ICD-10 Readiness Guide: Setting Yourself Up For Successful Testing

HIMSS ICD-10 Task Force
September 2014
Introduction

Health Information Management Systems Society (HIMSS) is committed to guiding the industry through a successful transition to ICD-10, regardless of compliance date. Postponement of the compliance date provides an opportunity for the industry to increase the amount and rigor of its testing.

Intended Audiences

The HIMSS ICD-10 Task Force is publishing its ICD-10 Readiness Guide for three key audiences: providers, clearinghouses and payers. It is intended as a supplement to the HIMSS ICD-10 Testing Guide published in June 2014.

To simplify this document we will refer to the activities of two types of organization:

- **Originators**: those that originate healthcare claims; and
- **Adjudicators**: those that process and/or adjudicate healthcare claims.

Originators could be physician practices, hospitals, or clearinghouses. Adjudicators can be clearinghouses and payers. Clearinghouses and some other larger organizations can play both roles. To simplify this guide, the roles will be discussed separately.

The timeline below is intended to provide guidance through the major, high level activities that need to be executed in order for any organization to transition to ICD-10. It is also provided as a navigation aid for this Readiness Guide. The timeline assumes that organizations began ICD-10 remediation efforts sometime after the completion of 5010-related work. Any organization that has not yet started will need to adjust these activities’ durations to meet the compliance date of October 1, 2015. ICD-10 implementation strategies will vary based on the available time and the size of the organization and were addressed in CMS’ Implementation Guides for Hospitals and Practices and HIMSS Contingency Planning Decks.
Revenue Impact Analysis

All Organizations

It is highly recommended that all originators perform some level of revenue analysis prior to the compliance date. There is a lot of speculation, on both sides of the reimbursement equation, that the introduction of increased code specificity in ICD-10-CM will cause negative changes in reimbursement.

There is, however, some evidence that this may not be the case. A recent study,¹ using Version 30 of the MS-DRGs assigned to FY2010 MedPAR data, shows that 99% of the test case scenarios had no DRG change and the net result of the remaining 1% was down by 0.04%. Said another way, that is an average decrease of $0.04 per $100 paid under ICD-9.

The results for your organization will vary based on the kinds of patients seen and the services rendered. Performing this type of revenue impact analysis is very data intensive. It is extremely likely that someone in finance is already doing this type of revenue analysis (for ICD-9) currently. If so, leverage their work and expertise. The data and processes used today with ICD-9 revenue analysis will not be substantially different for ICD-10 scenario modeling and revenue impact analysis. If not, the required skill set can be easily found via a part-time contractor resource.

To make your scenario models as realistic as possible, consider:

- using the 80/20 rule to determine which payers comprise the bulk of your revenue cycle;
- evaluating which contracts are reimbursed based on ICD-specific language: Hierarchical Condition Categories (HCC), Pay for Performance, Value Based Purchasing, etc.;
- trending your denials and points of complexity by payer. Understand denials related to ICD-9 and ICD-10, develop appropriate metrics and establish a baseline. Include denial key performance indicators (KPIs) on scorecards or dashboards and use them to inform your external integration testing strategy; and
- addressing the volume of non-contracted payers to see if there is an opportunity to leverage testing. This may be small volume at the payer level but combined could be a larger volume.

Data from historical transactions for analysis and scenario modeling should include:

- High volume/frequency/cost diagnosis codes
- Codes with significant impact from ICD-10 changes that apply to your specialty or practice
- Scenarios that are operationally complex today with specific payers
- Procedures or diagnoses that have a specific medical necessity policy governance or those that require an Advance Beneficiary Notice (Local or National Coverage Determinations and Commercial Coverage Policies)
- Different claim types: Medicare as Secondary Payer (MSP), Coordination of Benefits (COB), liability driven
- Surgical procedures performed by your specialty that will have a corresponding inpatient/outpatient surgery claim (important for ACOs, integrated health systems, etc.)
- Specific & non-specific codes on similar claims
- External cause codes
- Highly audited procedures/codes

Keep in mind: Mapping between ICD-9 and ICD-10, while necessary for scenario modeling and initial testing, is not recommended for post-compliance transactions. Native coding in ICD-10 is preferred.
### Planning

The following activities should be planned in order to facilitate a smooth transition to ICD-10. The details of these activities are discussed elsewhere.

1. Decide how your organization will approach its ICD-10 remediation.  
   - Will it take a **wholesale** (create or install systems to replace all functionality using either code set) or **piecemeal** (leveraging existing systems with changes to use codes as appropriate) approach?  
   - Does this need to be decided by individual departments or entities due to existing systems or other considerations?

2. Setup proper governance structures and a steering committee and plan to leverage as much of the same staff as was involved in 5010 remediation work as possible.

3. Plan as much concurrent system reviews and remediation work as possible based on ability to meet staffing requirements.

4. Plan to address and test any system that stores, processes, sends, receives, or reports diagnosis code information for any reason (internal and external) including, but not limited to: clinical documentation system, practice management or billing system, registries, scrubbers, eligibility portals, accounting systems, marketing, reports and tables, incident tracking, prior authorization websites/portals, etc.

5. Depending on the complexity of the organization, Originators should plan for both internal and external integration testing.

### Communication

Regardless of the timeframe available for the ICD-10 implementation and testing at your organization, communication needs to be prioritized as an important, recurring activity.

**Internal Communication Milestones**

Be sure you hit these points at a minimum:

- Announce the organization’s approach to ICD-10 remediation and the high level plan.
- Announce to any upstream or downstream partners your organization’s intent to test in an effort to solidify that area of the plan.
- Announce the goals of remediation efforts (bare minimum compliance or an advanced approach to leveraging the detailed information one can glean from ICD-10’s specificity).

Adjudicators have an opportunity to take a leadership role with respect to integration testing with various types of upstream partners.

Making “public” testing events available to your partners/customers and publicizing them will give your organization an opportunity to model the way.

Originators should find out as soon as possible how their downstream Adjudicators are planning on conducting their testing events.

Some may want only ICD-10 codes. Some may want both ICD-9 and ICD-10 codes on the same set of claims data.

Figure out what you’ll need to provide to accommodate testing scenarios as that may indicate certain remediation choices. It’s safest to determine this ASAP.
## Internal System Review

Systems that handle the following activities should be reviewed to ascertain whether remediation work is required.

- Scheduling of office visits, outpatient procedures, inpatient admissions
- Collection of eligibility and benefit information (internal and through standard transactions, if possible)
- Referrals (in/out), prior authorizations, advanced beneficiary notices (ABNs)
- Recording patient history and problem list, lab results and other patient data
- Running decision support rules and alerts, entering orders and other activities
- Coding encounters and claim generation
- Running frequently used reports
- Other key workflows

## Remediation Work

Any system that performs special processing or decision logic based on specific ICD-9 codes requires remediation at some level.

### Custom/In-House Development

Wherever possible, we recommend that remediation work performed be modular in nature. The biggest piece of trouble that systems have been dealing with has been finding hard-coded references to logic driven by ICD-9 codes.

All work should plan for its own obsolescence, especially since we know that ICD-11 is another eventuality that will cause the industry to repeat this process unless properly mitigated now.

Once remediation work is complete, the following activities should be performed prior to internal or external integration testing:

- Functional / Unit Testing
- Regression Testing
- User Acceptance Testing (UAT)

### Vendor Products

If your organization is in the position of having vendors responsible for all software, this is a bit of a mixed blessing.

One the one hand, your organization will not have to perform the development work required to remediate systems. This will be your vendor's responsibility.

It is important to request that your vendors conduct end-to-end testing with any upstream Originators and downstream Adjudicators. In many cases your vendors may have other customers affected by these same relationships and will already be planning or will have already done this testing, but if you are working with a smaller vendor you may need to be prepared to coordinate or oversee these activities.

Depending on the size of your organization, you may need to coordinate those activities between multiple entities and separately track the progress of each.

Be sure to set up the proper governance structures (e.g. a Steering Committee, Project Management Office, etc.) with the ability to collect meaningful data and provide accurate status reports on the systems that will require remediation and the ongoing disposition of those systems as time progresses regardless of whether they require in-house development or vendor management.
## All Organizations

The activities discussed here refer to those that require interfacing with multiple systems within your organization. Depending on the size of your organization, the scope of these activities may be similar to External Integration Testing.

All organizations, regardless of their role, should consider the following activities:

### Staffing Considerations:
- Having a strong project manager or detail-oriented individual involved as there will be a need for meeting agendas and minutes, status calls, issue/resolution logs, etc.
- Identifying and involving the right stakeholders early in the process

### Data Considerations:
- Case sensitivity in test data
- Past and future dates of service
- Standing/future orders

### System / Environment Considerations:
- Recurring test environment refreshes
- Date of service limitations in the test environment
- Test patient data coordination between environments

### Scenario Considerations:
- Entrance and exit criteria
- Denials that automatically generate a patient statement
- Paper claims, if applicable
- Multiple roles within the organization (e.g. an internal clearinghouse)

All organizations should consider joining social/proxy testing collaboratives and communities through professional organizations. The ability to learn from other similar organizations who may be ahead of you is invaluable.

For more information on collaboratives see [Joining Forces on ICD-10-CM/PCS: Collaboratives Form to Help Handle Coding Transition](#).

## Originators

The types of scenarios that should be rigorously tested include, but are not limited to, the following:

- The addition/update/deletion of codes to patient records, orders, etc.
- The “end-to-end” process for a variety of patient care scenarios from admission/registration to discharge.

## Adjudicators

Clearinghouses in this role should pay particular attention to the homogenization of their different upstream originators’ content into a universal format that would be transmitted further downstream.

One key area of interest for Adjudicators will likely be the interaction with systems that will be processing the data received to build future revenue models based on fully leveraging the greater specificity available in ICD-10-CM.
### Originators

Chances are you have a downstream Adjudicator (payer and/or clearinghouse). If they have not yet published integration testing events, get in contact with them ASAP!

Whether you’re ready for this stage or not, it’s in your best interest to make it known that you want and expect there to be **multiple** testing events at regular intervals. The sooner you know the schedule, the sooner you can make sure your staff has goals for participating in those testing events.

Also keep in mind that the sooner you can send test transactions and review the results, the sooner you can begin to connect your earlier modeling exercises to real data and get a more accurate picture of the variance between the model and actual claims results.

Knowing that, you can engage in conversations to address any unexpected reimbursement discrepancies or anything else that may have occurred **prior** to it becoming an actual revenue-impacting event.

Ensure that all downstream adjudicators are using the same version (that you are expecting) of the code set and groupers.

### Adjudicators

If your organization acts primarily as an Adjudicator, we suggest that you take this opportunity to get ahead of the ICD-10 remediation effort and highly publicize your coordinated testing events.

**Really make a big deal of it.**

The greater the participation prior to the compliance date, the lower the chances of having post-live turmoil with your upstream “customers” who will be demanding payments for transactions they may not be sending out successfully.

In addition to holding these testing events, it will be important to plan for post-testing debrief discussions as many questions are likely to be raised after the initial events. At a minimum, plan on summarizing overall trends and providing advice where seemingly negative outcomes are experienced by Originators testing with you.

For your larger Originators, offer to review any number of claim scenarios as they look to understand the adjudication process that lead to the disposition of certain claims.

### All Organizations

Originators should plan on sending (and Adjudicators should ask to receive) test claims ranging from basic data transmissions to full-scale detailed claims with both UB and 1500 formats.

If feasible, we recommend that a subset of records (to avoid a strain on coding resources) be coded for ICD-9, per usual, and ICD-10. Those records can then be processed every week in a recurring “mini-cycle test.”

- It will demonstrate that you continue to be ICD-10 ready.
- Even if done manually, dual-coding will provide additional training and reinforcement of ICD-10 learning that will lead to the development of **coding best practices** ahead of the deadline.
- It will add an off-line validation and analysis step to review the reimbursement levels for the ICD-10 records and the combination of dual-coding and recurring claims submission will give your organization real-time reimbursement variance data.
- You can find reimbursement variances that will help in understanding and adjusting the revenue model and develop specific ICD-10 coding guidelines for certain procedures, practices, etc.
References


2. Catherine Mesnik & Kristen Harleman. A Large Provider Perspective on ICD-10 End-to-End Testing. Retrieved from: http://www.w edi.org/docs/publications/(ppt)-a-large-provider-perspective-on-icd-10-end-to-end-testing.pptx

The ICD-10 Task Force produced a piece for the ICD-10 Playbook on Testing Guidance in June 2004, portions of which were referenced in this ICD-10 Readiness Guide.