More than 20% of Medicare codes in ICD-9 do not map to codes in ICD-10-CM/PCS. Simply implementing GEMS and crosswalks will not ensure revenue accuracy or clean cash flow in 2015. Errors made by any trading partner within healthcare’s revenue cycle result in revenue integrity problems for all.

To avoid the financial ramifications of a poorly executed ICD-10 conversion, end-to-end testing with a healthcare organization’s trading partners is an essential step for vendors, providers, clearinghouses and payers. A successful conversion ensures the accurate measure of quality reporting, which is critical for meaningful use attainment, CMS’s quality improvement, public reporting and pay-for-reporting programs.

Rather than waiting to test claims just prior to the October 1, 2015 deadline, innovative providers are already collaborating with their vendors, clearinghouses and payers to protect revenue and mitigate ICD-10 risk. This paper lays out a proven methodology to conduct end-to-end testing for ICD-10 claims.

First, we’ll discuss four foundational elements of clinical documentation improvement and coding that are applicable regardless of technology readiness or IT resources. Then we’ll describe an innovative model for testing ICD-10 claims submissions. This model is the only end-to-end testing methodology currently available and has received endorsement from HIMSS, WEDI and CMS. Finally, we’ll define what success looks like for providers, payers and patients under ICD-10.

**STEP ONE: IGNITE DOCUMENTATION AND CODING IMPROVEMENTS NOW**

The most important goal of your ICD-10 efforts is to find problems now, rather than later. Preliminary assessments, dual coding, education and ongoing documentation improvement work together to achieve this goal. There is no time to wait for technology vendors or system interfaces; organizations must begin Step One now.

**ASSESS** documentation and coding by selecting a set of ICD-9 claims to review. Analyze existing data to identify top MS-DRGs, highest revenue-generating cases, or specific CCs and MCCs. Another option is to focus on service lines with known ICD-10 risk—orthopedics, cardiology and obstetrics. Manually code sample cases using trained and certified ICD-10 coders, and then have the coding validated by outside experts. These preliminary assessments identify coder education needs as well as the gaps in clinical documentation.
**DUAL CODE** select cases as part of continual process improvement for coding and clinical documentation. Dual coding provides valuable experience for coding teams while also uncovering documentation hot spots and revenue risks. Finally, dual coding is an essential prerequisite for end-to-end testing.

**EDUCATE** physicians, sub-specialty by sub-specialty. Share the results of documentation assessments along with the associated financial impact. Leading healthcare organizations have discovered that ICD-10 is not a coding problem; it is a documentation problem. Physician education alongside strong CDI programs is the cure.

**IMPROVE** clinical documentation and coding through ongoing education, training and outreach. Maintain a consistent stream of communication up and down the revenue chain. And finally, measure and report improvement along the way.

Organizations that invest time, money and resources toward improving these two areas—clinical documentation and coding—make all other steps in their ICD-10 journey easier.

**STEP TWO: COMMUNICATE WITH PAYERS AND TEST CLAIMS**

Under ICD-10, revenue accuracy trumps revenue neutrality. Payers and clearinghouses are eager to work with providers that have begun dual coding, even if technology to test ICD-10 claims is unavailable.

Convert claims to paper if necessary. Test only a few claims processing steps. Both of these scenarios are acceptable, as long as some type of testing begins. Organizations should begin with whatever they can do, expanding outward from there.

Currently, the only proven approach to asynchronous end-to-end testing is the Lott Method. Endorsed by HIMSS, WEDI and CMS, the Lott Method uses manually-coded, clinically-based test cases instead of fictitiously mocked-up files. Complete medical records are the foundation for the Lott Method, and any provider able to submit their manually-coded ICD-10 cases is welcome to participate.

The Lott Method delivers high value collaboration across all ICD-10 trading partners with test cases shared by vendors, hospitals, providers, clearing houses, payers and more. The same set of medical records and data is used to review, code and compare. Rather than burden your staffs with testing, a central hub maintains communications and shares results between parties.

According to Christian Omba, ICD-10 Program Manager at UNC Rex Healthcare in Cary, North Carolina, the Lott Method helps his organization test with trading partners located both upstream and downstream in the revenue cycle. Omba states, “With HIPAA's 5010 transaction format, every organization tested their own way,
there were multiple issues and exorbitant costs incurred by all.” The Lott Method minimizes costs by using a common set of real events for testing across entities.

Payers review codes and documentation before replying back to providers through the central hub. Then they return coding and adjudication outcomes to the provider. Payers also apply lessons learned to adjust their own internal mapping and claim logic when discrepancies are discovered.

“There are no benefits to doing end-to-end testing first,” states Omba. “There are only benefits in doing it together—sharing costs, knowledge and lessons learned along the way,” he concludes.

**STEP THREE: RECOGNIZE ICD-10 SUCCESS**

The real measure of ICD-10 success is how quickly and efficiently organizations identify and remediate claims issues following the conversion on October 1, 2015. Precise ICD-10 coding, based on complete clinical documentation and thorough end-to-end testing of claims, is essential to this goal.

Secondly, there will be a surge in denied claims and revenue processing issues. Trading partners must be poised to manage the influx of reimbursement issues within the first 90 days.

ICD-9 code sets will still need to be maintained to support quality reporting over time and patient encounters spanning the October 1 deadline, which makes the move to ICD-10 more of a dimmer switch than an on-off button. Modifications in technology, coding and documentation must occur in small increments with all changes in place by October 1, 2015. The organization’s ability to support both coding schemas will be another indicator of success.

Finally, the expanded granularity and specificity inherent within ICD-10 supports greater medical research, new disease cures and more accurate quality measures reporting for meaningful use, pay-for-quality and continuing patient care.

**CONCLUSION**

The financial ramifications of poorly executed ICD-10 conversion could be devastating, especially for smaller hospitals and physician groups. Even well-planned implementations can face revenue losses due to denied claims, failed medical necessity or insufficient coding staff.

End-to-end testing conducted early and often will identify potential weaknesses well in advance of October 1, 2015. It will also ensure that all parties have the opportunity to shore up their people, processes and technology to keep claims and reimbursement flowing.