

**Centers for Medicare and Medicaid Services
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Morning Panel Session

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Moderator: Okay. We need to get started with our panel discussion. So between now and lunchtime, we have six representatives here who have graciously offered to join our panel discussion. We're going to have a brief presentation from each, and then we'll have, I hope, a lively discussion of a variety of issues that I think are going to be affecting everyone here.

I'm going to start by introducing Robert Jandorf. Bob is president of Software Unlimited, which is a Baltimore-based corporation. It was established in 1984. His company sells and supports the Medical Mastermind, which is a medical practice management system. Their services support more than 5,000 providers with everything from medical billing to claims submission, ERA posting, appointment scheduling, record scanning, as well as electronic medical records. Bob released the Medical Mastermind in 1986, upgraded it in 1998 from a DOS product – remember DOS? – to a Windows-based application.

So with that, we're very happy to have Bob give his presentation.

Robert Jandorf: Good morning. As Chris said, my name is Bob Jandorf and my company deals mainly with small- to medium-sized practices. So we have a very, very close rapport with physicians and their staffs since we deal with very small organizations,

sometimes with no more than one billing person and doctor, or one office manager and a doctor. So when we're dealing with these types of situations that are coming up, quite honestly, the staff and the doctors look to us for all the information. They don't really look to CMS or anybody else. They want to make sure that we know what we're doing and make sure that we have been talking to CMS, or whatever other organizations are involved to make sure that their system is going to still work after these changes are implemented.

The first thing that we looked at was the ICD-9 to the ICD-10 conversion, and these are kind of the questions that I was hit with when I talked to my clients. For starters, we're currently dealing with about 13,000 ICD-9 codes for an outpatient office and by October of 2013, in an outpatient environment, you'll be dealing with about 68,000 codes. So the first question that came up to me from the providers I talked to, "Is the software capable of storing up to 100,000 codes?" And of course, the answer is yes, and I told them I couldn't imagine any software out in the industry today that couldn't handle that many.

The second one was the size of the new ICD-10 codes. Currently, your ICD-9 codes could be a maximum of six characters. The new ICD-10 codes can be a maximum of eight characters if you include the decimal. Fortunately, our system is able to handle that, but my guess is there's going to be a lot of systems out there that won't be able to handle that. So that will be a significant change in the database structure for the software developers.

Then they wanted to know about the ICD-10, but since it's so far in the future, frankly, they really don't care. I know that CMS earlier was talking about how do we get them involved and have them know about it. They're not going to want to know about it. They're not going to get involved in it until it's thrust upon them. And I feel it's our job, as the software vendors, to keep them informed as to what's going on and what they need to do to prepare for that.

So what we've decided on our system is they'll be able to import the new ICD-10 codes, and they should be able to import it by specialty because, you know, if you're dealing with a pediatrician, you don't want to be bringing in codes for surgery and, I'm sorry, for different things that would involve surgery or other items that just simply wouldn't affect their particular type of practice. And that way, they have fewer codes to go through.

And finally, the most important thing that the doctors brought to my attention was what's referred to as both the translator and the crosswalk feature. I feel it's our responsibility as software vendors to have that incorporated into the system, so that if they're not accustomed to the ICD-10 codes, as of yet, they'll be able to type in the ICD-9, and have it come with alternatives for them to use for the ICD-10 codes.

Now, we also have to have our offices get ready for the changeover from ICD-9 to ICD-10, and the first thing is that doctors are going to have to learn the new ICD-10 codes. And frankly, they're not going to be happy about it. They're very, very comfortable with

what they're using, and they don't see a need for change. But frankly, that's irrelevant. It's coming, it's going to be there, and they're going to have to do it.

And from a systems standpoint, while we'll be dealing with probably the office staff, is that they'll need to redesign the superbills. So if they are having their superbills preprinted, they'll have to redesign them before they send them out for the next print job. And if your system, or like my system does, which generates the new...which generates the superbill, again, they'll have to redesign that so that all the new ICD-9, or I'm sorry, all the new ICD-10 codes will be on there and eliminate the ICD-9 codes. And one other little aspect with the EMRs, most EMRs that I've seen have what's referred to as a favorites list by provider, the most common diagnosis codes that they use. Those are also going to have to be changed, and that could be a major, major change for them.

Okay. As I said a moment ago, we're going from about 13,000 ICD-9 codes to about 68,000 ICD-10 codes, in some cases, a one-to-one relationship. I just plugged in 79.01, and the new ICD-10 code was R10.11, and again, the one below it is the 789.02 and the corresponding code is R10.12. But in a lot of cases, it's going to be one to many relationships. When I typed in 842.01 for a wrist sprain or strain of the carpal, I got three responses in the translator, because it breaks it out by right wrist, left wrist, or unspecified. So when they're trying to redesign their superbills, if it's a little crowded now, it's about to get a lot more crowded, because you could be increasing it three times or four times, based on what current diagnosis codes they're already using.

Okay. The first thing that's going to come and hit us in the face is what's going on between the 4010A1 and the 5010. Now, I've been doing this since about 1986, and this is the fourth time we've had to do an electronic change. Frankly, I don't really feel where it's that important to let the physicians know what version software they're using or what format they're using to send the claims. I haven't found a physician yet that cares what's going in the 4010A1 format or they're not going to care in the 5010 format. They really just don't care. They just want to be paid on a timely manner for the services they provide. So if I was to have a big conference and say, "Hey, guys, we're going from 4010A1 to 5010," I'd have nobody show up because what do they care?

Now, we've already gone through at our company and done the coding from the 4010A1 to the 5010 just to see what it looked like. By far, it is the easiest changeover that your programming department will have to deal with. If you're currently using the 4010A1, and when you go to the 5010, it took us less than two days to make the change. It was not that big a deal. They eliminated some loops, they modified some loops, they added a few more. But for the most part, it's exactly the same. At this point, we're just waiting to test it with Medicare, and I have been told that Medicare won't be able to test it until January 2011. And we also use Emdeon for our clearinghouse, and they're supposed to allow us to start doing the testing probably in the third quarter of this year.

So that's basically what I wanted to go through. Again, my feeling as a vendor is I think it's extremely important that we keep our clients informed and involved, that we know what we're doing, that we're taking the necessary steps to make certain that their claims

are going to continue to go through using our software, assure them that the electronic changeover from 4010A1 to 5010 is no big deal, and that we're on top of it. That way, there's no panic out there. And for the ICD-9 to ICD-10 codes, I feel it's important that we set up a list of what things that the vendor – I'm sorry, that the providers need to do in order to be prepared and ready for this, and let them know what we're going to do as software vendors just to make their job that much easier.

And that's my take on it from a small vendor point of view. Thank you.

Moderator: Great. Thanks, Bob. Next up, we're going to have a brief statement by Rhonda Taller. Rhonda is the regulatory product manager from Siemens Healthcare. She's been with Siemens for the last 27 years, holding a variety of positions within product implementation, sales support, product management. In her current role as regulatory product manager within the review cycle, Ms. Taller leads the Siemens Regulatory Council and co-leads the ICD-10-CM/PCS core team. She also represents revenue cycle on Siemens' Operational Core Team related to the American Recovery and Reinvestment Act.

So I will now turn the mic over to Rhonda.

Rhonda Taller: Thank you very much. In terms of organization for both 5010 and ICD-10, Siemens established core teams in 2009 shortly after the publication of the final rules. We have representation from product development, customer relationship management, and supply-chain management, and for ICD-10, this spans all our product areas. We meet regularly and our charter entails coordination of product development activities, risk mitigation strategies and consistent customer communication planning. Individual project teams for the different products report up through the core teams, and we have mechanisms to report up to our senior management on our progress.

Earlier this year, we developed an infopedia focused on a single place for our customers to access our regulatory information available on our customer-accessible Internet site. This has separate sections for both initiatives with links to customer memos, webcasts, positioning statements, and links to external industry sites including the CMS site. Siemens also participates in industry initiatives with WEDI (Workgroup for Electronic Data Interchange), HIMSS (Healthcare Information and Management Systems Society), and other organizations that are heavily involved with 5010 and ICD-10.

For 5010, we're on target to deliver software to our customers in fourth quarter 2010. In fact, we may have some early adopters at the end of third quarter 2010. This will enable our customers to install software in their test environments and demonstrate the ability to produce and process 5010 HIPAA transactions to start conducting external testing with their trading partners in 2011. For our clearinghouse health data exchange, we plan to begin external testing with our trading partners in fourth quarter 2010. We are also serving our health plan trading partners with direct connections and clearinghouses we exchange transactions with today to determine their overall level of readiness.

For ICD-10, we are currently in the assessment and GAP analysis or the analysis and planning phases, depending upon the product lines and the level of changes required.

For both regulations, we have timelines established for incorporating software changes into our product release schedules using standard software product roll out considerations. We will also be providing services to assist our customers with assessments, integration and testing required, and shortly, we will post information about that for our customers on our infopedia.

For the past few years, we have included 5010 and ICD-10 in our National User Group presentation during our regulatory update as a preview of the future. In 2009, we had more granular information on the regulations that we could provide to our customers, and in 2010, we will speak in more detail on our product plans overall. We have also provided a number of webcasts in 2009 and 2010, in particular, with a focus on 5010, because of the near-term dates, and we've gone out and spoken to customers one-on-one or in regional user groups about the need to get ready for these regulations.

For 5010, we believe a current risk is whether all trading partners will have the ability to begin testing in early 2011. From a provider perspective, there is a concern regarding health plan readiness, especially Medicaid, in these economically challenging times. Another risk relates to errata changes coming late in our development cycle, which will make it difficult to accommodate software modifications prior to the compliance date, or if changes are rolled out post-January 1, 2011, with required retesting needed for conversions could delay overall the process.

Another risk that is a potential is that some providers may need to reevaluate their NPI enumeration to ensure claims are submitted according to new rules defined by 837 transactions. This has been discussed at great length in the WEDI NPI workgroup. For ICD-10, our customers have resource constraints due to a variety of reasons. This was pointed out very clearly in the WEDI survey that was done in late 2009, early 2010. Key initiatives occurring or being planned for include clinical implementation for CPOE (computerized physician order entry), meeting the meaningful use criteria for ARRA, meeting the privacy and security initiatives from HITECH, and complying with RAC audits, along with maintaining technical currency for our customers.

Due to the ARRA timelines and financial incentives, hospitals may be shifting resources to meet meaningful use objectives. It's likely some of the resources that would have been focused on ICD-10. The downstream impact of health reform has yet to be felt. However, we think that may also have an impact in the future. For ICD-10, challenges include the complexity and the number of systems installed by providers in their environment, which will need to be assessed and tested. Many of the systems interface with one another, and timelines for updates from vendors may differ for ICD-10.

Another challenge is the large number of staff that require different levels of training across the health care enterprise. We believe that the ICD-10 initiative needs to be owned and embraced by the business users with IT as a participant. This is not another Y2K,

although we see that a number of our customers, when we go out and speak with them, think of this like Y2K. It's primarily an IT event, and we're always very careful to explain to them what we believe the impacts can be felt enterprise-wide.

To conclude, for 5010, we think most customers will be ready by January 2011 to begin level two testing with their trading partners. Some potential constraints could be provider resources to test with trading partners, their readiness, and the number of trading partners each customer needs to test with. For ICD-10, the more customers are educated on the potential enterprise impacts, the better chance they will have to execute in a timely manner. We always promote the CMS website in every discussion with customers. We think there's great information and great links to other industry sites.

We also would ask that CMS needs to continue with a consistent message that the dates will stick. That's one thing that we find often when we talk to our customers. They believe that the dates may slip, and we're always very careful to say, "We do not believe that to be the case."

Thank you.

Moderator: Thanks, Rhonda, and thanks for emphasizing that message about the dates sticking. Next up, we're going to hear from Holly Louie. Holly is the compliance officer for Practice Management, Inc., a multi-specialty billing company in Boise, Idaho, and is also an independent national health care consultant. Ms. Louie provides consulting services for health care attorneys and multi-specialty clients with emphasis in documentation, coding and billing compliance, physician education, and litigation support.

Holly Louie: Good morning. I thought before I really started in here, I'd give you a quick overview of the professional industry for billing companies, because what I've learned is the problems that Practice Management is struggling with are the same problems that every billing company and every practice who does their own billing are struggling with. They're not unique based on the fact that I'm in Boise, Idaho.

HBMA is the Healthcare Billing and Management Association and has currently approximately 650 professional billing companies as members, 30,000 employees and process approximately 400 million claims a year, which is a pretty decent chunk of change, and about \$31 billion. So I think we have a pretty good understanding of what we're going to face as 5010 and ICD-10 develop. Our members are pretty well aware of what they need to do and what's coming, the ramifications, the variable educational programs that need to be developed. We have a standing multi-organizational committee to work together with our fellows, just as this meeting is. We have website resources, links to CMS and AHIMA (American Health Information Management Association), journal articles, and multiple tools that we've tried to help our members develop.

Now, from our perspective, we're about a 70-employee billing company. We do all hospital-based specialties, so we don't have the real small practice issues with EHRs and

some of those other competitive things, but we have other challenging issues because they are hospital-based. We've completed our GAP analysis, our risk assessments, our projected budgeting as much as is possible right now, but I think one of the problems is that we really don't know how to move on from this point, because as has been iterated by several people, even if our vendors say, "We think we're ready to test," and we think we're ready to test, there is nobody to test with. So we're kind of in a holding pattern at this point in time.

Also really the missing group here, I think, for the most part, are the payers because all the vendors, all of our vendors, all of our clients and ourselves, are waiting on our payers to tell us what they're going to do, when they're going to do it, and how they're going to do it. And nobody's answered that question at this time in our world in Idaho at least. What we learned from NPI and some of the other initiatives is that some payers are not ready until the 11th hour. And then it's very difficult because testing fails, or claim submissions fail, and we know that – not to pick on Medicaid, but I know we all have challenges with them. Our Medicaid program typically runs 30 to 45 days behind just during an annual update for ICD-9 codes. They can't implement them on time, so we're very concerned about what this is going to mean for such a massive change versus a small change.

As I said, the unknown dates for testing with our payers is a challenge. We are hopeful that the industry can come to consensus. They will not allow payers to have an implementation date earlier than what it's supposed to be, which we've experienced historically. With HIPAA-exempt payers, we know that, or payers who don't meet the deadlines, it's incredibly challenging to have to support 4010, 5010, ICD-9, ICD-10, and run concurrent systems, parallel systems or lookup files to be able to successfully submit claims. Truthfully, our clients are physicians, and they don't care about any of this stuff. They just want to get paid. That's the only thing they care about, and that's their bottom line.

Companion guides present a challenge. It requires a lot of additional cost, time, and programming to accommodate idiosyncratic payer requirements on claims submission. There's really no such thing as standard claims. I think anybody in the billing industry knows that – and that not all the technical standards are currently supported through 4010. And I don't know how long it will be, if ever, before 5010 meets that criteria.

We talked this morning about some of the tools, the mapping, the crosswalks, whatever term we choose to agree to today or when we go home. We know from our commercial payers that most of them are going to build proprietary internal crosswalks or mapping programs out of their claims adjudication history systems. We understand that that's the way the world is going to be, but that's an important thing for us to know early as possible, so that we can accommodate individual programming if that's required, and to understand what their crosswalks and mapping are for payment and reimbursement purposes. If they truly vary amongst every commercial payer, that is going to impose a tremendous burden on physicians, vendors, billing companies, everyone in the story.

We're struggling allocating dollars, quite frankly, system upgrades, software, trying to accommodate all of our different vendors and clients who – none of them use the same software or vendors and so we have to work with a lot of different programs and products – the increased programming need for that. Clients – we don't have EHR implementation, although I know many of you are contending with that. The clients are picking different programs.

HITECH has presented a pretty significant challenge for billing companies with the new reporting and tracking requirements that are over and above what historically was required, decreasing reimbursement and our State Medicaid has stopped payments for an interim period because they've run out of money and they've had a budget cut. And some of our payers actually implemented the 21 percent CMS cut even though there's a hold for Medicare payers – other payers that went ahead and implemented it anyway. So there's a lot of decline in reimbursement. And then the operational requirements to comply with CERT and RAC and some of the other programs have really spread competing dollars very thin.

What we did learn in our billing industry is that size does matter. Some of our very smallest companies, similar to physician practices, those with 10 or fewer employees, many of them have not allocated \$1 over and above what their vendor is going to charge them for software development to implement operationalized 5010 and ICD-10. So that's a problem.

In our physician groups, truthfully, they're not looking to, unfortunately, CMS, AHIMA, their specialty society or anybody else. They think the billing company is the magic bullet that's going to fix all their problems. Yes, claims submission, as my colleague pointed out, is easy. That's a no-brainer. But where are they going to learn what they need to document, how they need to code, how they need to redevelop their superbills? And yes, we all know they're supposed to document to the highest level of specificity, and we all know they don't, and most of their codes come over as an unspecified something.

And that's a huge issue for us because we need to know, and our physicians need to know now, will unspecified codes be reimbursed once ICD-10 is implemented? If the answer is yes, then it's sort of a no-brainer, but it doesn't meet the goals of CMS to have the most specific information available for data analysis. If the answer is no, physicians need to learn a whole new way of documenting. And one of the problems for our providers is they're all hospital-based. What we need for CPT and diagnosis coding is not what the facility will need for PCS, and we have no capacity to train them to meet those requirements. So that's a, I think, a hole in the thing right now.

So I think our major concerns at Practice Management are sort of this naïve philosophy that this is just a technical solution – my computer will do it and all is good with the world. We would like to see actually required payer implementation and testing with dates firmed and dates committed. Real ramifications for those payers who don't meet the deadlines, rather than just you have to work around their problem. And we really do need

to know payment policies as soon as possible, so we can work successfully with our providers to meet the needs and requirements.

Thank you.

Moderator: Thanks, Holly. Next up, we will hear from Randal Roat. Randal is vice president of radiology services at Medical Management Professionals (MMP), and as such, he's involved in radiology practice, strategic planning and practice management, technology and billing operations, staff, professional and physician education, and regulatory and legislative issues related to radiology. Through the majority of his professional career, he served as owner and operator of the TriMed Group, which is a regional – which was a regional radiology billing and technology firm which was acquired by Medical Management Professionals in 2006.

Randal Roat: Thank you. As I get started here, I just want to point out how hard it is to follow Holly speaking – nice job. As I get started, I'd like to just give the audience a little bit of a snapshot of what MMP is and where it fits within the industry, so that everybody can understand where these particular observations are coming from. As a billing service, we serve radiology, pathology, anesthesia, ER, and a few smattering of miscellaneous specialties. We are responsible for the claims development process from cradle to grave. That is, it starts out at the date of acquisition, the coding, the billing, the denial follow-up, all the way through to ultimate adjudication, and the accounting for that process.

We also offer practice management services and this offers maybe a little bit different or a unique perspective into this whole issue. We handle the business and administrative functions, the accounting and the budgeting. Quite frankly, where this whole process comes into play is under the budgeting – strategic planning, compliance, and physician education with respect to the administrative and the billing end of their practice. Software development, we also have developed a practice management system, so we represent the perspective of a software development vendor as well.

We have, as far as our scope, we have a little over 2,000 employees across 55 offices in 26 States. Our annual metrics are approximately 4,000 providers, 20 million claims, \$2 billion in charges. We work with all Medicare carriers across the United States and most commercial carriers and Medicaid plans. We have multiple clearinghouse relationships including Emdeon, and we also do direct submit of our bills to Medicare, Medicaid, and some of the larger commercials.

We are operating under three proprietary software programs, those that we have developed, and we also utilize five commercial programs, so we bring a little bit of a perspective as a provider that uses a commercial software platform as well. As far as where we are on our project methodology, with respect to our proprietary software, like many, we've done the preliminary analysis, the requirements definition, and the design approach. We are also waiting to test as other entities become available and offer that to us, and I believe that this probably was Todd's work. If he's still here, thank you. This just illustrates a little bit the magnitude of the changes that are involved, but as Bob said

here, the actual programming changes are not that significant even though a lot of data elements are affected.

The 5010 milestones on the proprietary software, January 1 of 2010, we had completed our analysis and our requirements definition design approach. By July of 2010, we hope to have the data elements incorporated, the format changes incorporated, do a little bit of internal cross-team quality assurance. And we are also going to work with CLAREDI to do preliminary testing and certification. By January 1, 2011, obviously, we want to be ready for carrier testing certification beginning implementation.

With respect to our outside vendors, I found it interesting that as I listened to everybody, we find ourselves in the same position. We're kind of awaiting their lead. Even with the technical resources we can bring to bear, we're awaiting our third-party vendors to...as far as their plans for compliance. The same thing with clearinghouses. Now, I will say that we do keep very close communication. We're tied pretty tightly with them, but we're also very much in the same position as the rest of the industry in that regard.

Just a few points that I wanted to make in closing is that to the extent we can learn from our past experience, that will be wonderful. We have been through these format changes a number of times and this, to us, is yet another format change with respect to 5010. And to the extent that we can move toward true standardization, that will be a plus for everybody in the process, as well as the industry at large.

Enforcement, while I applaud CMS' efforts to bring all the players together, I think that as with any project of this scope, there are going to be those that, for whatever reason, are unable to comply by a certain date. In the past, we have brought those to CMS' attention and have waited literally a year for any type of response to that. So although we hope not to have to use it within the industry, I think that the enforcement does need to be relevant in order to move this project forward.

Adequate testing, and a number of people have talked about that. We think that's critical. One thing I would say is perhaps if we could get a clear definition of what 5010 compliance is. Is it just the 837? Is it the 837 and the 835? Is it all transaction sets? I think we need that guidance as an industry, and that'll clear things up.

And the other thing is as to the extent that we can, we really need entire industry adoption on this – private insurers, Medicare, Medicaid, auto carriers, etc. This is a significant change, a foundational change, a structural change that we see as a building block to allow the bigger initiatives going on in the United States right now. So we do need entire industry adoption.

From a user perspective, we depend on our vendors to make the programming changes. We're concerned, like many, about the ability to handle 4010, 5010 transactions simultaneously, ability to handle both ICD-9 and ICD-10 simultaneously. The insurers – and I have in parentheses here temporarily crosswalking ICD-10 codes back to ICD-9 for

payment purposes. Hopefully, the industry will migrate to native at some point in time. It may take a number of years, but hopefully, this will be a temporary situation.

And we do recognize the size of the task that CMS and the insurance industry has with this. And I do think that this type of event where we can communicate and collaborate together is going to be critical going forward.

And then finally, the implementation dates, some folks...the last time we went around with actually the 4010, had actually pulled the trigger and implemented things a little bit early or earlier than the target date. And that's as problematic to us as implementing it a bit late if there's not good coordination there.

With respect to ICD-10, we see 5010 as a building block. It's a prerequisite to us going forward with ICD-10. The insurance carriers really need to be ready to adjudicate the claims from our perspective. To the extent that can be validated by testing, that is going to be very helpful. And in the event that there are problems, I know probably everybody in this room believes there are going to be no problems with the implementation, but in the event that there are, maybe we could encourage a fast track for appeals or getting attention to those problematic claims that are a result of this transition. At least that would keep the money flowing and keep the physician stakeholders at bay.

Milestones, where are we? ICD-10, we've reviewed. We're developing the project plan. It's in process. We're looking at our internal coder training through 2011, 2012, physician training, dictation, charge ticket revisions, obviously through the 2013. Communication methods we use are newsletters, monthly meetings, in-service trainings, web-based training. We also see that there will be a lot of commercially available training for us to use as well.

I think a couple of concerns that we have are with the compliance. We're going through a change, we're going through a coding change. If our friends through this side of the CMS house could talk to their friends on the enforcement side and cut us a little slack, we'd appreciate it. And we as far as costs, we anticipate about – right at the onset, as much as a 50 percent productivity lag in the coders as they get working this through the system, leveling off at maybe a 10 to 20 percent productivity reduction across the board, just to give you some sense of what we're seeing as far as the budgeting.

And I think that that's it. I wrote a couple of notes based on everybody else's presentations this morning, but I think I hit them as I went through. And again, I'd like to thank CMS for sponsoring this. I think it's a great event, and we can all learn from it and do a lot better job. So thank you.

Moderator: Great. Thanks, Randal. So we've heard now from a couple of representatives from software vendors and third-party billers. Next, we'd like to, we're going to hear from some clearinghouses. First up will be James Mechan. James has more than 20 years of health care electronic data interchange experience and is currently senior vice president of EDI Services with Emdeon, formerly with WebMD and Envoy. James is

focused on HIPAA compliance with the modifications to transactions and code sets for Version 5010, as well as ICD-10. He works with a cross-functional team so the business and information technology are directioned to facilitate regulatory compliance for Emdeon and its customers while minimizing impact to existing EDI infrastructure. I will turn the mic over to him.

James Mechan: Good morning. I'd like to first talk about 5010. As everyone said, or have said already, it's a prerequisite for ICD-10, and so we need to be moving through that first. On our outreach, we have a website, HIPAASimplified.com, and on there, we have a lot of documents that would help our customers and others in the industry move along toward compliance. We brought this website out at the end of January, and we had over 7,000 site visits and there's now 4,500 downloads from that site. People have been on there to download our GAP analysis documents and some of the other documents we have out there.

An example here, I think Denise had mentioned earlier, a physician has no clue. He has no clue whether it's print image that's leading his software or if it's still NSF, if it's 4010, and he will have no more clue when it's 5010. He simply hits the same claim button, the big red button, presses that and off he goes. But he still needs to know it's not just an IT play. He needs to understand what is changed from where, how he gets his claims paid today to how he will get them paid in the brave new world of 5010.

And so on my left-hand side, there is just one page of our GAP analysis, simplified documents, where we took a non-geek-speak approach and just laid it out in color-coding for providers, for office managers, for the business side of our customers to use this document. The gray are the fields that are deleted; the green are the fields that are added; red means it's required. Red writing, black writing means it's situational. And so...we have that level of documentation at the business side for all three claim types out there on our website.

And on the right-hand side, it's just a one-page example of the technical GAP analysis which this particular version of that – we have the technical GAP analysis for all of the transaction types. And this one shows the loop segment, the element, the description, and then the color-coding on the right-hand side says whether it's new, deleted, changed, sizing change, usage change, all of that. And then in the big market that goes along with these documents, you can then click on and see just the new fields, just the deleted fields, just the other fields there.

So what we find is that on those resources, when people are downloading for claims, because most people have moved first on the claim side. We found that our customers and others that are on there are using our claims' GAP analysis simply just to order against theirs and make sure and call us if they see anything different there. For the other transactions, the point that Rhonda was making there, it looks like customers, and others in general, are seeking some new development, so while they may be quite far on in the professional or institutional claim side, they may not have started the 270, 271 or 276,

277, etc. And so they're actually using our GAP analysis there to kick-start those efforts and use them to start out.

We've...also in our outreach, we present quarterly to all of our health plans. We do a webinar telling where we are, what we're hearing in the industry from other customers, especially the other side of the equation. As a clearinghouse, we sit in the middle, and so when we're talking to payers, they're really interested in what you're hearing from your providers and your software vendors, your billing companies. And then we also present quarterly on the webinar to our submitter side and again, they're interested in what we're hearing from each other on that side, but also what we're hearing from the health plans. So we'll continue to do those quarterly as we move along the continuum here.

The interesting thing we're finding is in 4010, we had health plans, particularly the larger commercial health plans, banging on our door a year and a half, two years, two and a half years even, in the case of some of our very larger payers, and saying, "Pick me, coach. I want to test with you. I am ready." And the software vendors tended to be behind the times and so the providers were screaming, "I don't have the software on my desktop."

We're seeing the opposite this time. I have – and you've heard some here say the same thing. We have our software vendors saying, "When are you going to be ready? We want to test with you," because they came to the realization from 4010 that they need a long time to get out to 20,000 customers, 25,000, 30,000 customers, and get the software out in the desktop, train the users and especially if you're a software vendor who supports the multitude of transaction types.

And so, and they don't want, the software vendors don't want to go out and deploy claims and three months later, go around the whole base deploying ERAs and three months later, go out deploying eligibility. And so I say we're finding our software...at least our major key software vendors are ready, or will be ready shortly, to test all of the transaction types with us, but we have no payers to test with. And it's not the payers – payers are well organized, have got large IT areas, and they understand 5010 very well. But what the payers seem to be doing, at least from our experiences is they're tying their 5010 efforts to their ICD-10 efforts in some kind of way. And so they're making sure they're moving along simultaneously in both of those areas.

And so when we did our payer survey recently, we had some saying they were ready – a few saying they would be ready to test in Q3 this year, more saying they are ready in Q4, but many of them seem to have followed their CMS, HHS guidance and are saying January 1, 2011. Now, whether they're going to be ready before that, but it's politically wise to say that, I'm not sure. We hope so. We're hoping we see some payers ready before that.

So we...what we looked at...this is a simple layout from the front matter of the final rule on the guidance on compliance, and I think HHS did really well this time with 5010. And as a particular...instead of just saying, "And here's your compliance date and how you get there is your problem." But offering the guidance of level one and level two

compliance has helped us frame a reference so that we're all marching along in lock-step in just the compliance date. So I think that's really helping every industry meeting I've been at. People refer invariably to level one and level two compliance. So that's been a big success in getting there.

So the guidance for level two compliance, which will start testing with your trading partners, external testing and going to production, was January 1, 2011. What we found at Emdeon, and we're the largest clearinghouse in the country, and while it may be a good idea for a lot of covered entities to take two years to build from January 2009 through December 2011, and one year to test and deploy. With the number of trading partners we have, we just don't feel like that timeframe was sufficient for us, and we were getting push on our trading partners.

And so this is ours. We're – for all of these transaction types, we – our president and CEO sat with me about a year ago and said, “We can look at compliance and get dragged screaming to the party or we can summon what to do. If we get there early, if we get a good website out there with good documentation, then there's a leadership site along with the compliance side.” So he gave me the task of having our clearinghouse switches for all transactions ready on Q2 2010, somewhere between nine and six months ahead of the January 1 guidance for external testing.

And so we are – other than the 270, and any of you who do 270 understand why that's a little bit of a pain, but we have GAP analysis out on our website for every other transaction type, but we do not have any for the 278 because there's no point in trying to do a GAP analysis because the transaction was just totally blown up by the X12 278 work group.

So that's just a little bit behind what we're – we were aiming for July. I think I'm safer saying August for that one. But we are going to be ready to test with submitters, and we certainly have a few of those lined up. And today I've found we have a few more. Some of the fellow panelists on here seem to be looking to be testing at that same time with us...and the payers. So we are actually starting next week on – actually starting this week on the 270, 271 with two submitters, and we're starting next week on professional and institutional claims, and they'll test with us. They'll be, as they say, that we have one payer we believe we can – that looks like they're going to be ready late May, early June, but that's the only one there. So that's the only downside to the submitters who want to test with us, but it's not for lengthy end testing; it's testing with us. We “fake” payers behind us and go out to our “fake” payer and come back with the responses for the real-time transactions, but again, it's just us simulating a payer, and we need hopefully to get some payers before we can really say we've tested right.

Then with us, that's our testing schedule, and we believe that – and the progress, the levels of progress that Denise referred to on the GAP document, that we can be – if we can have submitters and payers ready, that we can be in level six production systems roll out sometime in the third quarter.

What we see as a clearinghouse that just like we did for 4010, if we have a payer who's ready before a lot of their submitters are ready, we can bring in 4010 and map it to 5010. And if we have submitters ready, we can bring in 5010. If they want to move fully to 5010, so they'll more...support dual formats. And we believe we can map – we'll pass it through to 5010 payers we believe we can map down to 4010.

We did it with 4010 – and 4010 was such a huge sea change in both the format and the level of content. I think a couple of partners have already mentioned here. 5010 – it's X12 to X12, and we're already betting our bullet...On the content is – actually, in the claims transactions, it works out roughly – there's three times more fields deleted from 4010 to 5010 than there are elements added.

And so we should be able to accommodate that. We believe we can do that, but it means that some data will be converted. Deleted data from a 4010 submitter will not obviously map out to a 5010 payer, because there's no place to put it, and new data from a 5010 payer while the 4010 payer is still on 4010...that will drop because there's no place to put that. What we think is the transition challenges that will allow us to test and come up prior to the compliance date, that payers should not expect new content or new rules around existing content until we're close to the compliance date.

Just like we did the last time, the concept of operational compliance, where health plans come up first on the format, so that we were passing the transaction and gradually, as providers and vendors and clearinghouses had more of the data to pass, we will raise the level of the content within that. We will provide guidance reports, just like we did for 4010 and the NPI to all of our trading partners. We'll show our payer, even if he's still on 4010, here's the level of 5010 data that we're getting from your submitters, that if you're on 5010, we'd be sending you.

We're going to send to the software vendors in front of us, because some of their customers come directly into us and not through a gateway, so they really don't know the level of content that's coming in, even if they have enabled it. So we'll give guidance reports to those, too. But, however, we will stress, continually stress on our outreach that providers need to comply with the requirements for the data content or risk having their claims deleted or rejected as we reach the compliance date.

We'll bring out such certification systems that fully mimic our production systems, and we're also working on having self-service testing, so our trading partners can go out and test on their timeframes.

On ICD-10, Emdeon is a clearinghouse, and we'll be ready to accept any 5010 transaction, either an ICD-9 or on ICD-10, and pass on whatever we receive. At this point, even though we're continually asked by our customers, at this point, we do not believe that we should implement a crosswalk to map from 9 to 10 or 10 to 9 due to the rest that were well covered in the NCVHS (National Center for Vital and Health Statistics) hearings and was in the letter that NCVHS sent to the secretary. There's just a real risk of creating invalid claims when we tried to take one 9-code and choose one of

the 18 or 20 or 25 10-codes that would be the most appropriate there. So we just don't feel like...while we're always trying to help with the mapping situation, at this particular point in time, we really don't feel comfortable with doing that in the claims workflow.

But we have recently acquired a consulting company, and they have an ICD-10 practice, which they're out and about talking with customers helping them with their GAP analysis and assessments. And what they found was the majority of our small- and mid-size clients are only at the very beginning of the phases of their ICD-10 planning, just like we heard earlier. The formation of their internal stakeholders, their governments and they're creating RFPs for assistance in the assessment and GAP analysis, and in a few instances, are really actually into the early phases of their assessment process.

So again, going with the levels of progress that Denise mentioned earlier, we believe that most of our clients are in the level one or level two, the orientation, and project organization or the assessment GAP analysis. Some others seem to be prioritizing assessment process as an end point to the planning and budget, so they'll have money next year to move faster along with this. But there's – as we've heard before, there's a great deal of competition even within organizations because of other projects in their portfolio, especially projects that are geared toward medical cost savings. Those are more likely to get early on and maybe compliance will fall behind those.

What we're hearing the obstacles are that resource availability, competing projects, the belief the dates will push out because of the added complexity of health care reform. Coordination and testing between the entire provider network is a real issue to the payers that we've been speaking to on ICD-10. And the fact that you need to continue to educate within your enterprise. The senior leadership needs to understand that this is here and in 2012, while it may seem a long way away, is not really with the amount of work that needs done. And the continuing education around the risks of crosswalking, and if we start early enough, we don't need to do crosswalking, because we can change our back-end systems to accommodate.

So one of the things that we were – talking to at NCVHS, I talked with Lorraine and Karen, Lorraine Doo and Karen Trudel from CMS. And one of the things they mentioned was as an industry, for ICD-10, we really need to start thinking outside the box for testing. An example that they used there was in the lead-up to the NPI. To me, 5010's like 4010. We can transition because people at clearinghouses can sit and meddle and map up and down. But ICD-10 is a much more huge version of the NPI, where all the way up to September the 30, 2013, the only code that's valid is the ICD-9. And the next day, the only code that's valid is the ICD-10. And as an industry, we're not near good enough in a transition situation over the years with...the big bang theory is probably not where we need to be.

So what we did for the NPI was there was this concept of – [inaudible], I think, was the first one to come up with it, of dual use, but even though it wasn't valid until May 23 in 2008, what we said was pass both. We'll use 9 in production and use the other one for testing. And that allowed payers to go to build the crosswalks or to validate the

crosswalks on what they were receiving. And then just prior to the May 23 date, CMS asked clearinghouses, they said, “We don’t want to wait and find out on May 23 that we’re not there.” And so they asked clearinghouses, seeing that we were getting both anyway, could we strip for one day, strip the legacy ID ahead of the compliance date for Medicare only, so that Medicare only received the NPI.

And that was – and clearinghouses, some of us were able to accomplish that. And so they were able – and they told providers what they were going to do. CMS did a great job of outreach and said, “If you don’t want to risk testing, just don’t send Medicare claims that day.” And so we had an NPI day ahead of the NPI, and it worked flawlessly. And it made us much more confident as we moved then. So could we use some sort of the same dual-use strategy for ICD-10?

So we looked at it in Emdeon and tried to figure out is there some way we could – and again, this is just an example of the type of thing that we could do. This is not saying what we should do or anything, it’s just the type of thing if we get together and collaborate well as an industry, what we could do. So we’re saying that in the 837 5010 transaction, the – the 837 transaction itself allows for multiple repeats of the HI segment where the ICD-10s are captured. The 5010 implementation guide, the TR3 says only one repeat is allowed, but the transaction itself allows for multiple. Just this implementation guide says only one.

If we opened the TR3, and let’s get 5010 out of the way, and maybe in January of 2012 when we’re there, open on the TR3 to say that you have two repeats of the HI segment. Have providers, just like we did for the NPI, saying your ICD-9 and one of the – the first repeat in the production place and send – what you would send later is the ICD-10 in the second repeat and then pass it through, have clearinghouses pass it, pass it onto health plans. We still have to pay from ICD-9, because it’s the only valid code at that time. But then again, they could use the ICD-10 way ahead, way ahead of the compliance date, to ensure that they could bring it in, take it and go into production with a 9 and go into the test systems with a 10.

And so this is – again, it’s just one idea that – you’d do things like translator companies would need to back off the 5010 version of the translator to allow to – and the front end would need to be able to – build something to send to. And again, this is just an instance of the kind of thing that I believe as an industry, we’ll be, it’s not that we have not been through this. We can think of ways to make this work. And this is just an example of the HI segment for the 9 and the HI segment for the 10, and as I say, go in production with the 9 and go into testing with the 10.

So that’s all I have there. I appreciate the opportunity to present here this morning and good luck with all of your migration efforts. Thank you.

Moderator: Thank you, James. Next, we’re going to hear from Mary Hyland. Mary is currently the assistant vice president of regulatory affairs and chief privacy officer for The SSI Group. SSI Group is a leader in electronic data interchange and software

services, as well as a clearinghouse processing more than 116 billion in claims annually. During her nine-year tenure with The SSI Group, Ms. Hyland led initiatives on privacy, security, compliance and other regulatory programs for State, regional and Federal agencies and programs, and currently is involved with several industry organizations related to the transitions for Version 5010 and ICD-10.

Mary Hyland: Thank you. Well, now that Jim has given my presentation, I don't have anything that I have to present now. It's wonderful. He truly did bring out a number of the topics that I wanted to hit on as well, and I think you'll see as we move along that the industry has really come together on these initiatives. And as you'll see with the information I have in my presentation, as compared to Jim's, we mirror each other in many of the ways that we've approached this. So that's also wonderful.

We've seen during the transaction code-set days, days that all of the issues that we have experienced and we have learned from that and have come together as a community of organizations to provide the information we need now to move forward, and move forward more efficiently. So that's wonderful.

Emdeon is the number one clearinghouse in the nation. We're number two as the hospital submitter of claims as a clearinghouse. We're also a revenue cycle software vendor as well, so we have the whole claims continuum of revenue billing software products.

For our organization, and as many organizations, each of us have different, unique capabilities and also different product lines that we have within our organizations that make us different in the overall scheme of things. We have to look at things uniquely as it depends on our business model. And I think that's one of the things that we found in years past that most people do not understand that vendors are different. When I chaired the vendor timeline for WEDI, that was one of the initiatives I wanted to bring out is that each vendor is not alike, and we have to allow for time for the implementation based on the type of vendor that you are. And I'll go into that a little bit further as we move along.

So with our preparations that we made at SSI, we approached this as well in a very similar fashion in that our teams had been working on these initiatives for the past two years, and we actually completed our training for our internal employees and administrative teams two years ago, and have continued to educate them along the way. We found that while the 5010 certainly is not going to be as impactful in terms of the modifications programming-wise that we need to do for other initiatives. With our efforts, we found that the educational process really was key this time around as it was with the transaction and code sets, so that everyone was on the same page, and everyone who is going to participate in the 5010 and the ICD-10 projects understand the relationships between the two and how the integration of the 5010 is necessary for ICD-10.

Currently, I do co-chair the WEDI Adopters, Early Adopters Committee with Stanley Nachimson, and in that committee, we're comprised of a number of trading partners, vendors, payers, clearinghouses, as well as providers. And within our group, we each are

trading partners with each other. So what we are attempting to do in our small group is to do the very thing that Jim was mentioning is being ready ahead of schedule and ahead of the rest of the industry, so that we can provide the information and feedback that you need, as an industry, in terms of issues and problems that we've identified during our early testing phases. And also, some of the best practices that we may identify during this process as well, so that it will then impact your implementation of the 5010 and ICD-10 as we move along. There are a number of our group here present today.

So we're trying to gather information as we move along too with each of our efforts, not only within our own organizations, but within other organizations such as CMS, and their efforts that they have taken in the upgrades of their front-end systems and how we can assist them in their efforts that will then impact us as we move along with ours as well.

We also conducted internal surveys of our own customers. I do participate on a number of committees for HIMSS and WEDI and other organizations, AHIMA, and various groups that have done surveys of their base. We did one of our internal customers, and we have continued to do that as well quarterly, as Jim mentioned that they do as well at Emdeon. And what we found with that is that 19 percent at this time are making or completing changes that are required, 73 percent are still assessing or have action plans in place, and 5 percent have not started or don't know. And of those 5 percent who haven't started or don't know, actually it may not be the key individual that's part of the group that's actually coordinating the mandates within their organizations. So their efforts are not as impacted as some of the other project management groups within their organization.

Now, their general awareness. We tied a number of questions in the industry together with our customer survey and when we looked at this, we identified a number of areas that our customers had problems with. One, they still don't know what the 5010 is or what it does. Most of them have knowledge of the timelines, the deadlines, the impacts in the terms of their system upgrades or their upgrades that their vendors will be making for them, but they truly don't know what the content changes are. So that was an issue that we looked at and have tried to identify through educational presentations. We do webinars monthly. We also have national and regional conferences where we provide education to our customer base, so that they are much more aware of the regulatory requirements and how that's going to impact them.

We also provide information from CMS and other entities, whether it be Availity or Emdeon or any of our other trading partners, as well in terms of their efforts. It's very important, as our customers move forward, to understand the complexities of this and how they need to have their timelines. I did a seminar this past week on GAP analysis. We found that a number of our customers, while they thought they understood what they should be doing, really were not as aware of the implications of not meeting their analysis for their risk analysis within their own institutions.

Some are going through full changeovers within their own systems. Their systems can't accommodate the 5010 and ICD-10, so that's also impacting their timelines, and they

didn't understand what they truly needed to be doing in terms of their GAP analysis. They thought, well, "We're upgrading our systems. What more do we need to do?" So that type of information is very significant as well in the industry to know that people may not be aware of the impacts of each of our organizations and how they are going to interface to make this happen.

We've also provided links to educational tools. We've created tools and in fact, we did a similar GAP analysis tool as well for our customers and also used it internally to identify the modifications and changes that were needed for each of the different areas for the 5010. It's very easy, very beneficial. Customers love it and, you know, it's something that can be implemented very easily within their own organizations and adapted to them, regardless of what type of organization they have, and what complexity they have within their own hospital groups.

We also use e-mail alerts. We also have our customer website that provides easy access to current and archived materials, as well as created computer-based modules, training modules, for our clients as well, not only for their new hires within their organizations, but also as it relates to these regulatory efforts. And that's been beneficial, because they can view those 24 hours a day regardless of what shift their employees are on. So they can have this information available to them and learn and also have key questions that are part of those computer-based training modules for them.

We also enlist industry speakers for our national and regional conferences. This year, our conference is in June for our national conference and I've enlisted some Washington speakers on the regulatory initiatives and health care reform, because a number of our clients are very concerned with the timelines for health care reform, and what they need to do to accomplish, to have their reporting mechanisms in place, their certification of their systems, what type of certification is going to be done.

All of these are questions unanswered at this time that we're looking forward to the final rule, so that we can engage our customers in terms of what we need to do as a vendor in terms of making our products compliant, as well as what they need to do to accomplish their reporting mechanisms to tie back in with their reimbursements that they're going to receive for the stimulus funds.

As most providers understand the timeline for the 5010 and ICD-10, as I mentioned, they're less clear on the changes. Now, some of the electronic health record initiatives that are ongoing within their organizations, as well, have impacted their initiatives in meeting the 5010 and ICD-10 guidelines. They see that stimulus fund as something that's tangible, and they can put their hands around and can grasp and move toward that goal to obtain the necessary funds they need to update their systems or to make their systems more compliant, even for error and HITECH with security and privacy.

And all of these initiatives are very important, but when an entity is looking at where do I segment my talents of my programmers and my developers and my various departments, they're very concerned with losing those stimulus funds. So they may not have identified

the 5010 and ICD-10 as something that is necessary to accomplish right away, and that is why most of them are relying on vendors to make those changes for them.

Now, while it's also a strain on them for all of these various initiatives, it's also a strain, as many of our panelists have alluded to, on not only the clearinghouses, but the other vendors as well, not only for regulatory initiatives for 5010 and ICD-10, but also for the EHRs and the certification process that we may need to be going through for that. We're looking at these overlapping initiatives within our own organizations and trying to segment the personnel that are going to be necessary to meet these deadlines and these guidelines.

That is why it's so important for the communication process between each of us as trading partners, and that's why it's imperative that we do our surveys so often with our own trading partners, with our payers and our fellow clearinghouses and also other vendors that interface with our customers, and our providers – provide us a significant feedback on where they are with their own initiatives.

These external trading partner points and internal trading partner points within the organizations are clearly going to be the key in making this work, and it's really going to be dependent on orchestrating this as a community effort, so that each of us are able to implement our upgrades as timely as the initial HMS or HIS-PMS vendor upgrade, because the rest of the vendors are dependent on that mainframe vendor, the Siemens and the McKessons of the world. If they don't have their systems in place timely, then we're going to have the same type of situation we saw with the transaction in code sets, where that we were impacted quite late in the timeline, and that's why we had delays in the implementation. So we want to avert that this time.

For our particular software, it can be hosted at the customer site or it can be an ASP-based software, and our systems upgrades are very similar for each. So there is no significant difference. Our customers can also submit direct to the payers or go through our clearinghouse, so that software also has to be updated.

With our payer timeline, we're seeing the very same results that Jim at Emdeon is seeing as well. The timeline for the payers certainly is going to be significant for us as a clearinghouse in terms of our testing with them. And as we've seen in our early adopter group as well, it's been very difficult to have payers that are at that point in time that we can start our testing with them during the summer, so that that precedes the rest of the industry.

And that's why we're pushing within that group to push the payers and fellow vendors and providers in becoming ready, and some of the vendors have certainly stepped up their efforts, as Jim mentioned. Most of them have been very proactive in their efforts. Some have very intricate product lines that is a significant impact on their business. So not only are they doing these upgrades, but they also have to continue with their own product line upgrades as well. As we look at moving forward with the timelines, the two steps with

these integrated activities are truly going to be the impact as well as with the payers in terms of meeting that, not only the interoperability standard, but also the testing as well.

And it was very funny. I had a customer call last week and she said, “Oh, we’re ready to test our 5010” and I said, “Oh, you know, what vendor do you have?” And she told me, and I said, “Oh, when did you get your upgrade for your systems?” And she said, “What upgrade?” And I said, “Well, then, possibly you may not be ready to test for 5010.” And it was a very striking moment. You could hear it on the phone that, “Oh, no, I have been told the wrong information. I was told we were ready for 5010 and truly didn’t understand the impact to our business.” So I think we are all seeing a lot of those aha moments, not only with our customers, but within the industry as well.

So we look at this and take that as another item, and I have a new button on our website and it’s called “Did you know?” And if the customer clicks on the “Did you know,” it gives them another small little snippet of something that they should be looking at in terms of their implementation efforts for 5010 and ICD-10 and how that’s going to impact them. Certain of these items are definitely things that they have not either been aware of or have not really analyzed as a part of their risk analysis.

So when we look at...for a clearinghouse perspective of the inbound and outbound claims, some of the impacts that we see, as has been mentioned by other panelists, is tracking and matching the versions that each payer is utilizing, as well as the provider version. So as a software vendor and a clearinghouse, we’re looking at all of these different activities and trying to map that so that we’re providing the correct part of the software that will provide them with the 4010A1 or the 5010 or the ICD-9 or ICD-10 initiative. And in converting those claims submissions, if you’re looking at the various payers that may be ready, and you have one that’s submitting a 5010 and you have another that’s submitting in 4010A1, some that are not going to be ready for years, that we’ve heard from various entities, you’re looking at a timeline that extends out at least four to five years.

Certainly, there’s a cut-over date of October 1, 2013, for ICD-10, but you’re also looking at resubmissions, and you’re also looking at the industry as a whole and who can accommodate all of the initiatives as we are looking at them today. So your primary payer, if I’m a provider submitting a claim, a primary payer may be accepting the 5010. Your secondary payer may not. You may have a payer that is continuing on those two versions and then one is accepting the ICD-10 version, and I have heard that some payers may not be ready for October 1, 2013, commercial side. So they may still require the ICD-9.

So we, as a vendor, are looking at these multitude of activities going on and trying to track them and make sure that we have the correct edits in place so that our customers are capable of still submitting the claims in the correct version for each of these various entities and still getting the reimbursements. With the talk of the crosswalks, you know, certainly, that’s going to be a challenge because as we’ve heard, each of the commercial payers are crosswalking in a different fashion. So you may have a claim crosswalked to a

particular ICD-9 to 10 code for one payer, while it is crosswalked to a completely different code for another payer. So in your primary and secondary submissions, you may receive reimbursements that are completely different based on how they've crosswalked.

And I think a number of us are looking at that as issues for the providers in how they move forward and also issues with us as clearinghouses and vendors in trying to track and keep that straight. Now, one of the efforts that I thought was most important with ICD-10 is the complexity of the ICD-10 codes and how that was going to bring not only greater reimbursement for the providers in terms of submitting claims that are appropriate with the services they're providing and getting the appropriate reimbursement for that, but also for the best practices in the industry as well.

So I don't want the industry to look at this as an opportunity to crosswalk and not utilize these codes in the fashion that we can utilize them. We're bringing the best efforts to the industry, not only now for our claims submissions, but also in looking at our health-related issues as well and tracking best practices as we move forward. So, you know, one of the possibilities in the industry is limiting the codes that we use, and I don't want to see that happen for us. I think that's most important for us to keep in mind as we move forward.

Also, as we look at our various scenarios, you know, certain payers are going to continue utilizing proprietary formats, or the 277 versus the 277-CA, or they may continue using the 996 rather than – excuse me, 997 rather than the 999. Are they going to require reregistration? This is another thing we have to track and assist to providers. Are they going to provide us with testing parameters? Will clearinghouses be able to test for all providers or are providers going to have to do their own submissions, especially if they submit direct to the payers?

And for us, we're going to be assisting our direct customers with their testing efforts with the payers, so that's going to be helpful to them. But these are all items that bring that complexity even further. So it's important for the providers, and as well as the vendors and payers, to continue monitoring the claims process. And as Jim mentioned, with that dual process of testing, we are capable of doing that so that we know what's working, what isn't. Are there certain codes that are missing in the ICD-10 – as we've already identified some of those in the orthopedic realm and in other areas. But we don't want the providers to be affected by this. And certainly that in this economic situation that we're in, we definitely don't want their impact to be felt as being directly related to the progress we're making with the ICD-10 codes as we move forward.

So some of the recommendations we made to our customer base is resolve their NPI enumeration issues. Some have enumerated in different fashions – some are providing lock-boxes or P.O. boxes in their enumeration. If they have that in place, they're going to have to change that prior to moving forward, so that their claims are paid. Because now, it takes a physical address, and they cannot to continue to submit in that fashion.

As Jim and others have mentioned to review the front mode of the TR3s and identify those operational and policy changes that are going to affect them to support the 5010 and ICD-10, and also look at the elements that have business impacts on each of their entities. I think that's one of the most significant portions of this that providers can relate to. If a particular usage rule has changed, and if it's not required, don't send. That's another simple thing. But if you look at the very systems that are affected within providers' organizations, that can be complex as well, and review the definitions of inpatient and outpatient.

And as we've seen and CMS has looked at, allow the appropriate amount of time for testing. We're looking at two months for Medicare, three months for Medicaid. It could be longer. It leaves only seven months for the complete testing and migration for other payers, and look at the position and compliance dates. And as we, as an industry, are looking forward, we're all supporting those ICD-10 efforts as well with our 5010 because most of our programmers are also making those programmatic changes for the ICD-10 as we're moving forward.

So many thanks to CMS for a wonderful chance to be able to get in this type of venue to talk about these issues, and it's definitely going to take a concentrated effort of all of us to meet these regulatory guidelines. And I thank you so much for attending today.

Moderator: Thanks, Mary. I'd like to take the last half hour now before we break for lunch to just discuss with the panel some issues that have come up during the various presentations. And one of the first questions that I wanted to pose was to ask what challenges you've been experiencing with customers, and it would be helpful to frame it as who your customers are and if you have any, if you have come up with any sort of best practices to help them address those challenges.

Bob, we haven't heard from you in while. Would you like to comment on that?

Robert Jandorf: What challenges do I have with my customers? Frankly, they expect me to take care of everything, so they don't see anything as a challenge. They expect that I'll have the 5010 format up and running, even though they don't know what it is, and they are really putting off, even worrying about, the ICD-10 codes for...because they know it's not due until 2013. So at this point, they're not really expecting to just have any problems with submitting their claims. And when the ICD-10s come around, they'll expect our system to automatically do the translation for them in order for their claims to be paid.

The 5010, 99 percent of them don't even know what it is, don't know what a 4010A1 is. They don't know what a 270, 271, 277, 276 transaction is, and frankly, they don't care, and I can understand that. That's really everything from an IT department standpoint, and as long as we do our job, and we do our testing, we'll be fine. The big challenge is going to be with the ICD-10 codes when they realize that they have to start selecting codes that they're totally unfamiliar with and that's why, in my original presentation, I recommended that each vendor incorporate a translator built into it to give your clients

options on what are the codes they should use – if they put in an ICD-9 code, have different options come with the ICD-10 codes, and then, hopefully eventually, they'll stop doing that, and they'll just use the ICD-10 codes on their own.

But I haven't really heard much about anything from my clients. They just want to know that I'm aware of it and that we're going to take care of it, and my guess is that most of the clients, or most of the vendors here, are probably experiencing the same thing. Has anybody heard anything different from their clients, any panic about the 5010? Does anybody hear anything about them from any of their people about the 5010 at all? Not one person? Okay. What about the ICD-10 codes, has anybody approached you about that? Not one person.

Well, it's good we got together today. It's worked out well. But really, they really do expect us, as the vendors, just to take care of everything, update their system, give them a button to press and boom, it'll all be done. And frankly, that's our job, that's what we need to be able to do.

Moderator: Any of the other panelists have a different opinion or a similar experience? The mic should be on.

Randal Roat: Yes, I think our situation with the expectation of our clients that we'll take care of it is similar, and I would suggest, or maybe plant a seed here, that CMS could actually help us in that regard through your efforts by adding a lot more credibility to the effort of what we're doing. A lot of times, we find ourselves competing for those resources including clients' time and attention on these issues. They don't see them as a huge issue. They expect us to take care of it, and to the extent that you can enhance our credibility on that issue or make it a little bit bigger in their minds, that would be helpful to us.

Moderator: And Randal, do you deal just, or mostly, with providers? You must deal with payers as well, right?

Randal Roat: We deal with – well, we bill to the providers. We work on – I'm sorry. We bill to the payers; we work on behalf of the providers.

Moderator: Okay.

Randal Roat: So with respect to the payers, obviously, a big challenge is going to be having this coordinated well enough that it doesn't impact cash flow and bring our providers into the issue farther than they need to be.

Moderator: Do you have further comment, Bob?

Robert Jandorf: No, what he said is absolutely correct. The biggest fear that I have frankly is with what Emdeon has to do, because they're also the clearinghouse that my clients use.

Male Speaker: Speak up.

Robert Jandorf: Sorry about that. My biggest fear is what Emdeon has to do once they receive the claims. They're going to have to, just like every other clearinghouse, but we just deal with Emdeon. They're going to have to be able to interpret and use the 4010A1 and also get the 5010. Then based on what type of claims are sent to them, and they're then distributing them out to different payers, some payers are going to be ready for the 4010A1, other ones will be ready for the 5010. Within your organization, you've got to split it out, and since the specs aren't the same, and there are segments that are missing in the 5010, how are you going to do that?

James Mechan: I think – is this on?

Moderator: Yes.

James Mechan: I think, Bob, we'll take care of it for you, as soon as you'll take care of it for us. We'll provide...

Robert Jandorf: I'm in my place now.

James Mechan: No, seriously, we believe, and I think Mary and other clearinghouses... some are in the audience and some others...I think we believe that we will absolutely be able to do what we did the last time. We took – if you think of what 4010 was, we were going from NSF flat-file formats to 4010 working structures, so we had both the format, which actually turned out to be a bigger deal than the content just because of the newness of it. But we were able to take the content and map up and down. And it was a huge sea change in content. This time, it's X12 to X12, right?

Robert Jandorf: Correct.

James Mechan: And it's also the fact that the content – X12 has done a really good job of getting rid of some of the more onerous things that were in 4010 that had no real reason to be.

Robert Jandorf: None whatsoever.

James Mechan: And so – but we don't take 5010 and then make it 4010, or 4010 and make it 5010. We bring it into a chronicle XML format and we work within that in our, their system and most folks would do the same, and then depending on where the payer is, we've already got the content internally right that we got. And where the payer is, we have translators on the back end that are at the level, and some of them, as you see. What we haven't seen yet from payers, and it was mentioned earlier, was – I think Mary mentioned it – was companion guides. And the last time 4010 was fine having a standard...apparently it was better having 1200 versions of the standard...

Robert Jandorf: What about NSF?

James Mechan: And so it was...NSF, national similar formats all over again.

Robert Jandorf: Right.

James Mechan: And that – what we haven't seen is any of that because the payers are not at that stage for two reasons. The payers, as I mentioned earlier, seem to be tying their 5010 to the ICD-10, but also there was – the X12 brought out an intellectual property situation back in January saying, “You cannot use our guides.” Like the last time, companion guides, all it was, was the 4010 guide, and we said, “For Emdeon, do this and this, and for Aetna, do this, and for this, do this.” But we by and large copied their guides. And...intellectual property things, you can't do that.

By the way, you buy one version – Emdeon – and then you send out 100,000 versions with our guide with just your tweaks in it. So they stopped that happening, and X12 and WEDI worked long and hard and it's just only in draft. It's out, but it's only in draft, a version of companion guides that we can all use, which were not just cut-and-pasting from the implementation guide. Once that gets approved and comes out, I think we'll see again, maybe not 1200, but a considerable number of payer companion guides that says even though 5010, I don't need this, but I need this and this and this, and we've done a lot right now. Because of the NPI, people demanding taxonomy codes in places that are not there in the guide.

Robert Jandorf: Right.

James Mechan: Payers are still demanding the legacy ID where in 5010, you're no longer allowed to send it.

Robert Jandorf: You can't even send in 5010.

James Mechan: So those kind of things...a payer may come out with a companion guide that says I still need the legacy ID and most...So we believe, so we bring it in pure chronicle format. We'll work with the payer. That's what we take as our job, same as it's your job to work with the providers.

Robert Jandorf: Right.

James Mechan: We'll work with the payers, and we'll negotiate this back and forward. We'll show them our guidance reports that said, “You can do that if you like.” If you want to be as strict as that, whatever it is, then you're [inaudible] better be really big because that's all you're going to get from that. But if you work with us, just like the industry did with the operational compliance last time, and focus on what you need for adjudication payer by payer, and don't demand things that you're going to drop in the back side of your translator. And then the providers are going to report you to their State [inaudible] because you're dropping data and you're rejecting on data that you're not

going to use. All of those conversations that were really the driving force for 4010 are not yet happening, because we're not yet at that stage with the payer side.

Robert Jandorf: Yes, I...that's what I was trying to talk about. If we send over a 5010, there's no legacy numbers in there, and if you're converting to the 4010A1, which you're going to have to do because a bunch of payers aren't going to be ready on time, you can't include the legacy numbers because we're not sending them.

James Mechan: Right. But so in that situation, our companion guide would say to you...

Robert Jandorf: Include the legacy numbers...

James Mechan: If you send 5010 for these health plans still include it...Or include it for all and we'll strip it for the ones who – if it's easier doing that.

Robert Jandorf: It would be.

James Mechan: Include it for all and strip it for the ones who...

Robert Jandorf: Like I said, your task is more daunting than what ours is. From the clearinghouse point of view, you have to deal with all of us idiot vendors and then you have to deal with worse, with the payers.

Robert Jandorf: What I was saying was, it's more daunting for the clearinghouse. They have to receive several different formats from all the vendors that they're dealing with and just like you were talking about on the 5010, it doesn't include any legacy numbers. So if they have to convert it back to the 4010 format for certain payers, because they won't be ready on time – they never are when we're dealing with a change of this magnitude – we're going to have to include the legacy numbers in the 5010 just so that when it gets converted to the 4010, they include the legacy numbers, even though the legacy numbers are totally eliminated in the 5010 version.

James Mechan: I would say what we have is just a different version of daunting.

Robert Jandorf: Yes.

James Mechan: I mean, on the desktop, you have the daunting situation with dealing with the readiness of providers who are probably at the bottom of the totem pole in terms of resources. So you have your own challenges. We have our challenges as clearinghouses, but I think all of the clearinghouses in here, we understand what our challenges are. We know we're in the middle and have to look in both directions. We have to help you understand what the various payers – and what we really aim at, and I know we all do the same. What we really aim at doing is having you send us one 5010 and let us worry about how we are going to get to the health plans, but we'll need help from you to do that. But if you say the 5010 doesn't allow, for example, legacy IDs...

Robert Jandorf: It doesn't.

James Mechan: Yes, I understand, but we're going to say to you, "When you're sending to us, you do not need to be that compliant." You send the legacy IDs for the payers who still need it because they're still on 4010 or if you move to 5010, you still require it, or send it all the time and we'll deal with when to send it on and when not.

Robert Jandorf: Okay.

James Mechan: So as I say, I think it's just a different version of it, but as comfortable as you are that you're going to be ready for your piece of it, I think we're comfortable that we're going to be ready, but it will take a collaboration between us all.

Moderator: But, you know, based on that discussion and clearly, all of your organizations have done a lot of work to think about where the risks are and what you're going to need to do to serve your clients, and addressing Randy's comments about what we can – what CMS can do on behalf to help this entire process. Certainly, we heard a lot in focus groups that providers, as what you have seen, are asking for assistance. They're waiting for someone to show them what to do. What do you think, based upon how you've analyzed your systems and moving forward, it would be helpful for us to communicate to, to providers?

Holly Louie: I think for us and our clients, one of the biggest things is we need to know what you're going to pay or what you're not going to pay from a coding perspective as we move to ICD-10. Are unspecified codes going to be paid, yes or no? We need to know that now so we can move ahead in educating our clients and our coders and building our correct infrastructure and our crosswalks and our maps, and not just for CMS. I mean, no offense to CMS – I love you with all my heart, of course. But, you know, our world is commercial payers, and there's thousands of them out there, and they're not going to do it the way you do it. And as soon as we can get the industry on the same page, so we know what's going to be paid, by whom, under what criteria, the better we can prepare. If we don't know that until September of 2013, then it's going to be absolute chaos for the providers.

Mary Hyland: Just one more comment to that too, as the providers move forward, their payer contracts are going to be essential in terms of matching what is going to be paid and the amount paid to that effort. So that's another important piece. And for some providers, it may be a couple of years before they actually have their contract in, so that they can begin that process. It may not be prior to the implementation date, so they may be on their previous contract terms. So that's another issue the payers and the providers are going to have to face.

Moderator: Do you all think that there's certain things that we can be telling providers to start to think about, or start to do, that will help bring them farther along?

Rhonda Taller: At Siemens, we have small, medium and large health care enterprises, as well as physician groups, and I think the challenge is there's just a general lack of awareness. Most people know there is a date out there, 10-1-2013 for ICD-10. Some may even understand that there's a linkage between 5010 and ICD-10, but their primary mission as providers is the provision of care. It's not these daunting regulatory and compliance initiatives, so the more that information can get out in terms of best practices that different entities have used, in terms of recommendations – I know CMS has done a great job. They've had a number of teleconferences and webcasts, and they continue to update their website.

But again, a lot of the providers think, “We have a lot of time. We have until 2013.” And the reality is, they don't have a lot of time. If you go back to the final rule and where different organizations should be, and even if you look at the WEDI timeline that's been published for vendors, providers, health plans, many organizations are very far behind. That's actually one of the reasons why we set our infopedia up for our customers, because we know that the regulatory piece is something they all need to comply with. However, we're trying to make it as easy as possible for them to get access to information in a one-stop-shopping type format.

Randal Roat: Yes, I would agree with that. I think to the extent that you can increase general awareness, hit on the urgency, and somehow – and I'm not sure, this might be the hard part, is instill some degree of confidence that all aspects of the revenue stream including commercial payers, these types of things, are factored in, and we're not, you know, urgently leading the whole group over a cliff.

Moderator: Jim, did you have a comment?

James Mechan: Yes. For 5010, I think earlier on, it was mentioned – I think it was in one of the CMS presentations – that 5010 was an IT play. It's absolutely more of an IT play than ICD-10, but if we go into it thinking it's just an IT play, then we're going to miss out because the, while Bob and all the other software vendors will enable providers by giving them a version of software that can take – so it'll facilitate that 5010 can be entered. That doesn't mean that the physician or office manager knows exactly what they need to do to get their claim paid in a 5010 world.

And so that's why we had developed, along with the GAP analysis which is technical and has a need, that we developed the simplified, which is a business view, no techno-speak in there at all, color-coded, as simple as we can make it. And I think that it would behoove CMS to do something equivalent to that to say, “Oh, you can use ours. It's freeware. We put it on the website, and they can use it,” but go out and say to people, say to physicians, “This is what it's going to take to get your claims paid.” These fields that perhaps you had to enter, you're no longer in a 5010 world, but in the transition, you do, right? So you don't want to be too overloaded with it, because it's not yet that timeframe.

So don't not send things, because there will still be some payers on 4010 while we're moving through the transition, but absolutely look at all the new fields. And just because

you enable a screen on a software version to have that field on it, that doesn't say there's anything in the business process in that office to collect that data. If it was something they never needed before for payment, then there's perhaps nothing on a form that collects that. There's no business – so there's business process engineering that needs to happen in the office. But we need to make it as simple as possible, because we're reaching out to the end point where they don't have the same kind of resources that some of us here have.

So I think if we enable through software vendors' versions of the software on a desktop, and we have software, and SSI and other clearinghouses have software that goes out there, but that's just a tool. We still have to train on what has changed that they need to enter and especially any new fields that they have to go – or new codes or any of that, so that they go out and actually obtain that information so they can enter it.

Moderator: So playing off that thought about training, do you think that this is going to be another significant obstacle in terms of making the transition, that providers are going to have the appropriately trained people in-house? ... Would you like to comment on that further?

Holly Louie: At least for our providers – I don't know about yours – our physicians aren't trained for this. Most of hospital-based providers don't even have staff. They don't have employees and that's why they have a billing company, practice management company. So they don't have people to train. We are it, and we're reliant on them understanding what they have to do from a documentation perspective.

For the smaller office-based type clients, at least for AMA, most of their – the majority of their members are less than five physicians. They're not going to have certified coders for the most part. The certified coders are not the world of the problem. They all have tons of training through AHIMA or AAPC (American Academy of Professional Coders) or whomever, but most of my practice physicians are not going to have a certified coder. They're going to have – they check it off on a superbill. It's all in specified codes and has to fit on one-half of the page, or they have office staff who's working from some kind of a checklist. And that's not the same world as reading and abstracting a medical record to pick the most correct code.

We have our physicians saying things like, “Well, which EHR should I buy? Which this should I buy? Which that should I buy that's going to get me to where I need to be?” And nobody knows the answer – that is the problem. Because they all document, but whether that documentation will truly be sufficient as we move forward with the goals of ICD-10, I think we get divergent answers depending on who we ask, and I don't think that's a clear thing. And physicians aren't going to be ready for that at this point.

Randal Roat: Yes, I would just say from the billing service standpoint, as has been said here before, we'll have our part ready, and I think that that is a large part of what we need to do. We need to do the research, we need to analyze the policy change and analyze the process changes, get that implemented on behalf of our physicians, and then train them

on what specifically it is that they need to do. Like I think you had said in one of your earlier observations are that physicians said, “Well, tell me when it’s ready, and we’ll plug it in.”

And that’s exactly what’s going to happen, because they’re busy treating patients. And that’s what they’re going to focus on until we, in this case, their business administrative arm – delivers to them the solution. How that’s handled in practices that don’t have the resources the billing company brings, I’m not quite sure how that’s going to play out.

Moderator: Yes, Mary?

Mary Hyland: And one comment too – I believe Denise mentioned it this morning in her presentation. The impact of the ICD-10 is felt in every system in a hospital. So you truly do have to take that trail and follow that trail to find out all the systems that are impacted by the ICD-10. So you’re not only including what we do in terms of our billing perspective, but you’re also including the medical records, you’re including the laboratory X-ray, all of the various divisions within the organization, inpatient and outpatient, that is affected by these codes and the changes that are made, and all of your workflow processes that are inherent in each of these areas and the changes you’re going to have to make there.

So it’s not just the simple fact of how we can educate the providers, but it’s more of a way of providing them with a global picture of the impact that it makes on their institution, and providing them some tools or some ideas of where to start, and looking within their own organizations to identify these areas.

Moderator: Well, speaking of the, that is actually a nice segue into what I want to discuss next. You know, we mentioned in a couple of talks this morning that there are more than one health IT initiative, which is going to be a concern for physicians in the coming years. So how have you seen your customers prioritizing these various issues? I know that when we do focus groups, electronic health records came up as a primary concern, and we kind of had to refocus groups back toward, you know, we were discussing ICD-10 at this point. Do you see physicians and the rest of your customers being concerned about these various initiatives, and how are they prioritizing ICD-10 and Version 5010 amongst them?

Randal Roat: I think that from a physician’s perspective, anything that touches clinical care is going to get prioritized up front. Anything that is administrative is going to be something for us to deal with. If it affects money, it goes above all.

Mary Hyland: Right. And I mentioned that in my presentation as well that you know the EHRs and the stimulus funds or the grant money that’s available to them, that’s their priority now. That’s what they’re looking at. They need that so that they can move forward.

Rhonda Taller: I also think that often, our customers don't see the linkages between what's happening with ARRA and where ICD-10 to the extent. That's why I was really happy to see that presentation earlier today because that message needs to consistently be rolled out to the industry, that these are not discrete initiatives – that they all tie together.

Moderator: You know, another question that we were thinking about was we've talked a lot about providers and certainly, we're very concerned about smaller providers, smaller practices. Do we see unique problems when it comes to larger based hospital-based systems that we have to address?

Mary Hyland: Yes.

Moderator: What might they be?

Mary Hyland: Depending upon the type of organization, we have one large organization, corporate entity that has just recently purchased 27 hospitals. Of those 27 hospitals, all 27 are now undergoing a change of their entire mainframe systems, their entire databases, so that they match the rest of the corporate model. Now, if you impact that on top of everything else that they're doing, that's a huge initiative and very stressful for them to not only manage and make those timelines work so that the new systems are implemented prior, or at least during the timeframe that they can be implemented for their 5010 and ICD-10 initiatives.

And they also have to be concerned with meeting those mandates with the current systems if those upgrades are not going to be in place at that time. So it's more of a dual initiative, and also, the complexity of the various organizations, too, are very much affected by all of these activities. If they own practice management organizations within the corporate groups, if they own the physician practices, then their responsibility then is increased for educating and upgrading those systems as well, not only the hospital mainframe systems and all the ancillary services, but also the practice management as well.

James Mehan: I'll just add a little bit to that, that many of the large hospitals who send in to us don't have just one software version in the hospital, that this department uses this version, this company's software; this one uses this one and this one uses another one. And if those three or four software vendors have different timeframes of their readiness, then the hospital is never able to apply a consistent view of readiness across their operation. They'll be doing readiness by department depending on what versions of software they have.

Moderator: Well, we've got about five minutes left, so I'll open it to questions from the floor. Does anyone have any questions that they would like to address to the panel? If you could go to one of the mics.

Audience Member: Tom Leary with HIMSS. Mary Rita, I want to make – for those of us who are a little less schooled in this issue, you made a statement about some providers,

their contracts with payers may extend beyond the 2013 deadline. Could you explain that a little more clearly?

Mary Hyland: Yes. In the payer world, the contracts with each organization are determined and outlined for a specific time period in terms of their reimbursement strategies, so they may have outlined the various codes that they are applying certain reimbursement guidelines to for each entity, and various rates are negotiated. So it depends on the size of the entity, as well as the complexity of the entity, as to how they relate to the reimbursement structures.

So for some organizations that have just entered into possibly a three- or four-year contract with their particular payer, then that may coincide with the same timeline and they may not be able to upgrade their contract reimbursements until on or after the date of implementation for the ICD-10 codes. Does that help a bit?

Tom Leary: So the question then becomes don't we need to say something to the payer community to modify those contracts or what percentage of the industry might be adversely impacted by that, and therefore, patient safety and patient – patients and patient safety? I'm not asking you to say the policy, but...

Mary Hyland: I used to work for BlueCross BlueShield, so...

Tom Leary: Okay, good.

Mary Hyland: Basically though, they're not impacting the patient care or the patient safety. The contracts are definitely based on financial reimbursements. It is not going to affect the care or affect their efforts moving forward. So what it really comes down to is the business model and how each payer sees the necessity of moving those timelines up to accommodate the ICD-10 changes.

Moderator: All right, great. Well, we have come to the end of our morning session. So I'd like to thank all the panelists for joining us and bringing their thoughts to this discussion.