
**WEDI Strategic National Implementation Process (SNIP)
ICD-10 Workgroup
ICD-10 Testing Sub-workgroup**

ICD-10 Testing White Paper



*Partnering for Electronic Delivery
of Information in Healthcare*

ICD-10 Testing for Small Providers

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WEDI WHITE PAPER

ICD-10 TESTING FOR SMALL PROVIDERS

PURPOSE

This white paper provides a starting point for small physician practices performing ICD-10 testing. (CMS defines a small physician/provider practice as having one to five physicians providing single or multi-specialty services.) This paper categorizes testing tasks under who, what, where, when, why and how categories. It focuses on providers' external testing with payers and assumes providers' internal systems are ready for ICD-10. It generally assumes providers do not use a billing service. Those who do should account for that when using this information (i.e., coordinate as needed with a billing service in addition to or instead of working directly with payers and/or clearinghouses).

ICD-10, which will replace ICD-9 code sets and update ICD-9 terminology, consists of two parts: (1) ICD-10-CM will be used for diagnosis coding for all claims, and (2) ICD-10-PCS will be used for procedure coding on inpatient hospital claims. The compliance date is October 1, 2015. Additional background is available in documents listed in the appendix.

WHY TEST?

ICD-10 testing is not required, but it is encouraged. ICD-10 has the potential to change how claims adjudicate in payers' systems. While CPT and HCPCS codes will still be the main determinant of how much physicians will be paid, we expect the ICD-10 codes will still be used by payers for some coverage and payment decisions. Performing testing will allow providers to better understand any impact regarding how their claims will be processed after the ICD-10 implementation and reduce the risk of unanticipated claims issues. Testing will benefit providers by helping minimize the following risks:

- Claim denials, claim delays and resulting administrative work and productivity loss associated with ICD-10 coding errors and other issues
- Cash flow disruption owing to those claims denials and delays
- Confirmation of your EHR (Electronic Health Record) and associated application(s) ability to generate ICD-10 claims.

However, ICD-10 testing has its challenges to include the following:

- Insufficient provider resources knowledgeable about and available for ICD-10 testing (e.g., coding, data collection/evaluation, testing facilitation, troubleshooting of test results)
- Insufficient training for staff on ICD-10 codes
- Insufficient testing opportunities with payers, clearinghouses and other partners (testing spots are limited, and payers may feel the bigger bang for buck comes from testing with larger providers)
- Lack of clarity and expectations among testing partners (lack of consistency of testing environments drives some of the misaligned expectations)
- Lack of readiness from vendors and their systems
- Confusion resulting from varying testing criteria and instructions (e.g., test file acceptance dates, compliance date for testing purposes); much of this can be solved by knowing which questions to ask up front
- Lack of availability of payers to test with and payer resources to contact about testing opportunities

WHAT TO TEST?

When determining what to test the focus should be on those diagnoses that have the greatest probability in impacting how a claim is processed based on experience. Considering this, determine what to test then perform testing based on actual utilization and real claims. This is highly recommended, because this enables comparison between actual and test data. It also reduces the need for testers to have the extensive clinical/coding knowledge necessary to create test claims from scratch.

Other considerations include:

1. Consider what others have tested and their test results to narrow the focus of your testing efforts. Prior provider test results are being posted and discussed in various forums, including WEDI.
2. Test high-impact diagnosis (Dx) or procedure codes (CPT) by claim volume and/or claim dollars (e.g., claim dollars could be high due to numerous claims or just a few high-dollar claims).
3. Test high-impact services by claim volume and/or claim dollars.
4. Consider complex claims. Examples are claims with Dx codes having more variation in mapping from ICD-9 to ICD-10, sensitive services or Dx codes, claims for all-government payers, services that require a referral or prior authorization. (If you commonly bill for services that require a referral or prior authorization, understand from payers if those rules will be used during testing process.)
5. Consider claims with potential impact to operational processes and reporting, such as customer service, research and development and health trend reporting.
6. Test diagnosis combinations in claims that will may trigger the medical necessity edits of a payer.

Based on your needs and guidelines specified by payers or others select the quantity of claims to test. The optimal number of claims varies based on resource availability and other factors. Depending on the variables, test files may be as small as 10 claims or much larger.

Cross reference what you would like to test with what actual claims are available. (As stated above it is recommended that you create test claims based on actual claims.)

Once you determine what to test maintain this information in a spreadsheet or other tool.

WHO TO TEST WITH?

Ideally you should test with one or more payers to ensure claims are being adjudicated correctly. The suggested steps below provide detailed information around this. If you are working with a billing service or other intermediaries, coordinate with them as needed.

1. Contact your EHR (Electronic Health Record) vendor immediately confirming your EMR and related application(s) are ICD-10 compliant.
2. Test with your top payers. Identify your payers and the percentage of your claims they process, both in terms of claim volume and paid amount. You may want to pull a monthly report showing claims billed by payer. Consider the 80/20 rule and test with the 20 percent of your payers that likely represent 80 percent of your claim volume and/or revenue. Expand your test profile as resources allow.
3. Contact and coordinate with your billing service and/or clearinghouse to determine how they can support your testing. Most clearinghouses have a dashboard or other report showing payers with whom they have made arrangements to support testing.
4. Identify key payer contacts to work with from your top payers list. Contact payer resources assigned to your contract; check payer ICD-10 websites and provider newsletters; ask your clearinghouse or billing service for references or check with WEDI and other professional organizations.
 - a. Confirm the payer is testing and that they will test with you. The latter may not be a simple 'yes' or 'no'. Some payers are creating web-based, self-service testing for small providers and doing more integrated end-to-end testing with large providers.
 - b. Obtain formal testing instructions, which many payers have created. If not talk to your payer contacts about testing details such as the following:
 - What testing have they completed to date, and what are lessons learned?
 - When will they test? Will they have more than one opportunity for you to test?
 - How will they test (e.g., paper, electronic direct, electronic via clearinghouse, spreadsheet direct)?
 - How many claims can be tested?
 - What are claim-specific requirements for testing?
 - Date of service (e.g., test claims must be dated xx/xx/xxxx, must be from production claims processed xx/xx/xxxx)?
 - Eligibility – beneficiaries must be active on date of test claim?
 - Should a specific claim identifier must be used to indicate test claims or test file (e.g., a certain field must have a 'T' value)?
 - Should test file have claims with ICD-9 codes intended to deny?

- What test results will be returned (e.g., 835, high-level acceptance/denial report)?
5. If some of your top payers cannot test with you determine if they are testing with other similar entities (e.g., family practitioners). Either way leverage testing already completed to get a sense for test results, lessons learned and more.
 6. Align payers you test with and what you test. Ensure you have covered all necessary testing.
 7. Contact Medicare Administrative Contractors (MACs) and CMS for testing during any of the remaining test cycles. MACs still have set aside March 2015 and June 2015 for acknowledgement testing, and have indicated that they will test anytime a provider entity is available. CMS is completing end-to-end testing in April 2015 for providers who signed up for testing. CMS is offering end-to-end testing again in July 2015 and providers should check with their Medicare Administrative Contractor for details.

WHEN TO TEST?

When to test will be somewhat driven by when the identified top payers are ready to test with you. Make sure you give yourself enough time prior to the compliance date to complete testing. Consider testing windows but also your own resource availability – then give yourself enough time prior to the compliance date to complete testing. The closer you get to the compliance date, the more providers will want to test, potentially limiting payers' ability to test.

Once you know when the payer is ready to test you will want to coordinate and confirm that your internal organization and resources are ready. This means ensuring your staff is ready and trained to code ICD-10 claims. (Not everyone needs to be trained, at least not right away. As long as staff members involved with ICD-10 testing are trained, you can successfully test even if the entire staff is not trained.) This assumes that you have completed any necessary ICD-10 standalone or pre-testing of clinical and billing systems – or confirmed that your vendors have. The success of your testing and the value of testing to your practice depend on your practice's readiness to test. If you test with faulty data, you will waste resources without getting reliable test results

Before testing also confirm when payers and other external partners are ready for you to test ICD-10. Contact payers, clearinghouses and/or billing service or visit their websites and other resources to determine testing windows. As an example Medicare's first testing window was January 26 – 30, 2015 and required registration for testing in October. Other payers may have similar registration requirements and testing windows.

Develop a test plan and timeline and if possible review with the payer. Track against and regularly update your timeline.

HOW & WHERE TO TEST?

After you determine what to test, with whom and when and then confirm those details with payers and other partners, you are on your way. Below are suggested steps on how to test. Adjust them as needed for your situation.

1. Prepare test claims. As recommended earlier create test claims based on actual claims. Consider instructions from payers and, where appropriate, billing services (e.g., if you will submit claims in a test environment when that will be available). Also note the following:
 - Gain the benefit of validating your documentation and coding by coding claims using ICD-10. This is recommended. If unable to use this model you can also use GEM crosswalk based on the ICD-9 code used on a previously processed claim.
 - How you do this will vary by format. Format options may be limited based on payer criteria.
 - If electronic it may not be as simple as modifying existing ICD-9 claims with ICD-10 codes. If it is a true Electronic Data Interchange (EDI) file and you are updating it manually, then it will likely be more complex than a find/replace. You will have to understand qualifiers, headers and other items.
 - If direct entry key into payer's test module.
 - If paper create mock paper claims.
 - Understand if you may need to change claim dates to avoid duplicate claim errors or to meet the payers test data requirements.
 - Some payers may require an indicator that it's a test claim.
2. Send test claims per instructions.
3. Review test results, comparing actual to expected. Note that you will need to work out with payers, and probably your clearinghouse, how test claim results will be provided.
4. Track findings, both successes and failures (e.g., issues with test file or payer processing).
5. Follow up on test results. Work with payers to understand errors and how to address them. Some payers may open their systems for testing but not make dedicated resources available for questions from all small providers. Understand the level of support available and the process to follow. Continue to work with payers until test claims process as expected:
 - Were denials received? If yes, what kind of denials and why did they occur?
 - How did claims pay? If they did not pay as expected, evaluate the cause of the discrepancy. Was the discrepancy ICD-10 related or due to other factors (e.g., contract setup in ICD-10 test environment, COB, problem with test claims)?

RESOURCES

1. Glossary
 - a. Dx - Diagnosis Code
 - b. WEDI - Workgroup for Electronic Data Interchange
 - c. CMS - Centers for Medicare and Medicaid Services
 - d. Crosswalk (noun) - The specification for the translation of one code within the source code set to one or more codes within the target code set without human intervention. Crosswalk may also be referred to as 'map'.
 - e. Crosswalk (verb) – The act of translating one code within the source code set to one or more codes within the target code set without human intervention. Crosswalk may also be referred to as 'matching' or 'mapping'.
 - f. Clearinghouse - companies that function as intermediaries who forward claims information from healthcare providers to insurance payers
 - g. General Equivalence Mappings (GEMS) A set of files developed on behalf of the Centers for Medicare & Medicaid Services (CMS) and National Center for Health Statistics (NCHS) to aid in data mapping and the creation of crosswalks between ICD-9 and ICD-10. These files include proposed generally equivalent mapping of ICD-9 and ICD-10 diagnosis and inpatient hospital procedure codes bi-directionally. These files include all plausible translations. Because all plausible translations are included, there are many instances where human intervention is necessary in order to make decisions on which translations to use
 - h. End-to-end testing:
 - i. *Submission* of HIPAA compliant ICD-10 enabled production-like test transactions (837 I/P and 278) through the providers billing system to the payers test environment for adjudication; and
 - ii. *Delivery* of a HIPAA compliant ICD-10 enabled production-like transaction (835 and 278) from the payer for evaluation by the provider.
2. Tracking tool sample (attach to paper)
3. CMS provider resources -
 - <http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10-ResourcesFlyer20130913remediated.pdf>
 - Small and Medium Practices ICD-10 Transition Checklist
 - Road to 10: The Small Physician Practice's Route to ICD-10
 - End-to-End Testing Checklists
 - [MLN Matters® Special Edition Article #SE1409\[links.govdelivery.com\]](#), "Medicare FFS ICD-10 Testing Approach"
 - [MLN Matters® Special Edition Article #SE1435\[links.govdelivery.com\]](#), "FAQs – ICD-10 End-to-End Testing"

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