



# **5010/ICD-10 BASIC EDUCATION & STRATEGIC PLANNING**

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# PART I – BASIC EDUCATION AND STRATEGIC PLANNING

## Objectives

- HIPAA Overview –The Legislative Framework
- General Overview of 5010 & ICD-10
  - What you need to know now
- Strategic Planning & Organizational Readiness
- Compliance Deadlines
- 5010 Readiness Checklist

# HIPAA 2002: THE PRIVACY FOCUS

2002 HIPAA was all about the Privacy Standards

- Mandated Privacy Notices to all patients from 2002- present
- Refresher: HIPAA is the

**Health Insurance Portability and Accountability Act of 1996**

In general, HIPAA contains a large part of the federal law that governs **electronic transactions and data code sets** for coding and billing

- 2002 Privacy Standards focus merely paved the way for the EDI (electronic data interchange) standards

# HIPAA'S GOAL & TRANSACTIONS

- HIPAA Goals:
  - To improve the **portability and continuity** of health insurance coverage
  - To **combat waste, fraud and abuse** in health insurance and health care delivery.
- Within these Administrative simplification regulations we find the electronic transmission requirements for:
  - **claims automation, eligibility, referral processes, and other internet-based e-Business (Electronic Data Interchange) standards**

# EDI TRANSACTIONS STANDARDS

- Current Electronic Transactions Standards:
  - ASC X12 Version 4010/4010A1 and
  - NCPDP (National Council for Prescription Drug Programs)
- January 1, 2010 Upgrade to EDI Transactions Standards:
  - ASC X12 Version 5010
  - NCPDP D.0. and 3.0

# THE HIPAA CONNECTION: DISEASE CLASSIFICATION

- Also Imbedded in the HIPAA law is the standard for classifying diseases for
  - Clinical and epidemiological purposes
  - **Health services payments (in the US)**
  - **Standardized health records**
  - Public health assessments
  - Mortality and morbidity statistics
- Disease classification standards rely on Diagnosis and Procedure Codes

# ELECTRONIC EMR: FUNCTIONALITY IMPACT

- HIPAA's Goal for Simplification is addressed through the required transactions standards and EMR functionality:
  - Required standardized data field content; and
  - Structured data content
- Electronic impact to EMRs include
  - Standard terminologies embedded in the software
  - Addition of ICD-10-CM/PCS (more specific coding)
  - Computer assisted coding (CAC) embedded in the software for some applications

## ELECTRONIC OUTCOMES IMPACT: IMPROVED OVERALL ORGANIZATIONAL PERFORMANCE

Increased electronic data capability means you will see process changes in how you perform your day-to-day functions and measure outcomes:

- Measuring quality and safety
  - Example: Core measures contained in structured data fields
- Payment systems
  - Eliminating many of the phone calls, web searches, and manual edit processes
- Research
  - More specific study case identification through structured data fields and coded information
- Resource utilization
  - Easier to pinpoint where resources are being utilized

## DISEASE CLASSIFICATION SYSTEM CHANGE: ICD-9-CM TO ICD-10-CM & ICD-10-PCS

Final Rule published in Federal Register Jan. 15, 2009 mandates:

- ICD-10-CM (replaces ICD-9-CM) – **October 1, 2013**
  - US Clinical Modification of the World Health Organizations (WHO) ICD-10
  - ICD-10 CM Diagnosis codes will be used in all healthcare settings
- ICD-10-PCS (replaces ICD-9-CM procedure codes)
  - Developed under contract by CMS to replace ICD-9-CM procedure coding
  - ICD-10-PCS will be used for facility reporting of hospital procedures

# CPT/HCPCS LEVEL II CODES: NO IMPACT

- No Impact to CPT and HCPCS Level II codes
- Will continue CPT/HCPCS Level II codes for
  - Reporting physician and other professional services
  - Procedures performed in hospital outpatient departments and other outpatient facilities
- However..... **ICD-10-CM Diagnosis codes will be needed for all claims—**
  - A HUGE change for many areas!
  - Are our EMR and e-Billing Systems ready for this change?

## WHY IMPLEMENT A NEW CODING SYSTEM?

- ICD-9-CM is 30 years old
- Terminology and classification of some conditions are outdated and obsolete
- System is running out of space for new codes
- Outdated codes produce inaccurate and limited data
- Lack of international comparability (US is the only country still using ICD-9-CM)
- Unable to keep pace with advances in medical terminology and new procedures

# COMPLETE CODE RESTRUCTURING

- ICD-9-CM
  - 5 digits numeric
  - 3-5 characters
  - First character is numeric or alpha
- 14,025 unique codes
- ICD-9-Procedures
  - 5 digits
  - 3,824 unique codes
- ICD-10-CM
  - 7 alphanumeric characters
  - 3-7 characters
  - First character is alpha
  - All letters except U are used
- 68,101 unique codes
- ICD-10-PCS (IP)
  - 7 alphanumeric characters
  - 71,957 unique codes

# ICD-10-CM GRANULARITY

- More codes = More information
  - To improve diagnosis and treatment
  - Improved tracking of medical conditions
  - Improved Management of Care
- More Information/Granularity = More training
  - Coding Staff
  - Provider Staff
  - Ancillary Services Staff
  - Billing Staff
  - Scheduling/Registration Staff
  - Everyone who uses ICD-9 codes!

# Preparation OR Panic Attack!



ICD-9 CM Code: 300.01

ICD-10 CM Code: F41.0

# REVENUE CYCLE CONVERSION TO VERSION 5010

The first big hurdle to get thru before ICD-10 Implementation: 5010 standards

- **Everyone must upgrade to 5010: 4010 doesn't allow for ICD-10 CM/PCS codes**
- Compliance Deadline for 5010 conversion:  
**January 1, 2012**

So....what a perfect time to upgrade all of the electronic standards and add new requirements, right?

# 5010 – THE INFRASTRUCTURE FOR ICD-10 & OTHER ELECTRONIC TRANSACTIONS

## ○ 5010 Version

- accommodates ICD-10 CM & PCS code sets and Version 4010A1 does not
- Accommodates Medicare FFS changes
  - processing up to 25 diagnoses and 25 procedure codes per electronic claim
- Replaces the 997 transactions acknowledgment with the Functional Acknowledgment 999 and
- The Claims Acknowledgment (227CA) will be used to replace proprietary error reporting

# 5010/ICD-10 IMPLEMENTATION TIMELINE

- Deadlines for Version 5010 & NCPDP Versions D.0 and 3.0 electronic transactions:
  - December 31, 2011 –End-to-End testing complete
  - **January 1, 2012** –Providers, payers and clearinghouses must be using the new standards exclusively
    - Consequence of non-compliance: **Payment denial.**
    - **Medicare and Medicaid will not accept electronic formats that are not in the 5010 format!**
- Deadlines for ICD-10-CM/PCS Coding Compliance
  - **October 1, 2013:** Compliance required for claims submission and payment, based on date of visit (outpatient) or date of discharge (inpatient)

## STRATEGIC PLANNING IMPACT IT/HIM/PFS REVENUE CYCLE PARTNERSHIP

### ○ 5010/ICD-10 is not:

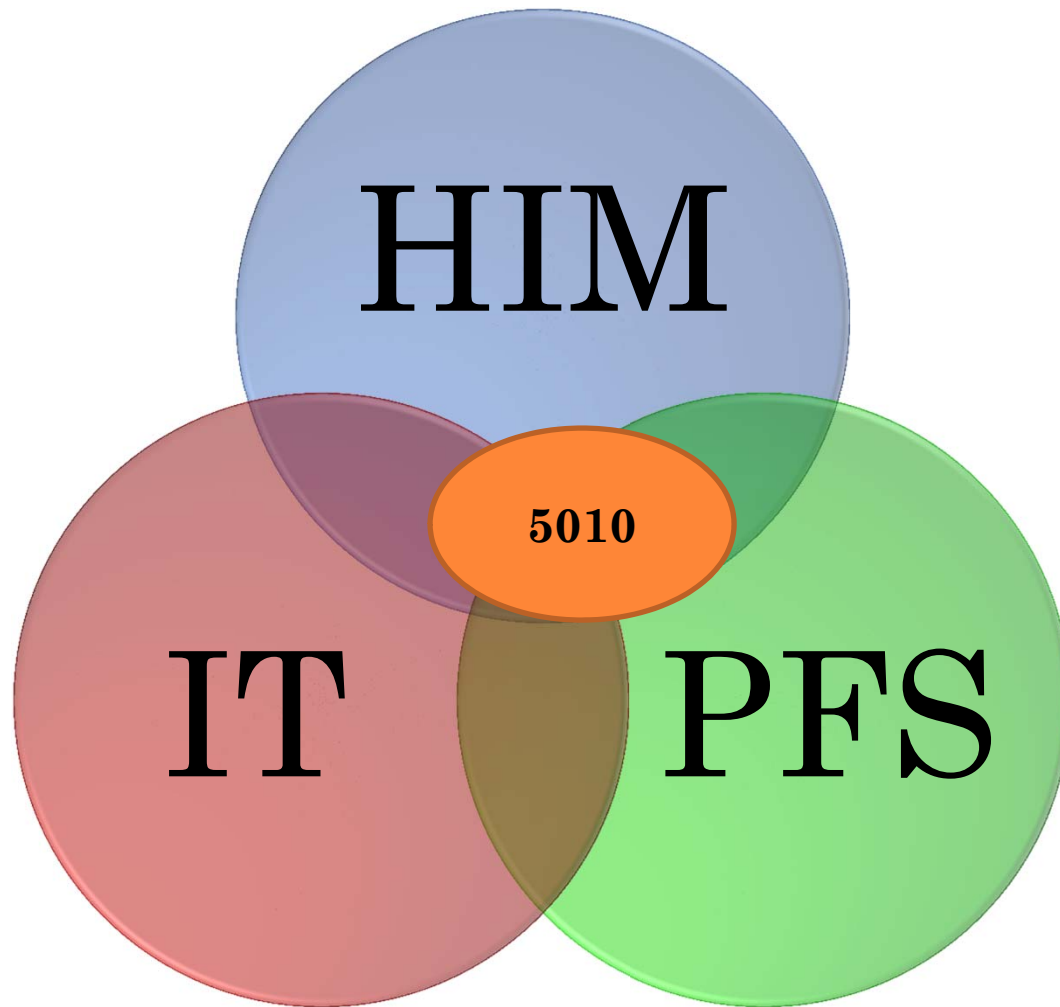
- It is not just an IT or vendor solution event
- It is not just an update to the electronic billing standards
- It is not just a change in the coding structure

So what is 5010/ICD-10?

### ○ 5010/ICD-10 is:

**An organization-wide process improvement opportunity** effecting all business areas, systems, and workflow

# 5010 IMPLEMENTATION: IT TAKES A TEAM!



## ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA)

- The ASCA prohibits payment of services or supplies that a provider did not bill to Medicare electronically
- Providers must submit a written request to their MAC to receive permission to submit some or all of their claims on paper (Waiver application)
- MACs are required to contact providers that appear to be submitting high numbers of paper claims to verify that those providers meet one or more of the exception criteria to submit on paper.

# 5010 REVENUE CYCLE WORKFLOW

Currently over 99% of Medicare Part A claims and over 96% of Medicare Part B claims are received electronically in 4010 formats

4010 and current NCPDP (pharmacy claims) lack functionality required by the healthcare industry.

- 5010 and NCPDP Versions D.0 and 3.0 address the shortcomings of 4010
- 5010 contains additional functionality (seen in referrals and authorizations)
- **5010 Incorporates more than 500 change requests**
  - Structural and content oriented changes
- 5010 provides consistency across transactions—most rules are the same throughout the suite

# STRATEGIC PLANNING: BUSINESS UNIT LEVEL

## ○ Each Business Unit Should Determine & Plan for

- **Key business processes impacted** by ICD-10 & 5010 Electronic Transactions in the entire payment system
- Look at Current and future operating models – **do you have the upgrades necessary in your software** to move to 5010 and ICD-10-CM/PCS?
- **Change management and training requirements** should be reviewed now
- Resource deployment –**what effects will automation have on staff and systems?**
- System Upgrade Costs (FY11 and FY12) – Begin assessment now. **Budget now for system upgrades.**
- **Review financial and budgetary opportunity costs** - Where might implementation of the 5010 changes actually reduce staffing created by our current paper workflows?

## BUDGETING FOR ICD-10

“Implementing ICD-10-CM/PCS will be **one of the most expensive** endeavors the healthcare industry has faced in recent history. Cost for the entire implementation will range from the obvious modifications to hardware and software applications to not-so-obvious costs resulting from decreased productivity in processing approved claims.”

Tori Sullivan, MHA, RHIA, PMP

Journal of AHIMA 81, no 9 (September 2010): 30-33

# 5010 PROJECT SCOPE: TRANSACTIONS

- Identify, modify and test the following transactions (mandatory):
  - **Eligibility for Health Plan Inquiry & Response (270/271)**
  - **Health Claim Status Request & Notification (276/277)**
  - **Referral Certification & Authorization (278)**
  - **Health Care Payment and Remittance Advice (835)**
  - **Health Care Claims: Institutional, Provider, Dental (837I, 837 P, 837D)**
  - **Acknowledgment (999 replaces 997)**
  - **Claims acknowledgment (277 CA) used to replace proprietary error checking**
- **Strategic opportunity to consider and test:**
  - **Benefit Enrollment and Disenrollment (824)**
  - **Health Plan Premium Payments (820)**
- Identify, modify and test the following HIPAA pharmacy transaction to new versions:
  - D.0 (Pharmacy and supplier transactions)
  - 3.0 (new standard for Medicaid Pharmacy subrogation)

Medicare has performed a comparison of the current and new formats for the transactions (see CMS website)

# 5010 PROJECT SCOPE: FUNCTIONAL AREAS OF IMPACT

Identify all electronic systems where ICD-9 codes reside to assess areas impacted by 5010 workflow changes, such as:

- Scheduling & pre-registration (Information gathering)
- Charge entry & billing (additional electronic capability—payment posting, changes in billing sheets, prior authorizations, referral processes)
- Referral staff, utilization and case management (electronic eligibility impact)
- Quality measures & clinical documentation (more specific diagnoses and procedure information needed from providers to code)
- Abstracting (structured data fields abstracted by coding staff/HIM staff)
- Coding (learning curve to accurate ICD-10 coding for staff)
- Revenue cycle management (changes in edits, new data fields)
- Claims Management (changes in refunds, denials processes)
- Health plan (changes in enrollment & disenrollment, referral certification, authorization and health care claim status)
- **Basically any area using ICD-9 Diagnoses Codes, and generating or processing claims can expect workflow changes**

# 5010 PROJECT SCOPE: NOT-SO OBVIOUS IMPACTS

- Revenue Integrity
  - Revenue Reimbursements (may see slow down in submissions/remittance)
  - Contract Management
    - Payer Contracting (ICD-10 will impact clauses in payer contracts)
    - Review these now for DRG payment clauses that may need to be reviewed
- Vendors (External Parties)
  - Collection Agencies (835)
  - RAC
  - Lock Box/Banks (835)
- Clearinghouses & Payers

# BRIEF EXAMPLES: 5010 DATA CHANGES

- Billing Provider Address vs. Pay-to Address
  - Billing Provider Address is a PO Box for 4010
  - For 5010, address registered is for the NPI where service was performed
  - May already be stored in your system; programming may be required to change how the address is pulled
- Zip+4
  - Ensure for all clinic/facility/provider locations
  - Issue may be where POS = Home
    - Service Facility loop addresses will be patient address
    - Will have to stop claims and add +4 to Registration

## WHY ARE WE LOOKING FORWARD TO 5010?

- The operating rules hold promise of better compliance among trading partners
- Looking for greatly improved responses in eligibility (271); more players, more information
- 5010 looming over our heads seems to have sparked **renewed activity among our trading partners in the 270/271 (eligibility) and 276/277 (claim status) functionality** (not widely used in 4010)
- There is hope that use of the 277 CA (replacement for proprietary reports) will solve some of the untimely filing denials

# MEDICARE FFS ADDITIONAL EDI STANDARDS

- 5010 requires changes to standard acknowledgment and rejection transactions
  - The Functional Acknowledgement 997 is being replaced by the 999 transaction
  - The Claims Acknowledgement (277-CA) will be used to replace proprietary error reporting

## 5010 CHANGES RELEVANT TO ICD-10

Version 5010 is essential to the adoption of the ICD-10 codes and includes the following infrastructure changes:

- Increases the field size for ICD codes from 5 characters to 7 characters
- Adds a one-digit **version indicator** to the ICD code to indicate Version 9 versus Version 10
- Increases the number of diagnosis codes allowed on a claim; and
- **Includes additional data modification in the standards adopted by Medicare FFS**

# KEY DIFFERENCES TO BE AWARE

- **5010 transactions distinguish between**
  - principal diagnosis
  - admitting diagnosis
  - external cause of injury
  - patient reason for visit codes
- **5010 supports monitoring of**
  - certain mortality rates
  - outcomes for specific treatment options
  - some hospital length of stays
  - clinical reasons for care
- **5010 addresses current unmet business needs**
  - such as an indicator on institutional claims for conditions that were “present on admission”

## IMPROVEMENTS IN PHARMACY TRANSACTIONS (D.0)

- New data elements and rejection codes to facilitate Medicare Part D and coordination of benefits claims processing
- More complete eligibility information for Medicare Part D and other insurance coverage
- Better identifies patient responsibility, benefits states, and coverage gaps on secondary claims;
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs

## BENEFITS OF PHARMACY TRANSACTIONS (3.0)

- Standardization of the pharmacy subrogation transaction process
- Increased efficiencies and reduced costs of the Medicaid Programs

## CMS SYSTEM ENHANCEMENTS INCLUDED WITH VERSIONS 5010 AND D.0

- Implementing standard acknowledgement and rejection transactions across all jurisdictions
- Improving claims receipt, control, and balancing procedures
- Increasing consistency of claims editing and error handling
- Returning claims needing correction earlier in the process; and
- Assigning claim numbers closer to the time of receipt

# 837 CLAIMS: BIGGEST CONVERSION RISKS

Why worry about the 837?

- Vendor software upgrades may include so many changes that staff need to be retrained and bugs need to be worked out.
- Every provider should be in dialogue with its clearinghouses (or with payers if the provider is a direct submitter) about level 2 compliance
  - Most clearinghouses have table-driven software, and they should have limited issues in the conversion process
  - **The challenge will be the large number of payers and how quickly they complete their own system upgrades.**

## CLAIMS: 837 & NCPDP STANDARDS

### THE GREATEST RISK OF IMPACTING CASH FLOW

- Your organization's patient accounting, practice management, or pharmacy systems vendors will be responsible for providing you with an upgrade to support data elements needed in Version 5010
  - Information about the upgrade and price should be in the organization's hands (2010)
  - Upgrades will likely *not* be solely related to version 5010. Many other fixes, patches, and enhancements will be scheduled for releases marketed under the "5010 compliant" banner
  - Watch for NM state level updates
  - If you have a retail pharmacy, you must migrate to the new NCPDP standard

# ELIGIBILITY INQUIRY: 270/271

CMS is making changes to its Information Technology infrastructure to address

- Standards for beneficiary eligibility inquires to the Medicare Fee-For-Service (FFS) program.
- **The changes will create the necessary national database and infrastructure to provide HIPAA compliant 270/271 health care eligibility inquiries and responses on a real-time basis.**

Extranet: Since May 2005, entities that wish to submit 270s to Medicare on a real-time basis have been permitted to submit 270s via the CMS AT&T Communication Extranet.

Internet: Internet access to conduct the eligibility transaction on a real-time basis is being developed.

**Regardless of the access method employed, all eligibility inquiries will be processed at the CMS data center. The CMS Data Center will use a single consolidated national eligibility database to respond to the eligibility inquiries.**

## 4010 TO 5010 ELIGIBILITY CHANGES (270-271)

In 4010 Version (today) Providers obtain eligibility information from patients, via EDI inquiries, Web sites and phone calls.

- The potential benefit of getting up-to-date, accurate, and complete eligibility information without human intervention is astronomical!
  - The first implementation of this standard failed because
    - payers did not populate an eligibility response as robustly as they populated a Web site performing the same function
    - The standard did not properly identify components such as identifying the patient versus the subscriber
    - Greater detail from payers was needed

## 270-271 ELIGIBILITY:

### WHAT PROVIDERS SHOULD LOOK FOR IN THE CHANGE

- Providers most often use an eligibility vendor or clearinghouse that processes a data feed from the underlying health information system
  - **Ensure that your feed is passing as much detail as needed for an accurate and complete outbound inquiry**
- Determine if you have the optimum capability to display and retain more robust response information
  - It would be a waste to get back a complete 271 response from a payer and find that the data dropped through a crack and were never captured in the system or used by the staff

## 270-271 ELIGIBILITY SAVINGS OPPORTUNITY

- The savings opportunity for an organization fully implementing electronic capability within the 270-271 standard could be significant.
  - There is no reason staff should be on the phone or the Web getting eligibility information if the system can obtain it without human intervention!
  - **The standard is not the issue; the work process improvement to use the standard is the issue.**

## CLAIMS PAYMENT: 835 (ELECTRONIC REMITTANCE ADVICE)

- Magnitude of upgrade depends on the number of payers for whom you receive electronic remittance data (3 vs. 50 for instance)
- With claims, the provider is usually dependent upon the application program vendor that provides auto posting functionality in the patient accounting or practice management system.
- Changes in the 835 are relatively minor, but the application vendor may use this opportunity to improve the functionality of the posting logic
  - **Watch for vendor upgrades that may effect resources!**

## SERVICE LINE VS. CLAIM LEVEL DENIAL (835)

- One commonly encountered problem with practice management software systems
  - Inability to process a claims-level denial where the insurance company denies the entire claim.
    - These vendors require a service line denial message for every service line
  - This requires insurance companies to create different 835 interpretations
    - for hospitals that post at the claim level and
    - medical groups that post at the line level.
- Some practice management system vendors will build new auto posting logic that supports a HIPAA-compliant claim level denial, thus expanding the payers a facility can deal with
- This represents a minor compliance challenge but **a major opportunity**—
  - Use the upgrade as a catalyst to implement claim level denial for most, if not all, of your payers

## OTHER ITEMS TO WATCH FOR ON THE 835

- Check with your vendors to see if state-specific mandates are supported for New Mexico in the new upgrades
- Organizations should be in dialogue with their remittance-processing vendor, which may be a clearinghouse or a bank.
- Providers should be working with their banks on the optimum solution for **re-associating dollars and data sent separately** should this be a requirement to meet electronic funds transfer legislation

## REFERRALS AND AUTHORIZATIONS (278): IMPACT ON UTILIZATION REVIEW PROCESSES

- The **improved 278 can eliminate many of the phone calls, faxes, and other communications** between payer and provider
  - Will leverage the scarce resources of the UR and CM staff.
- Can **provide an audit trail** superior to certifications received by phone and fax,
  - which may come in handy to the denial management team
- Providers with a substantial book of managed care business should look at the merits of a 278 project to determine how they and their payers could utilize it

## CLAIMS STATUS INQUIRY AND RESPONSE (276-277)

- 276-277 is an underutilized transaction—providers should consider how they and their payers are taking steps to eliminate “the black hole” into which some claims appear to drop
  - **These transactions (276, 277) were not mandated on the “compliance checklist in 2003”**
- The claims status exchanges (276-277) provide information about received claims that often require additional information to be included in order to be paid.
- The industry will make fewer phone calls and have speedier access to claims status with the widespread use of both acknowledgments and claims status transactions.

## ENROLLMENT (824) TRANSACTION STANDARD

- The 824 is a “Best Practice” in an effort to provide payers with accurate, up-to-date information
- Providers have a vested interest in widespread utilization of the 824 to automate the transmission of enrollment files
  - How many retroactive denials have institutions faced because an employer neglected to tell the health plan in a timely fashion that an employee had left the company?
  - In just one instance, you just might discover a \$750,000 billing error
  - Use the 824 for better controls (automated process)

# ELECTRONIC CLAIMS REQUIREMENTS

Electronic claims must meet the requirements in the following claim implementation guides adopted as national standard under HIPAA:

- **Providers billing an FI**
  - must comply with the ASC X12N 837 Institutional Guide (004010X096A1)
- **Providers billing a Carrier or DME MAC (for other than prescription drugs furnished by retail pharmacies)**
  - must comply with the ASC X12N 837 Professional guide (004010X098A1)
- **Providers billing a Carrier or DME MAC for prescription drugs furnished by a retail pharmacy must comply**
  - with the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard 5.1 and Batch Standard Version 1.1

## HOW IS YOUR 5010/ICD-10 PREPARATION GOING? COMMUNICATION PLAN: YEAR 2010

- ❑ Has your organization presented a Communication Plan to your organizational leaders about 5010/ICD-10?
- ❑ Can your Clinical, Financial, IT, Operations, HIM, and executive leaders name the person in charge of 5010/ICD-10 Implementation for your hospital?
- ❑ Does your organization have a functioning 5010/ICD-10 Steering Committee?
- ❑ Has your organization identified some functional areas with 5010/ICD-10 readiness gaps?
- ❑ Has the 5010/ICD-10 Steering Committee made some initial assignments and/or established a Project Team(s)
- ❑ Have you surveyed your vendors? Can they provide their 5010/ICD-10 roadmaps and/or plans?
- ❑ Has your organization created a structure for capital planning and budget?
- ❑ Has your organization developed a facility-wide training plan for staff?

## 5010/ICD-10 PREPARATION AND TRANSITION PLANNING YEAR 2011

- ❑ Has your organization completed an HIM/IT systems gap analysis, identifying all functional areas that will be affected by 5010/ICD-10? Gap analysis of....
  - ❑ Clinical information systems and processes (OR, ER, Nursing)
  - ❑ Ancillary information systems and processes (Lab, Rx, Imaging, PT, etc.)
  - ❑ Registration and scheduling systems and processes
  - ❑ HIM systems and processes, including documentation specificity audits
  - ❑ Chargemaster, billing and patient accounting systems and processes
  - ❑ Data warehousing, reporting and decision support systems and processes

# 5010/ICD-10 PREPARATION AND TRANSITION PLANNING YEAR 2011

- ❑ Has your organization rolled out a communication plan and education plan for the entire organization?
- ❑ Has your organization reviewed vendor surveys to learn their ICD-10 plans?
- ❑ Has your organization requested all payer plans and integrated them into the hospital plan and workflow for ICD-10?
- ❑ Has your organization updated all HIM and IT systems as well as related workflow to ICD-10?

# ICD-10 PREPARATION AND TRANSITION PLANNING YEARS 2011-2013

- ❑ Ensure that your facility can deliver detailed ICD-10 training to appropriate employee audiences
  - ❑ Friendly clinical documentation improvement to physicians
  - ❑ Clinical training to provider staff
  - ❑ Nursing and ancillary staff training
  - ❑ IT and decision support training
  - ❑ Business, quality and financial training
  - ❑ Scheduling, registration and administrative personnel training
  - ❑ HIM professionals—Coders—In-depth training
- ❑ **Simulate using ICD-10 in our test system**
- ❑ **Implement ICD-10 Coding by October 1, 2013**

# BREAK:

## PART II OBJECTIVES

- Strategic Planning 5010 & Beyond
- Steering Committee & Corporate Strategy
- Project Team(s) Development
  - Communication Plan/Team
  - Pharmacy Team
  - Billing Team
  - Eligibility Team
- Testing Readiness & Provider Testing

# STRATEGIC PLANNING: CORPORATE STRATEGY

- Important Strategy Key: **Must Investigate the potential new automation capabilities** in 5010/ICD-10 upgrades
  - Automation may provide strategic opportunities and value to the organization (i.e. the “lean organization”)
- Challenges are well beyond the 5010 EDI and ICD-10 Coding system changes!

# STEERING COMMITTEE: STRATEGIC PLANNING CONCEPTS

Begin with an evaluation of 5010 and determine the

- Risks & Vulnerabilities...Are you ready?
- Look for Opportunities
  - HIPAA EDI transactions were mandated based on a consensus that standardizing and automating the major exchanges between health plans and providers can **eliminate enormous administrative waste**
  - Transaction standards were designed to give providers more robust information and achieve more **uniform utilization** across all payers.
  - Focus on how to **increase the number of transactions done by the computer rather than exchange of paper documents** or time-consuming phone calls and web searches

# THE STEERING COMMITTEE: COMPOSITION & RESPONSIBILITY

- Suggested committee representation:
  - Senior Leadership, HIM, IT, Medical Executive staff, PFS, Contract Management, Patient access/admitting, clinical departments, coding, payee contract management, and Quality Management
- Establish Routine Meeting Dates/Times
- Project Update, Upcoming Milestones, & Next Steps
- Review Issues/Assign action items
- Assign a Project Manager/Project Lead(s)
- Develop a multi-year Capital Budget Plan
- Develop a Communication Plan

# FACILITY-WIDE COMMUNICATION PLAN

- Part I of this Presentation (is one example of material that can be used to facilitate facility-wide basic 5010/ICD-10 communication)
- Determine the scope of communication based on the size of your organization & the audience
- Determine communication & training avenues (all somewhat difference audiences)
  - Sr. Leadership -- Administrative Level Communication
  - Executive Level Communication (Large organizations)
  - Major Department Level Communication—HIM/IT/PFS
  - Ancillary Department Managers
  - Clinical Department Managers
  - Healthcare Providers

# STEERING COMMITTEE ICD-10 BUDGET ISSUES: (HARDWARE/SOFTWARE)

- Financing 5010/ICD-10 encompasses multiple project budgets over multiple years
- Hardware needs
  - Inventory all systems that require modifications to support ICD-10
  - System upgrade will likely require more robust hardware
  - Servers, workstations, and monitors may need to be upgraded or replaced to support the production environment
  - Hardware needed to support extensive testing and processing both ICD-9 and ICD-10 simultaneously
- Software needs
  - Vendor upgrades fees
  - Vendors may implement test applications, including interfaces, requiring deposits and implementation fees
  - Must work with internal contract management team to understand each vendor contract terms (additional service fee schedules)
  - Operating systems compatible?

# STEERING COMMITTEE 5010 BUDGET ISSUES: WORKFLOW CHANGES

- Evaluate software upgrades to determine additional data content collection and changes to the workflow processes
- Don't forget to plan for expenses to train staff on new workflow changes required for 5010

## STEERING COMMITTEE: ICD-10 BUDGET TRAINING COSTS

- Largest share of training costs (ICD-10) will occur late in the program (2012-2013)
  - All coding professionals should be trained at least six months prior to go-live
  - A few coding professionals should be educated each year through 2013
  - Budget key staff in HIM for training in 2011
- Provider documentation will need to be evaluated for compliance with the expanded terminology as well as coding and billing practices
  - Reaching out to busy professionals typically takes various methods
  - Will communication include survey tools, e-mail, printing & mailing?

# STEERING COMMITTEE: COMPLIANCE RESPONSIBILITY

- What role will compliance play in 5010/ICD-10 implementation?
- Who is responsible for up-to-date inventory of all applications that use the HIPAA transactions standards?
- Have you identified all associated vendors?
- Compliance team may need to be established.
  - As a detective—to identify every use of a HIPAA transaction standard
  - As a management consultant—be thinking about how increased or improved use of these transactions can save the organization time and money
- Why do we need to think about the compliance role?
  - The revenue cycle team may have a denials management package that works to upload remittance data using a HIPAA transaction.
  - The organization's bank may be providing a service that ties those electronic remittance data to associated electronic funds transfers

# STEERING COMMITTEE: DEVELOPMENT OF SUCCESS FACTORS

How will the Steering Committee determine if 5010/ICD-10 Project is a success?

- Examples of success factors:
  - Software modifications were 80% identified through system assessment
  - Vendors/contractors modified systems according to estimates within a 3% estimate margin
  - Software modifications were internally tested and passed with a 2% error margin
  - Staff Education was completed on time and on budget
  - Coding staff met testing and preparation activity estimates outlined in the Coding Education Plan
  - Claims submission rates decreased no lower than X% of the forecasted rate 30 days post Go-Live
  - Reimbursement rates decreased no lower than X% of the forecasted rate 30 days post Go-Live
  - Post Go-Live coding audit verified use of expanded code set as expected in the Go-Live plan

# STEERING COMMITTEE STRUCTURE: THE PROJECT TEAM(S) & SUB-TEAMS

- Lead by the overall Project Manager
- Project Manager will assign additional smaller/more purpose-defined teams or sub-teams as necessary (organization size dependent)
  - Communication team (Ex: HR/OPD)
  - Education team (PFS, HIM)
  - Billing team (5010)
  - Pharmacy team
  - Eligibility team
- The Project Team(s) is in charge of the
  - Tasks/work required to keep the project on time
  - Developing goals for the Steering Committee
  - Developing success factors

## PROJECT TEAM(S): INFORMATION GATHERING

- Clearly communicate the risk and necessity to leadership EARLY
- CMS 4010 to 5010 Gap Analysis by line item ([www.cms.gov](http://www.cms.gov))
- Which file types/transaction sets are utilized, where, and by who?
- Which software is involved and who manages those products?
- What business processes are affected?

## PROJECT TEAM(S): PREPARATION WORK

- Complete a gap analysis on the data changes between 4010 and 5010 for each standard (in the project team or sub-teams)
- Build the changes into your systems that allows production of a very clean 837 I/837P files (for example)

## PROJECT TEAM(S): PREPARATION WORK

- Software must be modified to produce and exchange the new formats
- Business processes may need to be changed to capture additional data elements now required
- Transition to the new formats must be coordinated:
  - Continue to use the current formats for some Trading Partners' exchange
  - Start to use the new formats with other Trading Partners
  - Can “phase in” 5010 submissions (e.g., when Medicare submissions are 95% compliant, can turn on 5010 submission in production) and prior to Jan. 1, 2012

## PROJECT TEAM(S): REPORT TO STEERING COMMITTEE

- The technical and business systems impact
- Complete systems/software inventory
- The workflow processes that need to be changed
- Any staffing resources that will be needed
- Any systems upgrades needed
- Education and training needed for physicians and staff
- Report Budget needs to the Steering Committee

# PROJECT TEAM(S): VENDOR ASSESSMENTS

- Complete vendor readiness assessment and present to the Steering Committee
- Determine hardware updates
- Determine software update requirements
- Timelines for software updates
- Testing readiness and implementation of updates
- Education and training on new software
- **COMMUNICATION is KEY!**

## PROJECT TEAM(S): PAYER ASSESSMENT

- Assess payer readiness
- Testing protocols
- Transactions testing
- Process to address issues identified during testing
- Re-test
- Approval process
- Migration and go-live dates

## LEVEL 1 TESTING: INTERNAL TESTING (SUGGESTED COMPLETION DATE 12/31/10)

- The testing is performed internally
  - to determine if programming or software changes for the 5010 transactions have been installed correctly and are functioning appropriately
- Completing internal testing will
  - allow you to identify and resolve any internal systems issues prior to initiating external testing
- Level 1 Compliance means a covered entity can create and receive compliant transactions

# TESTING: INTERNAL VALIDATION

- Can you generate HIPAA compliant files?
  - Valid segment structure
  - Zero content degradation using side-by-side analysis
- Are your internal business rules/scrubbers working properly?
- Is the transport or transfer of EDI working properly?
- Are you testing via a payer/intermediary gateway or are you informally sending a file?
- Challenges:
  - Real time vs. batch transactions
  - Connecting test environments to trading partners
  - Dealing with vendor delays or payer inconsistencies
  - Replicating the production scenario

# INDUSTRY HINTS: INTERNAL TESTING

## Checklist:

- Side-by-side Comparison completed (Enumeration of changes)
- Notified all trading partners (clearinghouse, billing agent, etc.) and individually contacted each payer for updates
- PO box updates
- Reviewed Provider edits currently in place for conflicts with the 5010 requirements
- Modifications identified
- Re-tool Processes Forms
- Data Reporting modifications and impacts
- Processes developed to monitor all transactions, both inbound and outbound

# PROJECT TEAM(S):

## 5010 TESTING CONTINGENCY PLANS

- Are you prepared for delays if undergoing hardware/software updates that will not be complete by compliance deadline?
- Have you identified a plan to prepare for trading partner and payer delays?
- Have you identified a plan to prepare for claims processing disruptions resulting in reduction of revenue or denied claims?
- Some vendors patch. Others develop.
  - Reminder....Develop = Delays
- Are internal or external customized rules still valid?
- Success = Dividing build work between vendor and provider IT department

# WHEN SHOULD LEVEL 1 TESTING BEGIN?

- Internal testing should begin **after your vendor(s) complete installation of 5010 systems/software**
- Test Practice Management Systems or Hospital Information Systems updates
  - prior to implementing integrated software component updates.
- Educate all personnel on systems/software updates prior to use of the system(s)

## 5010 CHECKLIST FOR LEVEL I TESTING ACTIVITIES-P.1

(CMS WEBSITE)

- Obtain the Technical Report Type 3 (TR3) documents
- Establish a project team and develop an initial project plan
  - Obtain executive sponsorship for the team
  - Elect a leader who can lead a multidisciplinary task force
  - Include representatives from IT department & all areas using the data and business end users
  - Develop metrics and measurement tools to track the status of the project

# 5010 CHECKLIST FOR LEVEL I TESTING ACTIVITIES-P.2

(CMS WEBSITE)

- Conduct a gap analysis
  - Inventory all software applications and vendors
  - Determine whether these applications take in or produce the HIPAA EDI transactions or Code Sets
  - Contact the Vendor(s) and determine when they will deliver their software upgrade
  - Understand the upgrade requirements: hardware, file conversions, implementation compatibility with the current version
  - Perform any necessary hardware or software procurements
  - Determine which payers represent the primary source of provider's revenue—contact these payers and get their implementation timelines

# 5010 CHECKLIST FOR LEVEL I TESTING ACTIVITIES<sup>-P.3</sup>

(CMS WEBSITE)

- Contact clearinghouses to learn when they will complete testing with the payers representing the provider's primary source of revenue
- Analyze hardware requirements to ensure the hardware supports the required upgrades
- Identify what is new in Versions 5010 and D.0 and determine what information is applicable to the organization
  - Medicare side-by-side 4010-5010 side-by-side comparison
- Identify what content was deleted from Versions 5010 and D.0 and determine the impact to business processes
- Identify changed content (example: infrastructure changes for ICD-10)
- Identify business processes affected by the new systems

## 5010 CHECKLIST FOR LEVEL I TESTING ACTIVITIES-P.4

(CMS WEBSITE)

- Communicate early and often
  - Identify internal and external stakeholders and trading partners and engage them in the planning process
  - Coordinate and manage direct connection with trading partners throughout the transition
  - Contact application vendors to learn of their delivery schedule for the system upgrade
  - Contact clearinghouse vendors to learn of their testing schedule for payers of key interest to provider
  - Contact key payers to learn of EDI exchange modifications (e.g., will a new Submitter ID be required for the 5010 version vs. the current 4010 version; will telecommunication connectivity changes be required?)

## 5010 CHECKLIST FOR LEVEL I TESTING ACTIVITIES-P.5

(CMS WEBSITE)

- Educate and train staff
  - Provide training for business and technical staff on changes identified through the gap analysis
  - Training focus
    - Understanding the transaction changes
    - Learning the practice management system (software) changes
    - Learning new workflow processes

# 5010 TEST PLAN

- All trading partners should be tested on every transaction if available (837, 835, 270271, and 276/277)
  - Most payers will not be able to facilitate end-to-end testing, but may offer Production parallel files
- Focus has been almost exclusively on 837 initially to minimize risk of revenue cycle impact
  - With the exception of analysis and planning for other transactions
- Start with low-hanging fruit and gain some experience:
  - Payers with ready to accept test files in Q2 of 2011
  - Payers with Companion Guides published
- Plan for what to do if some payers can't accept 5010
  - Your internal software would need to be able to submit both 4010 and 5010 for some time.

# 5010 HEALTH PLAN CHALLENGES

(INDUSTRY HINTS)

- Payers utilizing “direct connect” EDI, where providers submit claims directly to the payer, will need to upgrade their front-end validation and translation systems to accommodate the new standards
- Managed Medicare and Medicaid, as well as Medicare Advantage payers, will need to upgrade their claims adjudication and EDI systems in order to send compliant transactions to Medicare and Medicaid
- Coordination of Benefits (COB) claims must be accepted electronically
- **Complete eligibility responses will be required** instead of a simple “yes” or “no”
- The remittance advice will require implementation of a web page with Health Care Medical Policy explanations
- The claims EDI adjudication system may need to be revamped

# ROLE OF CLEARINGHOUSES IN THE TRANSITION TO 5010

- The role of most clearinghouses is to receive noncompliant claims from providers and translate them into compliant formats to send the transactions to payers.
- **The change to Versions 5010 and D.0 will add another layer**
  - Requiring clearinghouses to translate from Version 4010A1 to 5010 and Version 5.1 to D.0; and
  - Clearinghouses will need to upgrade their EDI infrastructure, including mapping, editing, validation, and translation systems

# 5010 TESTING GUIDELINES

## (INDUSTRY REPORT)

- Level 1 – Transmission/Transaction Integrity
  - High-level accuracy of the transmission and transactions
  - Validate the syntax compliance at the standard level
  - TRN Transaction Acknowledgment Report
  - TA1- Interchange Acknowledgment Report
  - 999 Implementation Acknowledgment For Health Care Insurance
    - a) 999R – rejection of total file
    - b) 999E – accept with errors
    - c) 999A – file accepted

# TESTING GUIDELINES

(INDUSTRY REPORT)

- An accept with Errors Code of 'E' will be identified in the 999 IK501 indicating that errors were identified, but transaction is being accepted for further processing
- 999 Accept With Errors will be returned at claim level via 277 Claims Acknowledgment

# TESTING GUIDELINES

- Level 2 – Data Integrity – Edits related to required data elements, relational data (e.g., numeric data in numeric-defined elements), and valid code values (e.g. qualifiers specific to the implementation guide).
  - 277CA Health Care Claim Acknowledgment
    - (Received in follow-up to the 999 accept and accept with error situations)

# EXTERNAL – LEVEL 2 TESTING (2011)

- External testing involves
  - sending and receiving 5010 transactions with your trading partners (e.g., clearinghouse, billing service, payers, etc.)
- If you submit transactions to a clearinghouse or billing service,
  - external testing will involve sending electronic test claims
- External testing will enable you to identify any issues that occur when you submit or receive translations to other organizations
- **Level 2 Compliance means a covered entity has completed testing with each of its trading partners and is able to operate in production mode with Versions 5010 and D.0.**
- **Level 2 Compliance Deadline: December 31, 2011**

# WHEN SHOULD LEVEL 2 TESTING BEGIN?

- External testing should begin
  - after the successful implementation of 5010 hardware/software updates and the completion of testing and internal QA
- Contact your clearinghouse, billing service, payers, or other trading partners
  - to determine available dates for testing
- If you are using a clearinghouse, billing service, or vendor software to generate transactions,
  - approval may be granted to all providers who submit to a clearinghouse, billing service, or software vendor that has passed transaction testing requirements with a payer.

# TESTING CRITERIA

- 25-100 Claims
- Professional and institutional claims submitted in separate files (ISA-IEA)
- 837 and 276 submitted in separate files (ISA-IEA)
- Test samples should be representative of services billed (bill types)
- Include Medicare Secondary Payer claims
  - ....early testers are finding these claims can be very problematic

# WHICH TRANSACTIONS SHOULD I TEST?

- Representative of the services that you intend to submit to the payer
- Test each transaction that your facility uses currently for 4010A1 transactions
- Submit additional transactions not currently used,
  - allot extra time for the testing process
- Ensure that all types of scenarios applicable to your business model are included
- Eligibility and Claims transactions should be tested
  - to ensure you can submit and receive remittance and eligibility response transactions
- If you exchange Institutional and/or Professional transactions 837 I/P, include in your testing monitoring and receipt of:
  - TRN Transaction Acknowledgement
  - TA1 Interchange Acknowledgement
  - 999 Implementation Acknowledgement
  - 277CA Health Care Claim Acknowledgement

# 5010 TEST PLAN

- Pre-Errata testing vs. Errata Testing?
  - Goal is to test all transactions on the Errata version of 5010 with each trading partner before moving to Production where possible
  - If a payer can only accommodate pre-Errata testing for some reason, evaluate on a case-by-base basis
- Production data will be used for all test files
  - Claim runs sent out of our Production environment in 4010 format will be recreated for 5010 tests from a test environment
  - Goal is to minimize post-Production surprises
- Early testers have noted that at least one payer requested a “Production test”
  - where, after testing from a test environment, they were asked to turn on 5010 in Production for a day,
  - then switch back to 4010 while they let the day’s worth of 5010 claims process through to ensure all is working

# TESTING PLANS

- Track post errata compliant 837 files
- Use HIPAA validation software to check all files before sending to trading partners—**Some HIPAA validation tools in use with 4010 will not support 5010**
  - **HIPAA validation software removes PHI from data (One software package (third-party software))**
- Test all transactions with as many partners as possible
  - **Goal: complete all internal testing by 3<sup>rd</sup> quarter of 2011**
  - Note: some trading partners may not be ready to test until 4<sup>th</sup> quarter 2011
- Test a copy of production data
- Analyze current 4010 claims, remittance and eligibility setup to identify opportunities to update, improve, or simplify your processes as part of the 5010 transition
- Plan to move to production as soon as each payer approves the test files to avoid the end of year crunch.

## TRANSACTION ELEMENTS TO ADDRESS DURING TESTING (837I/P)

- Ensure software updates capture new or changed requirements for 5010
- Monitor input from your HIM system to the 837 to ensure accuracy
- It is a must to monitor all transmissions and reports back from payers during the transition and migration phases as well as post implementation

## ELEMENTS TO ADDRESS DURING TESTING: ELIGIBILITY 270/271

- Proper identification of patient vs. subscriber
- Subscriber/dependent NPI data elements
- New service type codes
- Examine proper data feed from your HIM/PMS system
- Determine accuracy of submission
- Ensure 271 response from payer is captured in your system

## TRANSACTIONS ELEMENTS TO ADDRESS DURING TESTING-CLAIMS PAYMENT 835

- Ensure your HIM/PFS system provides correct auto posting functionality
- Review claims payment for correct reimbursement
- If you have state-specific mandates, is your system capturing electronic funds transfers, posted to correct provider

# TESTING ANALYSIS

- Attain 95% compliance results (self monitored results)
- Notify EDI via email when ready to move to production and disable 4010A1 capabilities
- Can move to 5010 standard transactions prior to January 1, 2012 if ready.

# CLEARINGHOUSE VALIDATIONS

- Who is responsible for clearinghouse validation?
- Will your clearinghouse agree to an end-to-end test?
- Replicating the production submission/inquiry and response
- Are your external scrubbing portals working properly?
- Does capability exist to mitigate clearinghouse errors?
- Conversion between 5010 and 4010 Challenges:
  - Trading partner policy on conversion
  - Trading partner 835 testing
  - Readiness for errata in production vs errata testing
  - Interpretation of 5010 compliance
  - Unknown area between a clearinghouse and payer

# PROVIDER TESTING TO CLEARINGHOUSE

Obtain the following:

- Companion or other documents regarding testing
- Testing syntax and content validation
- Translation of applicable transaction standards
- Translator tests for the edits:
  - Required data elements
  - Relational data (i.e., numeric data in numeric-defined elements)
  - Valid code values such as qualifiers specific to the implementation guide
- Validation – can encompass structural and business compliance at various levels
  - Level of compliance drives decisions regarding additional testing or production monitoring

# PAYER TESTING

- End-to-End Validation:
  - For direct connections, same risks as clearinghouse +
  - Testing electronic remittance advice can be difficult
  - Testing eligibility requires a large sample set with characteristics of that may cause difficulty
  - Receiving claims acceptance from the payer
- Challenges:
  - State medical assistance payers are the least progressive
  - Many payers do not comply with strict HIPAA standards
  - Testing actual adjudication with test patients is difficult
  - Testing with all payers is impossible for most providers

## PROVIDER TESTING TO PAYER

Obtain the following:

- Companion Documents
- Transaction changes
- Testing Requirements
- Testing on ERRATA or baseline
- Transactions to be tested
- Submission protocols and connectivity requirements
- Testing review process and issues resolution
- Approval and 5010 production process

# EARLY LESSONS LEARNED

(INDUSTRY REPORTS)

- Initial tests have revealed a few discrepancies between facility interpretation of the 5010 requirements and the Practice Management System vendor's interpretation
  - Example: Facility Loop – NPI reported vs. not reported
- In order to get the logic needed, vendor must update, test, and deliver new programming logic which takes time
  - May put your facility in a holding pattern for testing with additional payers unless you want to manually update files before sending for testing.

## EARLY MEDICARE TESTING “HELPFUL HINTS” (INDUSTRY REPORTS)

- Must include both the 999 and 277CA as part of the implementation plan
  - 277CA replaces proprietary forms (Medicare and other Vendors)
- New physician fields have been added to registration
  - Ensure your staff understand the purpose of the fields and do not just add information they think they should enter – not what the field is intended for (educational issue)
- ISA04 must be “padded” 10 spaces, not empty
- Identify custom programming in 4010. Re-evaluate what custom programming is still needed in 5010.
- Insurance address now required – cannot use default insurances with no addresses for things such as Financial Aid
- Must purchase the 5010 guides

## EARLY TESTING...ITEMS ORGANIZATIONS HAVE STATED THEY WOULD DO DIFFERENTLY...

- Allow more time to test Errata – all critical changes are in place in errata; there will be some deviations from the MAC installations
  - Each MAC is unique—should test with any MAC that you use (e.g. MACs set their own telecommunication standards)
- Purchase the guides sooner rather than later...
- Test early with multiple Health Plans
- Have input on process
- Review Billing Vendor and Health Plan Companion Guides

# 5010 IMPLEMENTATION MEDICARE FREE SOFTWARE

- Free Software 5010 Readiness:
  - PC-ACE Pro 32
    - Upgrade and full install will support 5010 errata versions only
    - No testing required by submitter
    - Look for this software on your MAC web site
  - PC-Print
    - 5010 version available 1/1/2011
    - Support both 5010 and 4010A1
  - Look for Software availability on your MAC website
  - Also—National Test Dates Announced to maintain 5010 momentum:
    - June 15 (firm)
    - August 24 (tentative)
    - Do not have to register to participate, but registration with your MAC is requested

## 5010 IMPLEMENTATION RESOURCES

- CMS 5010 Web Site for technical documentation
  - <http://www.cms.gov>
- Medicare Companion Guides
  - CMS developed standard template for Medicare Companion Guides
  - MACs will update with any MAC-specific information
  - Available via MAC web site
- 5010 Implementation Guides available from X12 at
  - <http://store.x12.org/>
- 5010 Technical Report Newsletters available from X12 at
  - <http://www.X12.org/newsletters/tr/index.cfm>

# RESOURCES

- Medicare Fee-for-Service Provider Resources  
[http://www.cms.gov/ICD10/06\\_MedicareFeeforServiceProviderResources.asp#TopOfPage](http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp#TopOfPage)
- Provider Resources (for all providers)  
[http://www.cms.gov/ICD10/05a\\_ProviderResources.asp#TopOfPage](http://www.cms.gov/ICD10/05a_ProviderResources.asp#TopOfPage)
- WEDI (Workgroup for Electronic Data Interchange)  
<http://www.wedi.org>
- HIMSS (Health Information and Management Systems Society)  
<http://www.himss.org/icd10>
- AHIMA (American Health Information Management Association) <http://www.ahima.org>
- HFMA (Healthcare Financial Management Association)  
<http://www.hfma.org>

## 5010 READINESS:

### WHERE ARE YOU IN THE IMPLEMENTATION PROCESS?

According to a survey by HIMSS,

- **More than one third of healthcare providers do not have a conversion program in place to transition to the 5010 electronic financial transaction standards.**
- At least two-thirds of respondents said they used resources to meet federal meaningful use requirements instead of on projects to switch financial transaction standards.

**JANUARY 1, 2012:**  
5010 IMPLEMENTATION DEADLINE

Only 246 Days to  
HIPAA 5010  
Compliance

# THANK YOU!

- Are you ready for 5010!
- Will you be ready for 5010 by January 1, 2012?

Questions?

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