ICD 10 Testing
The SSI Group, Inc. Clearinghouse and Revenue Cycle Vendor Perspective

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ICD-10 Testing

- Identify the Payer Matrix
- Create a Valid Test Transaction
- Testing Process
- Testing with Payers
- Tracking Testing Status
- Go-Live 10/1/2014
- Post Go-Live
Identify the Payer Matrix

- Create a spreadsheet or database of all payers the organization actively submits or works with.
- Categories by transaction tested should be captured.
- SSI posts a spreadsheet containing:
  - Status on payers readiness to test and several status levels throughout testing
  - Delays in testing
  - Estimated resumption of testing as well as the status of ready to go-live, in production, etc
- Providers - If you use more than one clearinghouse, add them to the list.
- Providers - If you submit direct, create a spreadsheet of your own to capture this information.
Create a Valid Test Transaction

- First step is creating a valid transaction containing ICD-10 codes. In an 837I (institutional) or 837P (professional) claim.
- Examine the claim content and ensure that you can produce a report showing any errors the claim may contain.
- Identify your largest payer. If you are utilizing a clearinghouse, they usually test on behalf of their provider customers. If you submit direct to your payer, it is your responsibility to test with the payer.
- Ensure that the transaction batch used for evaluation is produced by the application that has been updated to accommodate ICD-10 codes and that you are transmitting test files containing ICD-10 codes.
Testing Process

- Level I internal testing should be completed prior to engaging trading partners in testing. All integrated ICD-10 software updates and any database integration should be completely implemented and fully tested.

- Each payer will outline their specific requirements for trading partners to participate in testing.

- Clearinghouses may contact providers to provide test claims for submission.

- Level II compliance is the confirmation of claims sent meet syntax, content (ICD-10 codes validity check of structure and appropriate alpha numeric codes, not for the appropriate use of the code) and transmission requirements.

- Payer specific edits are necessary as far in advance as possible so that programming can be completed and additional transactions tested (if not included during initial testing).
Testing with Payers (Health Plans)

- Problems can be identified at various steps in the process (batch and claim level) through various responses. Address any errors as they are identified.
- The ANSI 999 batch level response will provide errors.
- An organization must be capable of reading or printing the 277CA file (confirmation report).
- 835 remittance advices will be critical to ensure what was the expected revenue was actually obtained. (Payers may not be able to address this step during testing.)
- Once resolved, the clearinghouse can be considered to submit in “production” and be provided a date by the payer.
As testing is completed for each transaction, the spreadsheet/database will be updated.

Internally track details of issues identified and their resolution with each payer. Note any programming modifications necessary to resolve the issue.

Use this information for lessons learned or to use the information in investigating similar issues.

Keep in mind that testing with payers is an ongoing evolution of identification of issues, programming changes and re-testing.

Should payers identify issues while testing with another organization, this may delay your testing until the issue is resolved.
Clearinghouse capabilities must include the ability to continue to submit transactions that are prior to 10/1/2014 with ICD-9 codes.

Payers must continue to accept re-bills with ICD-9 codes.

With ICD-10, don’t expect clearinghouses to crosswalk ICD-9 claims if Provider’s systems are not ready or capable of generating transactions with ICD-10 codes.

Documentation is key with coding ICD-10. Medical records must be used for correct coding. Crosswalks inaccuracies have been identified and abandoned by many clearinghouses, payers and other organizations.

Plan ahead, if you know your systems are not going to be ready for ICD-10, internal decisions should be made now to define alternative steps to ensure no interruption in billing occurs.
Post Go-Live 10/1/2014

- Monitor your systems and reports.
- 835s should always be monitored. Patient accounting system postings, payments and adjustments, of the adjudication of the claim should be included in your activities.
- Verify that every aspect of your systems are functioning correctly. Identify and address issues quickly.
- Keep track of post go-live issues and resolutions. They may be beneficial lessons learned for not only your organization, but others in the industry.
- Communicate and Collaborate with trading partners.
- Ultimate goal – successful transition with minimal disruption.
ICD-10
Creating ICD-10 Testing Approaches – Learning from the Past & Present; Vendor, Clearinghouse & Testing Service Perspective

Rhonda Taller (Government Affairs Specialist – Siemens)
Siemens at a Glance

- Global company – local footprint (190 countries)
- Founded in 1847 – Berlin, Germany
- Siemens Corporation, USA – Founded 1970
- 4 Sectors: Healthcare; Energy; Industry; & Infrastructure/Cities
- Healthcare Divisions: Health Information Technology, Imaging/Therapy, Clinical Products and Diagnostics
Siemens and ICD-10

• Core Team formed 2009 – subject matter experts cross multiple domains
• Cross-Product Design Team formed 2010 – focus on consistency
• Industry advocacy
• Regulatory Infopedia – “One stop shopping” for all ICD-10 related information, i.e., product report cards, FAQ’s, customer memos, webcasts....and more
Levels of Testing - Siemens

- **Unit Testing** – Software developers on their “code”
- **Integrated Testing** – All software changes tested together to ensure all works “as designed”
- **System Testing** – Testing software implementation process
- **Beta Testing** – Software delivered to customers to test in own environment
Key Testing Considerations

- Performance testing
- Usability considerations
- Software quality goals/checkpoints
- Ensuring backward compatibility
- Minimize “Day 1” impacts – software applies
- Implementation procedures – software application
- Outside the box testing
Elements of Beta Testing

- Define roles/responsibilities of beta customer/vendor (beta agreement)
- Vendor education/knowledge transfer – customer beta site(s)
- Test plan options – vendor-developed vs customer-developed
- Beta process – tracking progress (workplan); weekly communication; customer feedback; and sign-off
Challenges – ICD-10 Testing

- Usability – volume of new codes
- Productivity – longer searches due to larger code sets
- Multiple coding vendors – approaches for testing
- Supporting ICD-9 & ICD-10 concurrently – *many* scenarios to test (date-based)
• Simulating testing with 3rd parties – feasibility of end-end testing/claims generation (prior to 10/1/2014)
• Readiness of secondary vendor(s) testing efforts (for primary vendors testing process)
• Impact of staff knowledge (or lack of) with ICD-10 codes on timing for testing process
• Software customization considerations
Potential Vendor Questions

- Pre-requisite release/version for ICD-10 ready software
- Day 1 impacts for customers
- Vendor test methodology and tools utilized (prior to beta software delivery)
- Documentation to assist customers in understanding changes to software
END-TO-END TESTING STRATEGY

THE STRENGTH AND COST EFFECTIVENESS OF COLLABORATIVE TESTING

QUALEDIX – NATIONAL ICD-10 DUAL CODED SHARED TESTBED

LOTT QA GROUP – HEALTHCARE QA CONSULTING

Mark Lott
CEO – The Lott Group & Qualedix QA
ICD-10 Requires Paradigm Shift in Testing
ICD-10 Clinical Test Data
Shared Industry Approach for Testing
Testing Lessons Learned
End-to-End Testing Asynchronously
End-to-End Testing Pilots
Questions and Answers
Deep Domain Expertise in Testing
- Dual-Coded ICD-10 Shared Industry Testbed
- Asynchronous End-to-End Testing Methodology
- National Coding Accuracy Analytics
- Regional and National Pilot Leadership
  - NCHICA End-to-End Testing Pilot
  - HIMSS/WEDI End-to-End Testing Pilot
Unfunded mandates require cost containment
Testing cannot be accomplished in a silo
How trading partners remediate systems matters
Testing must help small/medium sized providers
ICD-10 requires clinical skillsets for testing
No dedicated end-to-end test environments

“ICD-10 can’t be accomplished with the square peg approach”
ICD-10 TESTING OPPORTUNITIES

- Business Driven Testing Approach
- Frequency Distribution of Clinical Events
  - Which ICD-10 codes are more important to be tested
  - Superset of test cases shared nationally
- Coding Accuracy Analytics
- Greater Provider Testing Involvement
- More Clinical Data for Testing not Mapped Data
- Testing must replicate the real ICD-10 world
How can providers and payers all test with each other?
How can clearinghouses handle all the demand?
How can you ascertain the health of your supply chain?
How can mapping tools be verified for accuracy?
How can 5010 testing lessons learned be applied
How can coding accuracy be measured?
How can coding tools be verified?
How can testing costs be reduced?
How can the industry collaborate efficiently?
End-to-End – Very Challenging
End-to-End – Who Gets Left Out
The human medical condition is not unique per entity

Thousands of clinicians and testers are embarking on creating the same ICD-10 transactions but all in a silo

This means as an industry we are incurring more than 1000 times the cost of creating tests that are common

Collaborative test data and testing efforts will greatly reduce the industry’s overall testing expenditures

Using medical records as the baseline helps everyone
  - Helps providers understand coding accuracy and improvements
  - Helps payers with more accurate ICD-9 to ICD-10 tests
  - Measures all stakeholders to the same test case standard

Collaboration is the Answer
ICD-10 Testing is Unaffordable

- **Silo Testing Costs**
  - 5000 Hospitals * $100,000 each = $500,000,000
  - 50,000 Providers * $10,000 each = $500,000,000
  - 100 Largest Payers * $2,000,000 = $200,000,000
  - **$1,200,000,000 in test data and coordination costs!**

- **Collaborative Testing Costs**
  - 5000 Hospitals * $10,000 each = $50,000,000
  - 50,000 Providers * $1,000 each = $50,000,000
  - 100 Payers * $200,000 = $20,000,000
  - **$102MM in test data and coordination costs!**

**Over $1,000,000,000 savings in test data costs!!!**
Collaboration can dramatically reduce ICD-10 testing costs
- Shared clinical test bed helps all industry stakeholders
- Multi-threaded dual coding and peer review of records
- Shares testing of vendor upgrades across all entities
- Shares testing of clearinghouse functionality
- Shares testing of payers mapping technologies
- Determines national coding accuracy rates by specialty
- Identifies specialties for additional training
- Identifies documentation improvement areas
- Creates superset of test cases for all to share
- Shares data across entire supply chain early and often
SHARED DATA FOR ICD-10 TESTING
4 Stages of Testing

Stage 1: Internal Unit/Integration
- Vendor Testing
- Documentation Improvement
- Dual-Coded Clinical Records
- ICD-10 Training
- ICD-10 Coding Accuracy
- Computer Assisted Coding
- Compliance Testing

Stage 2: User Acceptance Testing
- Dual-Coded Transactions
- Coding Consensus
- Clinical Frequency
- Contract Tests
- Computer Assisted Coding
- ICD-10 Coding Accuracy
- Billing Testing
- Compliance Testing

Stage 3: Trading Partner Testing
- Dual-Coded Transactions
- Clearinghouse Tests
- Revenue Cycle Tests
- Contract Tests
- Benefits Tests
- Payer Mapping Test
- Compliance Testing

Stage 4: End-to-End Testing
- Dual-Coded TXN’S
- Contract Tests
- Benefits Tests
- Pricing Tests
- Payer Mapping Test
- End-to-End Tests
- Compliance Testing

Shared Data
ASYNCHRONOUS TESTING - INTERNAL
Asynchronous Testing - External

Vendor

Revenue Cycle

Diabetes Type 2

Provider

Diabetes Type 2

Payer

Diabetes Type 2

Clearing

Diabetes Type 2

Shared Data

A SYNCHRONOUS TESTING - EXTERNAL
ASYNCHRONOUS TESTING

- Vendor
- Revenue Cycle
- Payer
- Clearing
- Provider

Diabetes Type 2

Shared Data

SYNCHRONOUS TESTING
**End-to-End Testing – By Category**

**National Testing Weeks**
- Common Test Cases
- Known Clinical Outcomes
- Payment Verifications
- Mapping Consistencies

**Testing By AHRQ Category**
- Infectious Diseases
- Neoplasms
- Endocrine
- Diseases of Blood
- Mental Illness
- Nervous System
- Circulatory System
- Digestive System
- Genitourinary System
- Pregnancy
- Diseases of the Skin
- Musculoskeletal System
- Injury and Poisoning
Two Current ICD-10 End-to-End Pilots

- NCHICA – North Carolina Regional Pilot – Completion 2Q 2013
- HIMSS / WEDI National Pilot – Completion 3Q 2013

Desired Outcomes

- Identify gaps in coding via peer review of clinical events
- Use clinical data to validate ICD-10 mapping tools and coding tools
- Shares clinical data with participants for internal testing activities
- Shares test data for end-to-end testing activities
- Allows concurrent testing by all trading partners

Participants:
Vendors, Hospitals, Physician Practices, Healthplans, Revenue Cycle Management, Coding Tools and Clearinghouses