ICD-10 testing: What you need to know

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Physicians have less than 50 days to transition to the ICD-10 code set and should be well into preparations now as the Oct. 1 deadline draws close. One major piece of your prep should be testing your systems and processes.

Testing is vital to making sure you can create and submit claims using ICD-10 codes. Testing as early as possible allows you time to resolve any issues during the claims creation process, which lasts from documentation to claims submission. It’s also one of the best ways to avoid potential cash flow issues.

Use these tips from the AMA and the Centers for Medicare & Medicaid Services (CMS) to bring your practice up to speed for the new code set.

Types of testing

There are different types of testing, and each type serves a different purpose.

- **Perform content-based testing** to assess your practice’s documentation and ability to code in ICD-10. In this type of testing, your practice uses documentation to code a clinical scenario in the new code set. The Healthcare Information and Management Systems Society offers resources to help your practice with this kind of testing.
- **Conduct internal testing** to evaluate your practice’s ability to create and use ICD-10 codes throughout the patient work flow in place of when you currently use ICD-9 codes. This type of testing requires your practice to have system upgrades installed already and helps you follow the flow of a patient through a visit to identify the points at which codes are used. Use this testing to identify any gaps in your ICD-10 upgrades.

URL: https://www.ama-assn.org/practice-management/claims-processing/icd-10-testing-what-you-need-know
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Do external testing to test your practice’s ability to send and receive transactions that use ICD-10 codes with your external trading partners, including your billing service, clearinghouse and payers. Check with these groups about their testing plans.

Two important parts of external testing are acknowledgement testing and end-to-end testing:

- **In acknowledgement testing**, physicians and other submitters, such as clearinghouses, submit claims with ICD-10 codes and ICD-10 companion qualifiers. While claims are not adjudicated, submitters receive an acknowledgement that their claim was accepted or rejected. This is an important step to ensure you don’t experience problems getting your claims into the adjudication pipeline. Physicians can perform acknowledgement testing with their Medicare Administrative Contractors and the Common Electronic Data Interchange contractor any time until the Oct. 1 implementation date.

- **During end-to-end testing**, physicians submit claims containing valid ICD-10 codes. Health insurers process the claims through system edits to return an electronic remittance advice. While registration has closed for Medicare end-to-end testing, some health insurers continue to offer opportunities. If you have not conducted end-to-end testing yet, check with your health insurers, clearinghouses and billing services about opportunities. Check for testing opportunities with the Cooperative Exchange, an association of clearinghouses.

**Make a plan**

To get the most out of testing for your practice, you should:

- Review testing requirements to understand the scope and format of the testing available
- Focus on your highest-risk scenarios, such as claims processing and the diagnoses you see most often
- Prioritize testing with health insurers, concentrating on the ones that account for the majority of your claims
- Avoid common billing errors, such as an invalid National Provider Identifier, invalid Health Care Procedure Coding System codes, or invalid postal ZIP codes

When testing with vendors, clearinghouses, billing services and health insurers, make sure you:

- Verify that you can submit, receive and process data with ICD-10 codes
- Understand how ICD-10 updates affect the transactions you submit
- Identify and address specific issues before Oct. 1
Even if you don’t have an ICD-10-ready system installed yet, you still can conduct testing. CMS recommends looking at the ICD-10 codes for the top 10 conditions you see. Consider the volume of conditions and those that account for most of your revenue. Look at recent medical records for patients with these conditions and try coding them in ICD-10 for practice. Do the records include the documentation needed to select the correct ICD-10 code? It could be beneficial to use any cases of insufficient documentation as the basis of a checklist that you can consult in the future.

**Tools for testing**

CMS offers the following tools to assist with testing:

- National coverage determination and local coverage determination conversions from ICD-9 to ICD-10
- The ICD-10 Medical Severity Diagnosis-Related Groups (MS-DRGs) conversion project, which is available along with payment logic and software replicating the current MS-DRGs. Also on this Web page are the:
  - ICD-10-CM MS-DRG Grouper
  - Medicare Code Editor (available from the National Technical Information Service)
  - MS-DRG Definitions Manual, which allows you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9 to ICD-10
  - The 2015 versions of the Integrated Outpatient Code Editor, which include ICD-10

**More resources**

The AMA secured flexibilities with CMS to address claims processing and denials, quality reporting penalties, payment disruptions and navigating transition problems. Mainly, physicians should be aware that for the first year ICD-10 is in place, Medicare Part B claims will generally not be denied solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

Still, physicians should be as prepared as possible. Get everything you need to know about ICD-10 at *AMA Wire®*. 

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