization and its trading partners.

With the deadlines rapidly approaching, many organizations will have a tendency to focus their strategies on meeting the deadlines. Instead, organizations need to develop strategies that meet deadlines and consider how they will use the standards and technologies once the deadlines have passed. For example, the proliferation of HIEs – in their current form or how they're envisioned in the future – create new opportunities for organizations to exchange information on a larger scale. Ingenix and other HIE proponents support an HIE approach where health care organizations exchange administrative and clinical data utilizing the EDI infrastructure already in place. This would further leverage existing infrastructure while adding only a small incremental cost. However, all of this is dependent upon the industry's adoption of available standards. The organizations that fully embrace the standards may position themselves to take advantage of the new opportunities as they arise.

Final Thoughts

As the industry moves forward with its planning and implementation efforts, most organizations will realize that they cannot complete the entire process alone and that they will need help. As pointed out earlier, it's important to reduce interdependency (e.g., waiting for payer or vendor readiness before developing plans, etc.), but it's also vital for organizations to recognize their limitations in terms of skills and expertise.

About Us

Ingenix Consulting is a premier, data-driven consulting organization in health and human services. We have over 1,000 consultants with experience working with hospitals, physicians, health plans, employers, government agencies and pharmaceutical companies. No other consulting firm operates on this scale with an exclusive health and human services focus.

Ingenix offers a broad array of products and services to assist organizations with their 5010 and ICD-10 efforts. The experience of the Ingenix team spans from the implementation of ICD-9 and the 4010A1 standards, to being an active participant in the development of the ICD-10 and 5010 standards. In addition, Ingenix provides the solutions and services that will help organizations comply with the HITECH Act's meaningful use criteria as it becomes finalized.

While developing their integrated approach to address these issues, organizations need to strategically choose their partners, since there are numerous pitfalls that have the potential to derail efforts. Ingenix not only has the solutions and services to help organizations keep their efforts on track, but also the experience to help organizations meet these rapidly approaching deadlines.