ICD-10 End to End Testing

Successful ICD-10 claims testing yield valuable Lessons Learned

As part of our approach to discovering, understanding and predicting the impact of ICD-10, we’ve conducted extensive End to End Testing with selected providers and clearinghouses. This testing occurred in 2014.

Overall Testing Strategy

We asked testing providers to create natively ICD-10 coded claims by recoding previously processed ICD-9 claims from the original medical records. All file submissions followed the live process of submitting 837 files electronically to clearinghouses which we received through our electronic gateway. We processed and adjudicated claims, then delivered 835 files back to providers electronically.

Who Tested With Us

Test participants included the following in our 14 Blue Markets (CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, OH, VA, WI):

- 44 provider organizations (61 entities)
  - 36 Hospitals
  - 25 Professional Provider Groups
- 13 Clearinghouses

Lesson Learned #1: We are able to accept and deliver electronic claim files with ICD-10 codes through our EDI gateway.

We successfully tested with 13 clearinghouses and received 91% of the claims submitted for testing. The types of claims and files validated or supported were 837I (Facility), 837P (Professional), 835 remits, and EDI L2 Reports (TXT). Clearinghouses who tested with us:

- AthenaHealth
- ClaimLogic
- Emdeon
- Gateway EDI
- GE Health
- MedAssets
- Navicare
- NEBO/Passport
- Quadax
- RealMed/Availity
- RelayHealth
- SSI
- Zirmed

EDI errors we found during testing:

- Incorrect ICD E-code usage – We educated clearinghouses on how to map E-codes with correct Qualifier and how to interpret the EDI edit per CMS guidelines. This accounted for most of the errors.

- Incomplete and/or Invalid ICD-10 codes – Some claims had the last few characters of the ICD-10 codes trimmed while populating claims data on HIPAA 837 files.

- Invalid data – Some claims had incorrect usage of some of the 837 fields to populate the information.

Lesson Learned #2: We can process claim files with ICD-10 codes on all claims systems tested.

We successfully tested with the five (5) local claims platforms that support our 14 Blue Markets and the two (2) national platforms, FEP and NASCO. We were able to process over 6,900 test claims submitted by providers. Claim edits performed as expected in our test environment. Types of claims included:

- Inpatient – 65%
- Outpatient – 11%
- Professional – 23%

For inpatient claims, approximately 15% of the claims tested demonstrated some DRG shifts in certain categories, consistent with industry findings. Industry analysis of these DRG shifts has resulted in corrections in the subsequent DRG grouper versions so that the shifts are no longer happening.

For the outpatient and professional claims tested, we found no significant shifts in the ICD-10 coded claims. There was also no shift in benefit categories (i.e., preventive, emergency, etc.)

Lesson Learned #3: Our systems can process preauthorizations containing ICD-10 codes.

Our care management team conducted a successful testing effort with providers. Preauthorizations processed with no issues.

Lesson Learned #4: From a medical management perspective, there was virtually no impact due to ICD-10 codes.

Claims were reviewed for pay/pend/deny status to see if this would change with using ICD-10 codes. No changes were found.

Future Testing with Providers

This information was from the 2014 End to End Testing with providers and clearinghouses. Though we consider this testing successful, we will continue to verify our findings with additional internal analysis and a limited external testing effort in 2015. Participants for testing have already been identified for this year’s testing. No additional providers are needed.