



KY Medicaid ICD-10 837 INSTITUTIONAL TRANSACTION TEST PLAN

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- Email to KY_EDI_Helpdesk@hp.com
 - Subject line: ICD-10 testing

TESTING TIMELINE:

DATES	TYPE OF TESTING	DESCRIPTION/IMPACT
August 18, 2014 – September 19, 2014	Focused ICD-10 Testing	HP will begin focused testing with the MCOs in the following areas: <ul style="list-style-type: none">a. All institutional provider typesb. Crossover claims

General Information for ICD-10 Claims Testing

ICD-10 testing is scheduled to start on August 18 2014.
ICD-10 Effective Cutover Date for testing is 6/1/2014.

TESTING EXPECTATIONS

Test transactions must contain all possible fields that are applicable to your business for ICD-10 MCO testing. The following is a summary of the ICD-10 changes for the 837I Transactions. ICD-10 qualifiers and format for ICD-9 and ICD-10 code sets

- Policy, i.e., sterilization, hysterectomy, and policies mandated by federal regulations
- It is the responsibility of the tester to submit all claim scenarios based on your business practices or those of your Kentucky Medicaid clients. For example, adjustments, voids, TPL, Medicare Crossovers, etc.
- A 999 will be available for retrieval in the same manner for each test file submitted.
- The MCO can check claim adjudication results by retrieving the Pended Claim Status (277U transaction). The 277U should be available within 72 hours.
 - The focused timeframe for ICD-10 testing is August 18 – September 19, 2014. It is the responsibility of the trading partners/providers to submit claim files that represent your day to day operations. Testing will ensure readiness – and readiness will reduce the impact of this implementation for all parties
 - The Clearinghouses and Providers have the primary responsibility for transitioning their practice and billing system to the new code sets. Completion of testing is at the Clearinghouse, MCO and Provider's discretion. Testing will eliminate errors and glitches before the October 1, 2015 ICD-10 implementation and ensure that ICD-10 claims are adjudicated appropriately. Correcting these errors after implementation will consume valuable resources and could affect reimbursement to Providers.

Limitations

- Each test file should contain **a maximum of 2,000** test claims
- Each claim must contain valid data
- Any claim scenario can be tested, creativity is heavily suggested.

File Naming Convention

- Each EDI ICD-10 test file, always send file in a zipped format and the file in the zip container should have a file extension. Example: <FileName>.dat. or ".rpt", example: <FileName>.rpt. Further "<FileName>" standards are explained in detail below.
- All test files will be preceded with **ICD-10_** in the file name for **all ICD-10 test files**.

Recap Summary of ICD-10 Implementation format and qualifiers

- ICD-10 diagnosis codes up to 7 characters alphanumeric (A/N)
- ICD-10 procedure codes up to 7 characters (A/N)
- ICD-10 qualifiers must be:
 - 837I Transaction ICD-10 code qualifiers*
 - ABK: Principal Diagnosis
 - ABJ: Admitting Diagnosis
 - APR: Patient's Reason for Visit
 - ABN: External Cause of Injury
 - ABF: Other Diagnosis
 - BBR: Principal Procedure Code
 - BBQ: Other Procedure Code

MCO TESTING EXPECTATIONS OF HP

- Provide point of contact(s) to assist in testing
- Provide 277U Transaction

The following are suggested test scenarios but not all inclusive. The same test scenarios are expected as you require from your providers to test with you, using the same guidelines.

Section 1 Compliance/Translator Testing

Test Case	Task	Expected outcome
	Compliance/Translator Testing	
1.01	Submit an 837I transaction that contains ICD-10 diagnosis codes and code qualifiers that are applicable for the ICD-10 testing. Dates of service are on or after ICD-10 effective date June 1, 2014 A 999 will be created for retrieval	A 999 will be created acknowledging the accepted claims.
1.02	Submit an 837I claim with multiple ICD-10 diagnosis codes using a mixture of ICD-9 and ICD-10 code qualifiers.	The claim will be reported as rejected This is not permitted."
1.03	Submit an X12 837I transaction with ICD-10 Qualifier codes from list above* and ICD9 diagnosis codes	The claim will be reported as rejected This is not permitted.

Section 2 – 837I Claim Data test scenarios related to ICD-9 and ICD-10 format/qualifiers.

Test Case	Task	Expected outcome
2.01	Submit an 837I file with multiple claims containing multiple ICD-10 diagnosis and procedure codes. All code qualifiers are ICD-10. Dates of service on or after ICD-10 effective date. Claims may be used for adjustment/void claims submission.	A 999 will be created acknowledging the accepted claims.
2.02	Submit an 837I ADJUSTMENT claim that has multiple ICD-10 diagnosis and procedure cores. All code qualifiers are ICD-10. Dates of service on or after ICD-10 effective date.	Adjustment claim processes according to KY Medicaid guidelines.
2.03	Submit an 837I VOID claim that has multiple ICD_10 diagnosis and procedure codes. All code qualifiers are ICD-10. Dates of service on or after ICD-10 effective date.	Claim is voided A 999 will be created acknowledging accepted claims.
2.04	Submit an 837I file with multiple claims containing multiple ICD-9 diagnosis and procedure codes. All code qualifiers are ICD-9. Dates of service are prior to ICD-10 effective date. Claims may be used for adjustment/void claims submission.	A 999 will be created acknowledging accepted claims.
2.05	Submit an 837I ADJUSTMENT claim for an original claim that had multiple ICD-9 diagnosis and procedure codes. All code qualifiers are ICD-9. Dates of service prior to ICD-10 effective date. FOR ADJUSTMENT - CHANGE one of the procedure code qualifiers to an ICD-10 procedure code qualifier.	The claim will be reported as rejected This is not permitted."
2.06	Submit an 837I VOID claim that has multiple ICD-9 diagnosis and procedure codes. All code qualifiers are ICD-9. Dates of service prior to ICD-10 effective date.	Claim is voided. A 999 will be created acknowledging the voided claim.

Test Case	Task	Expected outcome
2.07	<p>Submit an 837I Home Health claim where the “from” date is before the ICD-10 effective date and the “through date” is after the ICD-10 effective date. Use all ICD-10 diagnosis and procedure codes. All ICD-10 qualifiers.</p>	<p>The claim will deny for claim processing edit. Per new processing –Providers will be required to split claims out for dates of service that span before and after ICD-10 effective date. Use ICD-9 dates of service and code set for claims prior to ICD-10 effective date. Use ICD-10 dates of service and code set for claims on or after the ICD-10 effective date.</p>
2.08	<p>Submit an 837I claim with multiple ICD-10 diagnosis codes and ICD-10 code qualifiers. Dates of service are prior to the ICD-10 effective date.</p>	<p>The claim will deny for claim processing edit.</p>
2.09	<p>Submit 837I transaction with the following: * Detail 1 ICD-9 diagnosis and code qualifiers with related diagnosis pointer to ICD-9 diagnoses only. From and through date of service is prior to the ICD-10 effective date. * Detail 2 ICD-9 diagnosis codes and code qualifiers with related diagnosis pointer to ICD-9 diagnosis only. From and through date of service is prior to the ICD-10 effective date. * Detail 3 ICD-10 diagnosis codes and code qualifiers with related diagnosis pointer to ICD-10 diagnosis only. From and through date of service is on or after the ICD-10 effective date.</p>	<p>The claim will be reported as rejected. Per new processing –Providers will be required to split claims out for dates of service that span before and after ICD-10 effective date. Use ICD-9 dates of service and code set for claims prior to ICD-10 effective date. Use ICD-10 dates of service and code set for claims on or after the ICD-10 effective date.</p>

Test Case	Task	Expected outcome
2.10	<p>Transaction Set # 1 - Submit 8371 transaction with the following: ICD-9 diagnosis and code qualifiers with related diagnosis pointer to ICD-9 diagnoses only. From and through date of service is prior to the ICD-10 effective date.</p> <p>Transaction Set # 2 - Submit another 8371 transaction with the following: ICD-10 diagnosis codes and code qualifiers with related diagnosis pointer to ICD-10 diagnosis only. These ICD10 codes should be the corresponding/ equivalent codes for ICD9 codes used in the claim submitted above. From and through date of service is on or after the ICD-10 effective date.</p>	Both Transaction sets should pass with claims being submitted and paid successfully with amounts paid being the same or within the defined Financial Neutrality limit.