MGMA Center for Research
American College of Medical Practice Executives
Medical Group Management Association

February 1, 2012

The Honorable Secretary Kathleen Sebelius
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

The Medical Group Management Association (MGMA) requests that you take immediate action to address the payment disruption issues that have occurred as a result of the federally mandated transition to HIPAA Version 5010 electronic transactions on Jan. 1. Medical practices throughout the nation are experiencing significant challenges implementing these new transactions, a situation that has led to considerable cash flow problems for physicians and their practices. Problems are being reported with both Medicare Administrative Contractors (MACs) and commercial plans.

Should the government not take the necessary steps, many practices face significantly delayed revenue, operational difficulties, a reduced ability to treat patients, staff layoffs, or even the prospect of closing their practice. As the transition to Version 5010 is a mandatory step toward ICD-10 implementation, this raises even more concerns, understanding the magnitude of ICD-10 is exponentially greater than Version 5010.

MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices. Since 1926, the Association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals. The Association represents 22,500 members who lead 13,200 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

Version 5010 Issues and Concerns
Physician practices have reported numerous problems across various areas of the United States stemming from the transition to Version 5010. The most frequently reported problems have involved:

- Issues with practice management and/or billing systems that showed no problems during the testing phase with their MAC, but once the practice moved into production phase, found their claims being rejected
- Issues with secondary payers
- Rejections due to various address issues (pay-to address being stripped/lost from claims; pay to address can no longer be the same as billing address; no PO Box address)
- Crosswalk NPI numbers not being recognized

- "Lost" claims with MACs
- Old submitter validation information not being transferred
- Certain "not otherwise specified" claims being denied due to not having a description on the claim (CMS sent a notice of correction of this issue Jan. 27, 2012)
- Sporadic payment of re-submitted claims (with no explanation for rejections)
- Protracted call hold times (most typically 1-2 hours) when attempting to contact MACs for further explanation of unpaid and rejected claims (a problem that dates as far back as November 2011)
- Unsuccessful claims processing (with no reason cited for rejection) despite using a "submitter" that was approved after successful testing with CMS

Many of our members report not having been paid by Medicare and TRICARE since as far back as November 2011 as a result of Version 5010 issues. While practices have contacted their MACs to receive clarification on the reason for rejected claims (CMS reported itself in a recent Open Door Forum Call that the call volume has tripled since the transition to Version 5010), they are provided with little to no information beyond a vague explanation that the problems must "lie with your clearinghouse." Meanwhile, our members continue to hear from their clearinghouses that the reason for the claim rejection lies with the MAC. Many of these practices re-submit the rejected claims. Some report no success in having these re-submitted claims re-processed while others have sporadic success and continue to re-submit claims that have not been processed and paid.

These issues have resulted in a significant back-log at the Medicare contractor level. CMS even reported recently on an Open Door Forum call with physicians that practices should no longer submit large numbers of claims, as this is only exacerbating the problem. In the meantime, many physicians have not received payment from Medicare or TRICARE in months, forcing some to take out lines of credit simply to meet payroll and other expenses. Other practices are taking drastic action such as reverting to paper claims to avoid serious cash flow issues resulting from this mandate. Reverting to paper claims, however, will lead to a further back-log of claims and an unacceptable delay in payment. MGMA's principal concern is, without immediate action from HHS and CMS to alleviate this situation, disruptions caused by Version 5010 will ultimately interfere with patient access to quality care.

Recommended HHS Action Steps

1. **Instruct the MACs to immediately provide advance payments for physician practices that are struggling to meet the Version 5010 mandate.**

2. **Extend the enforcement delay until at least June 30, 2012.**

3. **Permit all covered entities to submit and accept Version 4010 claims until at least June 30, 2012.**

4. **Permit clearinghouses and health plans to accept and adjudicate Version 5010 claims that do not have all of the required data content, but that have sufficient**

data content to be successfully adjudicated. HHS should encourage providers and health plans to concentrate strictly on the most critical data content requirements of the electronic claims and other transactions. Medicare should announce that, assuming the claim contains sufficient data to be adjudicated, minor errors in the claim will not trigger an automatic rejection.

5. **Instruct the MACs to expeditiously adjudicate all outstanding claims, both electronic and paper.**

6. **Instruct the MACs to take all appropriate steps to ensure that they can accept and adjudicate Version 5010 claims in batch mode.**

7. **Instruct the MACs to take all appropriate steps to ensure that call centers are manned appropriately and that they are able to answer incoming provider questions in a timely manner.**

8. **Closely monitor the readiness level of the industry and take additional steps as needed prior to and after June 30, 2012 to ensure that transactions continue to flow and that physicians are paid.**

It is imperative that HHS address these issues without delay. We strongly urge the Department to put in place the steps necessary to ensure that claims will be paid in a timely manner so that practices can continue to keep their employees paid, and physicians providing care to the patients they serve.

We look forward to working with you as the industry continues its migration to Version 5010. Thank you for the opportunity to bring these issues to your attention. Should you have any questions please contact Robert Tennant at rtennant@mgma.org or 202-293-3450.

Sincerely,

Susan Turney, MD, MS, FACP, FACMPE
MGMA president and CEO

CC: Marilyn Tavenner, Centers for Medicare and Medicaid Services, Acting Administrator