DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Subscribe to the *MLN Connects™ Provider eNews*: a weekly electronic publication with the latest Medicare program information, including MLN Connects™ National Provider Call announcements, claim and pricer information, and Medicare Learning Network® educational product updates.

MLN Matters® Number: SE1435 Revised | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: N/A**

Related CR Transmittal #: N/A | **Implementation Date: N/A**

FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing

Note: This article was revised on June 9, 2015, to provide updated information for physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to Know Prior to Testing

1. **How is ICD-10 end-to-end testing different from acknowledgement testing?**

   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. **What constitutes a testing slot for this testing?**

   A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. **What data must I provide to the MAC before testing?**

   For each testing slot, you must provide the MAC the following:
   - Up to 2 submitter identifiers (IDs);
   - Up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and
   - Up to 10 Health Insurance Claim Numbers (HICNs).

   You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

   If you want to change your selected submitter IDs, NPIs, PTANs, or HICNs, you must contact the MAC. If the MAC is not aware of these changes, claims submitted will not be processed.

4. **What should I consider when choosing HICNs for testing?**

   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. **If I was selected for the January 2015 or April 2015 end-to-end testing, do I need to reapply for July 2015 testing?**

   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. **Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?**

   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to Know During Testing

1. **Is it safe to submit test claims with Protected Health Information (PHI)?**

   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. **What dates of service can be used on test claims?**

   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

   For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. **Can both ICD-9 and ICD-10 codes be submitted on the same claim?**

   ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and

when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to the following MLN Matters® Articles:

- SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims That Span the ICD-10 Implementation Date," located at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf** on the Centers for Medicare & Medicaid Services (CMS) website;

- SE1408, "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492," located at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf** on the CMS website; and

- SE1410, "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015," located at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf** on the CMS website.

4. Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?

Institutional claims that fail RTP editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the ERA, and they will not be available through Direct Data Entry (DDE). If claims accepted by the front end edits do not appear on the ERA, please contact the MAC for further information.

Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. Will a summary of test claims be provided at the conclusion of testing?

Yes, the MAC will provide testers a summary of all accepted test claims after the April and July testing rounds. These reports will be delivered to testers approximately 4 weeks following the testing week. Reports for April 2015 testing were delivered by May 29.

6. **If a CMN or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**

   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after October 1, 2015), you do not need to submit a new CMN/DIF.

   If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

   If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

7. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

8. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**

   You will not need to provide NOEs to the MAC prior to the start of testing. MACs will set up NOEs for any hospice claims received during testing.

9. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.