



May 20, 2008

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: May 23, 2008 National Provider Identifier Compliance Date

Dear Secretary Leavitt:

As you know, beginning on May 23rd, all medical claims transactions are to be processed using NPI Only. The Healthcare Billing and Management Association (HBMA), the nation's leading organization representing 3rd party medical billing companies, is very concerned about the ability of commercial 3rd party payers to properly process these claims.

Unlike Medicare, many large and small commercial insurance companies have yet to even begin testing NPI Only claims, despite the looming deadline of May 23rd. We understand that many of these payers have provided verbal assurances to CMS that they will be ready to process NPI Only claims but that there has been no independent verification of these assertions.

Our own analysis indicates that HBMA member companies have had success submitting NPI Only claims for their physician clients with those 3rd party payers that are able to accept NPI Only claims. However, there are many commercial insurers, Medicaid agencies and some Medicare Contractors that continue to experience difficulty processing some or all types of NPI Claims.

Members of our Association met recently with senior staff at CMS to discuss NPI issues. We presented our NPI member survey data as well as information from a major clearinghouse that processes millions of HBMA member claims. Based upon that information, we had a high level of confidence that Medicare and its contractors would be able to process appropriately completed medical claims using the NPI Only, but commercial insurers and many Medicaid agencies would NOT be able to do the same.

Based upon our findings we indicated to the Medicare staff that proceeding ahead with the May 23rd effective date was appropriate. Unfortunately, information has come to our attention since that meeting that has caused us to question our optimism that the system will be ready by May 23rd.

For example, Emdeon, the nation's largest clearinghouse, recently informed HBMA that if the Department of Health & Human Services (HHS) terminates the contingency timeframe on May 23 and requires the NPI for all provider types possible in a claim, this could result in the rejection rate of almost 69.3 percent, on 10.5 million claims. Under this strict compliance interpretation, the 10.5 million claim sample could translate into \$2.5 billion of rejected claims.

In addition, HBMA member companies from CMS jurisdictions across the country have provided us with thousands of examples of claim denials and "development letters" that demonstrate that Medicare contractors are unable to link single NPI numbers to multiple practice locations despite their obligation to do so. Examples of this problem were supplied to CMS during our meetings on May 14 and additional reports from more jurisdictions have continued to come in, including reports during CMS' National NPI Question and Answer Conference Call on May 19, 2008. The resolution of these problems is almost exclusively manual, taking hundreds of thousands of Medicare claims back to the proverbial horse and buggy era.

HBMA members have worked diligently with their physician clients, software vendors, clearinghouses and 3rd party payers to comply with the NPI deadline. We are confident that HBMA member companies can and will be able to submit medical claims on the 23rd that meet all of the HIPAA transaction standards necessary to appropriately process those claims. Based upon both anecdotal and empirical data, we are not confident in the ability of some clearinghouses or 3rd party payers to process and pay those claims despite the fact that they are appropriately submitted.

We strongly recommend that in the short time we have between now and the 23rd, CMS reassess the ability of Medicare and Medicaid contractors and commercial insurances plans to appropriately process and pay claims that contain all of the necessary NPI information. This assessment should not rely upon verbal assurances of the plan to accept NPI Only claims, but evidence that the plan can process and pay these claims appropriately.

Should CMS conclude that a significant number of payers (any of the 20 largest commercial payers based upon claims processed data) or claims (>10% of claims) that are properly submitted cannot be paid by the 3rd party payers, CMS should consider delaying the effective date for an additional 60 days in order to allow plans to do the remaining work necessary to pay these claims. If, at the end of the 60 day extension, a plan still cannot demonstrate the ability to appropriately process claims, some type of fine and/or financial penalty should be assessed against this plan. Further, this fine and/or penalty could not be passed through to customers or physicians in the form of higher premiums or lower payments.

If there are failures in the system due to payers' lack of planning and preparation or, worse, incompetence, it will be the physicians and patients who will be harmed. This is not acceptable.

HBMA has sought to hold firm to the effective dates as we believe it is important for effective dates to have meaning. If people have little or no confidence that an effective date will be enforced, they have little incentive to undertake the steps necessary to be in compliance by the effective date. We continue to believe that this is the right approach. Unfortunately, it appears that the consequences of such an approach could compromise patient access to needed medical care and would be financially devastating to many physicians.

Because of the breadth of medical practices our members work with – local, regional and national – and the extensive contacts we have with a broad assortment of 3rd party payers, we believe we have a reasonable ability to assess the readiness of many payers. But despite the size of our footprint on the medical billing arena, we are not everywhere. CMS, through the Office of E-Health Standards, has the ability to determine the readiness of all covered entities.

If the Office of E-Health Standards determines that more time is needed to assure a higher level of readiness on the part of clearinghouses or 3rd party payers, then we urge you to listen to their opinions. Much progress has been made to date on preparing the industry for the switch to NPI. Medicare has been aggressive in its public education efforts and they are to be applauded for their work. Unfortunately, CMS cannot control the commercial insurance world and many Medicaid agencies have simply chosen to ignore the federal mandates. While we do not want to lose the progress we've made, our healthcare delivery system cannot sustain the types of huge financial losses some are predicting.

Therefore, we strongly urge HHS to:

- **Consider extending the contingency timeframe should you determine that the Medicare, Medicaid OR commercial insurance industry is not ready to process NPI Only claims appropriately.**
- **Continue working cooperatively with the stakeholders as a whole to ensure this transition moves ahead without wide scale cash and claims processing interruptions which could ultimately trigger access problems to the patients;**
- **Increase the level of communication between CMS and commercial insurers and the healthcare provider community to determine whether the vast majority of claims are being processed successfully without interruption.**

HBMA remains committed to moving towards electronic claims transactions. We believe that the efficient submission and payment of medical claims can greatly reduce administrative expenses and result in more of our healthcare dollars going towards patient care and away from administration and overhead.

We want to take this opportunity to reiterate our position that the roll-out of the electronic claims transaction standards should be sequential and not concurrent. Each segment of the healthcare delivery system should be given a separate date for compliance and once that segment of the chain has demonstrated compliance, we would move to the next segment of the claims chain with the provider being the last in the chain to demonstrate readiness.

By taking this type of sequential approach, we ensure that by the time the roll-out gets to the physician level, all of the technical problems have been resolved and there would be minimal disruption to the claims submission process.

Your consideration of these concerns and suggestions are greatly appreciated. If you have any questions or need any additional information, please do not hesitate to contact me or Bill Finerfrock, HBMA's Washington Representative.

Sincerely,

A handwritten signature in black ink, appearing to read "K Goodin". The signature is written in a cursive style with a horizontal line at the end.

Ken Goodin, CHBME,
President,
HBMA

cc: Kerry Weems, CMS Acting Administrator
Herb Kuhn, CMS Associate Administrator
Jeffery Rich, CMM Director
Stewart Streimer, Director, Provider Billing Group
Karen Trudel, Office of E-Health Standards