



# End-to-End Testing Volunteer Call



*Everything Testers Need to Know to Have A Successful Testing Week*

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# Purpose

The goal of this call is to:

- Review the minimum testing requirements for end-to-end testing
- Review common testing errors
- Answer frequently asked questions

# Minimum Testing Requirements

- Testers must be established electronic submitters, with active Medicare submitter IDs, and capable of receiving electronic remittance advices (ERAs) to be eligible for this testing. Electronic submitters are defined as clearinghouses, billing agencies, or a professional or institutional provider that submits directly to Medicare.
- Testers must be ready to test ICD-10, meaning, all vendor and practice management software needed to test has been updated and internally tested prior to conducting end-to-end testing with Medicare.

# Minimum Testing Requirements

- Testers must be able to provide the National Provider Identifiers (NPIs) Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) they will use for test claims when requested by the MAC. This information will be needed several months prior to the start of testing for set-up purposes.
- Testers must be able to submit future dated claims.

# Deadline to Submit NPIs, PTANs, and HICNs

- Submission of the NPIs, PTANs, and HICNs is a requirement to participate in testing.
- Completed forms are due June 26.
- If the form is not received timely, you will lose your slot in July 2015 testing.
- If you cannot locate your form, contact your MAC or the CEDI helpdesk to receive a new one.

# Why Limit NPIs, PTANs, and HICNs?

- MACs and CEDI must ensure that all NPIs, PTANs, and HICNs are available in their test environments. This is a manual process to verify:
  - NPIs and PTANs are valid for testing.
  - Beneficiary eligibility for testing.
  - All files and downstream systems in the test region are ready.

# What Types of Claims Should I Test?

- Review the testing checklist provided.
- Create a test plan.
- Submit claims that represent the majority of services you typically bill.
- Claims must pass current front-end edits to be accepted and processed for payment.
- Use codes from previous claims you know will pass basic edits.
- Use the valid billing NPIs, PTANs and HICNs you submitted for testing.

# Future Dated Claims

- Professional claims must have a date of service on or after 10/1/2015.
- Inpatient claims must have a discharge date on or after 10/1/2015.
- Supplier claims must have a date of service between 10/1/2015 and 10/15/2015.
- Refer to MLN Matters Special Edition article SE1325 for more information on ICD-10 claims with span dates.

# Why Future Dated Claims?

- ICD-10 is effective for Dates of Service on or after 10/1/2015, therefore, this is a critical part of our claim edits.
- Only future dated claims will go through all edits as they will on or after 10/1/2015.
- This allows for the most-accurate test of Medicare system and edits.

# How Testing Works

- Test claims must be submitted July 20-24, 2015.
- Test claims will be sent to the contractor the same as production claims.
- For Professional and Institutional claims, test files must use one of the Submitter IDs (Trading Partner ID) used during volunteer registration.
- For Supplier claims, test files must use the Submitter ID (Trading Partner ID) assigned to you for testing.

# How Testing Works

- Claim files must be marked as “Test” in the ISA15 field with a “T”.
- Test claims with ICD-10 diagnosis codes must be submitted with dates of service (or discharge date) on or after October 1, 2015.
- Test claims with ICD-9 diagnosis codes must be submitted with dates of service (or discharge date) before October 1, 2015.

# How Testing Works

- Test claim volume is limited to a total of 50 claims for the entire testing week, submitted in no more than 3 test files. If more than 50 claims are submitted over the course of the testing week, they may not be processed.
- You should receive Electronic Remittance Advice (ERA) files within 3 days after claims are submitted. However, it may take up to 2 weeks to receive all ERAs.
- ERA files returned to you will be marked as “test” files in the ISA15 field with a “T”.

# How Testing Works

- Testing will use BETA versions of the Medicare Pricing Files, with current (FY 15) rates.
- Rates for claims after 10/1/2015 are not yet available.
- Claims will pass through all existing edits as if it was really after October 2015.
- Claims will go to the Common Working File (CWF) and other downstream systems that may affect payment.
- Crossover (COB) testing is separate from this testing.

# Claims that Receive Edits

- CMS defines "finalization" for this testing to mean the claim is rejected, denied, Returned to Provider (RTP'd), or paid.
- If a claim suspends for Additional Documentation Request (ADR), the MAC shall assume the documentation was received to support payment, and continue to process the claim.
- MACs will work suspended claims up to two weeks after testing week ends (August 7).

# How are RTP'd Claims Counted for Testing?

- Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (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.

# Should NOEs Be Submitted for Hospice Claims?

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

# How Should RAPs Be Submitted for Home Health Claims?

- 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.

# For an IRF or SNF stay, can the CMG or RUG code be submitted?

- Yes, you can send the IRF claim with a valid Case Mix Group (CMG) code on the claim and a SNF claim with a valid Resource Utilization Group (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.

# Should a CMN or DIF Be Submitted for 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 10/1/2015), 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.

# Testing Support

- MACs and CEDI will be prepared to support you during testing.
- Contact the MACs or CEDI using the contact information provided in the “You Have Been Accepted” letter.

# More Information

- Additional information about ICD-10 and testing with Medicare can be found at [www.cms.gov/Medicare/Coding/ICD10](http://www.cms.gov/Medicare/Coding/ICD10), and on your local MAC website.
- Questions regarding this presentation can be sent to [ICD10-National-Calls@cms.hhs.gov](mailto:ICD10-National-Calls@cms.hhs.gov).