Founded in 1986, SSI’s EHNAC certified healthcare claims clearinghouse has over 1,000 direct payer connections and processes over 600 million transactions annually, totaling in excess of $800 billion in billed electronic claims revenue.

SSI’s end-to-end Revenue Cycle Management solution features front-end eligibility, patient estimation and patient access; Best in KLAS® billing and contract management, claims attachment processing; and an advanced analytics and business intelligence product suite.
TESTING

- Landscape of ICD-10 Testing
  - Provider
  - Payer
  - Clearinghouse

- Complexity of Testing

- Clearinghouse Testing

- Payer Testing

- Provider Testing Initiatives
  - What do Providers really want out of testing?

- ICD-10 Compliance
Testing Landscape

- Scope includes nearly all business processes combined
- Traditional testing is gone
- Outcomes are unpredictable
- Provider’s due diligence critical
- Complex collaboration and coordination is essential
- Overlapping initiatives create strategic challenges
- Testing volume differs by the type of testing being conducted
Complexity of Testing

End-to-End

Define Testing
- End-to-end testing – does the definition differ by trading partner?
- Criteria for testing
- Test data to be used
- Scope of testing
- Testing partner selection
- Testing volume
- Analysis and feedback timelines
- Correction of identified issues timelines - retest
- Complexity of trading partners involved in testing
End-to-End Testing

- What does end-to-end testing mean to you?
- Anticipated results of end-to-end testing?
- Can your results be achieved by the type of testing your payer is conducting?
- If you are unable to obtain the results of testing you seek, what are your options?
- What steps should you be taking now to define the answers to these questions?
Complexity of Testing

Systems Infrastructure

Contracts

ICD Code Conversion

Clinical Protocols

Medical Records

Patient Benefits

Patient Satisfaction

UM

CM

DM
Testing Criteria

Define
- What criteria for testing has your payer established?
- Does it include:
  - Data validation
  - Errors
  - High risk transactions
  - Variety and complexity of types of claims
    - Top DRG transactions
    - Unique transactions
    - High complexity cases
- All transactions or specific transactions such as 837, 277CA, 999, etc.
Clearinghouse Testing

- Payer Matrix
- Payer Testing Process
- Will the Payer be utilizing internal cross-walks
- Has the Payer updated their ICD-10 Grouper
- Has the Payer released their Payer edits and will they be testing utilizing those edits
- Tracking Testing Status
- Go-Live 10/1/2014
- Post Go-Live Monitoring
Clearinghouse Testing

- Payer performance testing
- Quality goals/checkpoints
- Ensuring compatibility
- Remediation of Errors
- Re-testing initiatives
- Minimize “Day 1” impacts
- Think outside of the box for testing ICD-10
Clearinghouse Testing

- Capability to continue submission of ICD-9 transactions post 10/1/2014
- Clearinghouses will not cross-walk ICD-9 codes to ICD-10
- Will work with all trading partners to assist in identifying issues to mitigate interruptions in processing transactions
Payer Testing

Payer Test Plans

- Identify your Payer testing approach and initiatives – check their website for information
- What processes will be targeted
- Risk based approach targeting high volume
- Medical or clinical based scenario approach targeting top DRGs, or high cost/revenue impacts
- Technical integrity approach targeting systems, databases, interfaces, applications and supporting processes
- Business integrity approach targeting critical business processes, functions and supporting services including business continuity of claims processes and functions
- Type of test data to be used
Payer Testing

Payer Testing Strategy

- ICD-10 file validation
  - File format/content/edits validation
- End-to-End Testing
  - Internal and external testing of systems and business functions
  - Claims processing
  - Processing based on business outcomes
- Medical or Clinical Test Scenarios
  - Engaging selected providers to encode ICD-10 to top 10 DRG selected record types
  - Engaging selected clearinghouses to process transactions to payer for adjudication
Open or Managed Testing

- Selection process - selected trading partners
- Open testing
- Managed testing
- Portal testing
- National Testing
- Testing partnerships
- System testing
- Regression testing
- Testing performance
- Internal/External Testing
- Error testing
Types of Data for Testing

- Test data
  - Production data
  - De-identified data
  - Created test scenarios
  - Historical data
  - Centralized test data repository
  - Medical/clinical data from actual claims
  - Mapped/cross-walked data
Payer Testing Collaborations

Selection process

- Selected Providers
- Selected Clearinghouses
- Selected other trading partners

- National Collaborations
- Organization/Non-Governmental Collaborations
- Governmental (CMS and NGS) Collaboration
Provider Readiness

Stage of Readiness

- Have you re-negotiated Payer contracts for ICD-10 code updates and DRG shifts
- Has your HIS/PMS/EHR systems and software been updated with ICD-10 ready products and have they been thoroughly integrated and tested?
- If not, determine your timelines for integration and readiness
- Have you completed internal training on the software enhancements?
- Have you determined your risks – operational and financial impacts?
- Have you planned for possible interruption of revenue?
- What mechanisms have you determined to monitor and manage results of testing and go-live 10/1/2014?
Stage of Readiness

- Have you determined if your internal integrated ICD-10 information flows correctly to provide necessary information components to properly populate transactions?
- Have you verified the output from each system?
- Have you identified individuals in your organization to participate in testing initiatives?
- Do you have sufficient personnel to engage in creating test scenarios or code selected medical records in ICD-10 for testing?
- Do you have sufficient analytic staff to analyze test results and identify corrective action plans?
- Have you enough staff to sufficiently monitor transactions post go-live?
Next Steps

- If ready to initiate testing with trading partners, determine top Payers and identify their testing initiatives.
- If Payer is limiting initiatives to a select group, identify mission critical elements that need testing and work with payers to “get on their list to test”.
- Build collaboration with trading partners.
- Initiate communication strategies and implement internally and externally - this will be key to a successful implementation.
- Evaluation of potential reimbursement changes will be crucial to your bottom line. Your communication protocols with Payers will assist in expediting resolutions.
Follow-up post go-live 10/1/14

Impacts

- Scope and complexity of transition to ICD-10 should not be underestimated
- It’s not just a coding change, it’s the most complex implementation undertaken in 30 years
- Identify opportunities to improve efficiencies and consolidate systems and processes.
- Initiate documentation and coding improvements through automated tools, advanced training or other means
- Resource management will be critical pre and post implementation
Impacts

- Communications with CFO should be tightly structured to alert administrative team of immediate or anticipated long-term revenue impacts
- Analyze changes in case mix index, reimbursement groups and diagnosis and procedure code assignments
- Analyze shifts in reimbursement groups
- Communicate with payers about changes in reimbursement schedules or payment policies
- Monitor systems functionality and work with vendors to resolve issues quickly
- Implement contingency plans if needed
Resources

Industry Resources

- WEDI – resources are created by sharing of information by participants in workgroups – VOLUNTEER
- HIMSS/WEDI End-to-End Testing initiative; ICD-10 Playbook
- AHIMA – Coding training, information and resources
- CMS – valuable resources are available on line, national calls and recorded webinars available
- Healthcare Financial Management Association
- The North Carolina Healthcare Information and Communications Alliance, Inc.(NCHICA)
- Too many to list, so much information is at your fingertips.
- Communicate with WEDI and let us know your needs!
Contact Information

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Look to the Future
ICD-10 End To End Testing

Clearinghouse Roadmap to Testing

Betty Gomez, VP IT Operations Support, ZirMed
About ZirMed

Founded in 1999, ZirMed is one of healthcare’s premier health information connectivity and management solutions companies.

Combine innovative software development with the industry’s most advanced transactional network and business analytics platform to give organizations a clearer view of their financial and operational performance.

More than 160,000 providers at over 25,000 locations rely on ZirMed

Major Offerings: Revenue Cycle Management, Clinical Communications, Analytics

Top tier in KLAS®
Objectives

We will discuss the following:

- The role of a clearinghouse within the ICD-10 mandate and testing arena
- ICD-10 testing from a clearinghouse perspective
- Opportunities available within the ICD-10 testing space for clearinghouses to assist providers
- Identify risks associated with a lack of full end-to-end testing and mitigation strategies to minimize impact
Role of Clearinghouses in ICD-10

In a perfect world we would like to:

- Guide you through the transition to ICD-10 like we did with NPI or 5010
- Work with each provider to test all of their identified critical payers
- Do end-to-end testing for all payers and providers
- Provide payment response back to all providers for claims submitted during ICD-10 testing
Unfortunately, there are some limitations:

- Only the provider organization can code a claim:
  - We can’t automatically convert
  - We can’t input codes for providers

- Cannot test every payer-provider combination:
  - Not feasible to test all payers for all providers
  - Not all payers will engage in end-to-end testing
  - Too many collaborative testing initiatives to test them all
Role of Clearinghouses in ICD-10

But, we can ease the transition by:

- Take the lead in helping providers prepare for ICD-10
  - Resources
  - Education
  - Tracking progress (project plan template)
- Provide a self-test area for providers to test transaction functionality, code validations and clearinghouse edits
- Engage everyone in the industry – providers, vendors and payers
- Offer analytics and denial management tools
- Evaluate collaborative opportunities that will make end-to-end testing available to a broad set of providers
Role of Clearinghouses in ICD-10

Ease the transition - continued

- Facilitate end-to-end testing with payers that will work with us
- Track visibility to providers of payer testing availability
- Track and incorporate ICD-10 payer validations
- Identify problems that lead to claims being rejected
- Provide guidance about how to fix the rejections caused by ICD-10 transition
ICD-10 Testing

Clearinghouse perspective

- **End-to-end testing** is the ability to validate that the ICD-10 code submitted on a claim adjudicates in an expected manner from the ICD-9 codes in order to achieve financial neutrality.
- Clearinghouses can test format, syntax and code set validation with payers.
- Test with 80% of our volume.
- Test high risk, high dollar specialties.
- Test with our providers to ensure they are submitting compliant codes and that those codes are triggering the appropriate edits/code validation.
- Understand to what extent each payer will be testing, communicate and facilitate where appropriate.
Clearinghouse perspective

- Perform end-to-end testing for a certain number of providers where payers are making it available
  - Payer dependent they've identified the providers they want to test with by volume and dollar level
  - Payers requesting ETE testing directly with the provider bypassing CH
  - For some providers use the national pilot model or other industry collaborative
ICD-10 Testing

Testing approaches

- Internal system testing
- HIMSS/WEDI national pilot testing
- External testing with trading partners
  - Provider to ZirMed (self test area)
  - ZirMed to payers
- Understanding provider needs and payer availability and test to the highest level of availability
- Understand payers testing offerings
- Understanding what the provider wants and cross reference with what the payer is willing to provide as it relates to criterion of testing practices – prioritization of volume and impact
- Participate in an ICD-10 collaborative program to assist providers that may not be able to test
Clearinghouse Testing Challenges

- Industry is still figuring out the testing parameters
- Creating test data for ICD-10 – will have to use GEMs based crosswalk to take current ICD-9 claims and convert to ICD-10 to test only technical functionality and code set validation NOT coding accuracy
- Managing multiple payer testing requirements with different payer claim data requirements
- Payers don’t have the bandwidth to test
- Payers and providers are not ready to test (not enough time to coordinate testing with all)
- Payers are not offering testing through clearinghouses
- Payers systems are not set up to do end-to-end testing
- Current industry testing status: very low % have tested with or scheduled testing with payers
What have we discovered with early testing?

ICD-10 Pilot testing

- Providers don’t have their PM Systems upgraded to generate claims with ICD-10 codes
- Vendors are behind and haven’t deployed their ICD-10 ready versions
- Very few payers are even ready to test or know what type of testing they will allow
- Provider practices haven’t even started thinking about testing – behind in their implementation plans
- As we begin testing we will learn quickly about how claims are getting paid and will be able to share that knowledge with our entire network so that everyone benefits
- We will use the power of crowdsourcing to leverage our network and benefit all clients
Lack of full end-to-end testing

**Risks**

- Financial risks: Providers can’t fully plan the financial impact to their claims payment both in rejection and denial management and collection in dollars.
- Operational risks: bogged down processes to slow the production and processing of claims and other transactions – increased patient frustration because of delays.
- Increase in denial rate

**Mitigations**

- Take out a line of credit
- Training – improve provider documentation and more granular coding
- Avoid using un-specified codes
- Post implementation plan in place to act quickly
- Ensure you have a solid denial management/analytics capabilities to analyze denials
Recommendations

How do we as an industry prepare our providers for this transition?

- Providers should test and ensure that their coders can code in ICD-10, test that your system can produce a 5010 transaction with ICD-10 codes
- Payers provide visibility of medical policies and ICD-10 edits early on
- More participation in collaborative efforts
- Stop thinking about a contingency period and get your systems ready now
- Providers reach out to your critical payers and understand what type of testing they are willing to offer and get on their testing schedule right away don’t wait
- Payers leverage clearinghouses for testing high volume, high risk specialties
- Clearinghouses provide as much information available to you regarding testing and ICD-10 education
What are we doing?

To help ease the ICD-10 transition

- Leverage our modern technology platform to support ICD-10. Gained ICD-10 capability with 5010
- Focus on meeting and anticipating the needs of our clients
- Test environment for providers to self test – May 2013
  - Current state: ability to test a 5010 ICD-10 file
  - Type of testing: Code set validation
- Future: will have payer edits (as they get published) and processing rules driven by the payer (payer business validation)
- Assess and Track provider readiness through – Provider ICD-10 dashboard
What are we doing?

To help ease the ICD-10 transition continued

- Visibility to payer testing approaches as information is available based on interactions with the payers
- Helping our non-compliant providers understand their options making sure we have a plan in place to either remediate or move to a 5010 format
- Analytics and denial management tools to assist in post-implementation – helps providers monitor the outcomes of their claims
- Facilitating down conversion from ICD10 to ICD9
- How to fix articles – on how to resolve ICD-10 rejections or denials
- Education & training – on going
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