NCVHS Testimony on ICD-10 End-to-End Testing

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Overview of the Problem

ICD-10 conversion presents a myriad of testing challenges for organizations. The are many testing relationships, representing the flow of data from the time a patient presents to the clinic, hospital or other ambulatory site, that need to be tested in order to determine the areas of remediation prior to the compliance date of October 1, 2014.

Challenges

- Creating a test bed—time consuming, costly
- Ensuring that processes and systems have been tested and remediated
- Testing to ensure that all systems are interoperable
- Ensuring that legacy systems are interfacing with new ICD-10 software/applications
- Coordinating and orchestrating an organization-wide effort
- Using multiple test sets from a variety of health plans and other trading partners—if they are willing to test with providers (some are not testing with providers directly)

Challenges (cont.)

- Timing the testing schedule to coincide when vendors are ready to test their products and solutions
- Confusion coordinating schedules to test within organizations as vendors may not all be ready at the same time
- Many organizations do not currently agree on the test data that needs to be tested
- Determining how much testing is enough
- When to test/timing of testing
- Establishing matching data base
- Validating results of testing

Challenges (cont.)

- Conducting synchronous end-to-end testing may be costly/cannot be accomplished until all systems are in place
- Once systems complete, lost time and not enough dedicated time for remediation and “re-testing” to fix high risk issues and flag low risk/negligible issues for post-go-live date
- Late uptake may result in “testing deluge” or a “bottle neck effect” -- majority will wait to test until their vendors and systems are fully ready
- Medicare contractors may not conduct testing with partners (providers, clearinghouses, vendors) before Oct 1, 2014

Overview and Goals of the HIMSS/WEDI ICD-10 National Pilot Program

- Advocates that testing begin now using a set of basic 100-200 standardized test cases derived from “real medical records,” not “made up” scenarios
- Enhances the efficiency of the testing process, thus reducing the cost of “trial and error”
- Allows asynchronous testing method to begin now although all parties or supporting software may not be completely ready for full system launch yet

Value of Using Standardized Test Scenarios

- Enables a base level of testing
- Helps to establish a minimal testing threshold
- Applies common threshold values
- Identifies best practices in each sector
- Uses actual de-identified medical records that are multi-purpose
- Facilitates "re-use" for final testing as well as testing systems for other federal mandates beyond ICD-10

HIMSS-WEDI ICD-10 National Pilot Program Value to Industry

- Test cases will be available free for use by all entities implementing ICD-10 after Phase 1 (July 31, 2013) in the ICD-10 PlayBook (www.himss.org/ICD10PlayBook)
- Vendors may utilize test cases for clients, add to it, but cannot own or sell to clients
- Will work for most large and small providers testing processes

ICD-10 National Pilot Program Test Case Development Report

- Coding and Testing Workgroup has been hard at work
- 153 scenarios (IP and OP) submitted by 11 facilities.
- For seven months, 16 AHIMA ICD-10 Trained coders have been coding the scenarios on the HIMSS SharePoint site
- Coders continue to code the scenarios- 67% completed

ICD-10 National Pilot Program Test Case Development Report

- Subgroups for coders involve four coders who verify the cases by reviewing the scenarios for best practices in ICD-10 coding
- If necessary, they refer scenario and ICD-10 codes back to the facility and coder I and II for discussion and final approval
- 52% are completed by the Steering Committee
- Ten cases each week are sent for testing - 52% sent thus far

Testing and Coding Work Group Observations

- Appears to be sufficient documentation to assign ICD-10-PCS, even with the increased specificity
- More detailed documentation in some cases may result in a more specific code
- The disparity between coder I and II is most often due to poor documentation and the coder may make best estimate at what the best code should be – thus the difference in one character of the code. This would have been an issue in ICD-9 as well.

Testing and Coding Work Group Observations

- Contrast is noted to be needed in I-10, which the coders didn't need to code in I-9, and which, the documentation may need to be "hunted for"
- No specific therapy documented in some rehabilitation cases that needed specific therapy coded
- There is some variation in MS-DRGs from ICD-9 to ICD-10

Why are "real" medical records important vs. "fake scenarios?"

- Fake scenarios cannot capture the nuances of provider documentation that will deploy use of more granular codes
- Generated scenarios with canned coding responses will help in systems testing more than end-to-end
- Unable to predict provider coding behavior; medical documentation will present more realistic information for code assignment
- Real documentation may help identify potentially deficient documentation and report feedback on high risk areas to be focused on prior to go-live

Other important points regarding HIMSS-WEDI NPP

- Involves multiple stakeholders; output is not one-sided
- Represents collaboration at its best – includes every entity type within the revenue cycle (providers, payers, billing companies, clearinghouses, vendors, etc.)
- Gives other stakeholders that may not have a Testing Plan framework from which to begin

Questions?

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