ICD-10 Medicare FFS End-to-End Testing: July 20 through 24, 2015

Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in a third successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor from July 20 through 24, 2015. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

- Approximately 1,200 were selected to participate, including 493 returning testers from the January and April testing weeks.
- Approximately 1,400 National Provider Identifiers (NPIs) were registered to test, of which 174, or 12%, were repeat NPIs from previous testing weeks. This indicates that many clearinghouses that participated in previous weeks chose different providers for July.

Overall, participants in the July end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. In some cases, testers may have intentionally included errors in their claims to make sure that the claim would be rejected, a process often referred to as “negative testing. The acceptance rate for July was similar to the rates in January and April, but with an increase in the number of testers and test claims submitted.

- 29,286 test claims received
- 25,646 test claims accepted
- 87% acceptance rate
- 1.8% of test claims were rejected due to invalid submission of ICD-10 diagnosis or procedure code
- 2.6% of test claims were rejected due to invalid submission of ICD-9 diagnosis or procedure code

Additional rejections were from non-ICD-10 related errors, including incorrect NPI, Health Insurance Claim Number, or Submitter ID; dates of service outside the range valid for testing; invalid HCPCS codes; and invalid place of service. These types of errors also occurred in the January and April end-to-end testing weeks. Most rejects were the result of provider submission errors in the testing environment that would not occur when actual claims are submitted for processing.

Types of test claims received:

- 52.7% - Professional
- 40.9% - Institutional
- 6.4% - Supplier

Provider types:

Type	January Tester %	April Tester %	July Tester %	Combined %
Ambulance	1.8%	1.1%	0.8%	1.2%
ASC	1.0%	0.5%	1.0%	0.8%
Behavioral Health	0.6%	1.4%	1.3%	1.2%
DME	11.5%	4.8%	9.8%	8.3%

ESRD	1.9%	1.4%	1.3%	1.5%
FQHC	0.3%	0.8%	0.5%	0.6%
Home Health	0.9%	1.5%	4.0%	2.3%
Hospice	1.0%	1.1%	2.3%	1.5%
Hospital - All Others	23.4%	24.5%	22.3%	23.4%
Hospital - CAH	2.9%	3.9%	3.9%	3.6%
Hospital - Psych	2.2%	2.8%	2.8%	2.7%
Hospital - Rehab	2.5%	2.0%	0.7%	1.6%
Imaging/Testing	0.5%	0.3%	0.5%	0.4%
Lab	2.2%	1.7%	1.7%	1.8%
Non-MD	3.6%	3.4%	0.4%	2.3%
Other	3.1%	0.7%	0.9%	1.3%
Primary Care	4.9%	9.5%	5.2%	6.7%
RHC	1.0%	2.2%	2.0%	1.9%
Skilled Nursing	3.1%	3.2%	5.3%	4.0%
Specialty	31.6%	33.2%	33.3%	32.9%
	100.0%	100.0%	100.0%	100.0%

Testing demonstrated that CMS systems are ready to accept ICD-10 claims:

- No new ICD-10 related issues were identified in any of the Medicare fee-for-service claims processing systems.
- There were zero rejects due to front-end CMS systems issues.
- Issues identified during previous testing weeks were resolved prior to July testing.

July end-to-end testing participants received Remittance Advices (RAs). In addition, all testers received a specially generated report on the disposition of their test claims.