About UnitedHealth Group

OUR HEALTH BENEFITS BUSINESS: UNITEDHEALTHCARE

Helping People Live Healthier Lives
UnitedHealthcare Community & State
UnitedHealthcare Employer & Individual
UnitedHealthcare Medicare & Retirement

“Health in Numbers”
• Serving 35 million Americans at every stage of life
• Innovation-driven growth
• Exceptionally well positioned to evolve and grow through health care reform

FOUNDATIONAL COMPETENCIES
• Domain knowledge around care management and care resources
• Actionable health care information and intelligence
• Advanced, enabling technology

OUR HEALTH SERVICES BUSINESS: OPTUM

Making the Health Care System Work Better for Everyone
OptumInsight
OptumHealth
OptumRx

“Good for the System”
A dedicated and independent business providing services to:
6,000 hospital facilities, 250,000 health care professionals, 60 million consumers
ICD-10 Testing Requires Expanded Scope

Organizations may have experience, resources, environments and processes that support traditional testing:

- Focus on ensuring accuracy of known **internal** system or process changes

- WEDI and other industry organizations advocate that ICD-10 requires an expanded scope to include testing with your **external** business partners and vendors.

- The scope and purpose for **external testing** of ICD-10 codes is much broader than recent HIPAA 5010 or future Operating Rules partner testing.

### HIPAA 5010 & Operating Rules vs. ICD-10

<table>
<thead>
<tr>
<th>HIPAA 5010 &amp; Operating Rules</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>Testing between payers and direct EDI submitters to validate compliance with required transaction formats</td>
<td>Testing with entities in the entire value stream to identify, understand and predict potential differences in claim outcomes when ICD-10 codes are used</td>
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<tr>
<td>Automated tools and certification standards available</td>
<td>No defined certification standards available to assess accuracy of results</td>
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ICD-10 testing requires collaboration between payers and providers to:

- Identify and mitigate potential risk areas, including:
  - Incorrect, partial, or invalid ICD-10 coding
  - Potential claim processing variations between providers and payers due to selected ICD-10 codes applied to benefit plan or medical management policies
  - Readiness and predictability of multiple vendor systems and intermediary processing through claim pathways

- Understand and prepare for potential reimbursement variations (due to DRG shifts or other factors)

External “end-to-end” testing may not be feasible, cost effective, or available to many payers, providers, vendors, and claim intermediaries

There are other effective collaborative strategies to test for these risks
ICD-10 External “End-to-End” Testing Challenges

- Each provider-payer processing path is unique and may branch to multiple paths based on provider or payer systems, intermediary services, product lines, etc.
- Significant number of partners and process combinations
- Not feasible for most organizations to test with all business partners in the chain (providers, payers, vendor systems, intermediaries and clearinghouses).

Health care providers

Provider Coding: Practice Management & Billing Systems Or Vendors

Claim Intermediaries / Clearinghouses

Payers
More ICD-10 External “End-to-End” Testing Challenges

● Testing with external partners requires multiple companies to be “ready” and have resources committed to test at the same time.

● Payers and providers will be impacted by, but may have limited control over, vendor readiness, including their test schedules and ICD-10 remediation logic.

● Procedures may be needed to conduct manual hand-offs between partners:
  – Cannot use existing production connections
  – EACH combination of test partners may require unique procedures
  – Depending on testing scope/approach, substantial resource time and cost required to test with each partner

● Organizations may need to train staff to perform these new test processes – including research and resolution of processing constraints and claim result differences.
More ICD-10 External “End-to-End” Testing Challenges

● Unplanned (un-budgeted) system or test environment modifications may be needed to accommodate testing with external partners.

● Consider common data requirements:
  – Each **payer** may require test cases that use their existing data (benefit plans, members and provider contract provisions) in order to process claims through test systems.
  – Alternatively, **providers** may want to use existing/mock medical records as the source for ICD-10 test cases with one or more payers, which would require payers to find or create corresponding member data for claim system testing.
  – Test claims transferred manually may require de-identification of member information to avoid passing PHI data through non-secure channels.
### Recommendations

<table>
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<tr>
<th>Risks &amp; Findings</th>
<th>Test Approach</th>
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<tr>
<td>Early test findings shared by WEDI member organizations identified common coding</td>
<td>Promote creation and use of standard ICD-10 coded medical scenarios:</td>
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<td>issues that impact processing and payment:</td>
<td>• Being developed by a few national and state organizations, vendors, payers,</td>
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<td>• Invalid ICD-10 codes (O versus zero, partial/subcategory codes vs. full ICD-10</td>
<td>etc.</td>
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<td>code, missing primary Dx code, etc.)</td>
<td>• Gives providers an opportunity to practice ICD-10 coding against a validated</td>
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<td>• Inconsistent application of the ICD code indicator</td>
<td>set of results</td>
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<td></td>
<td>• May reduce provider duplication of effort to code claims for multiple payer</td>
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<td></td>
<td>test efforts</td>
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<tr>
<td>Not feasible to conduct thorough testing with all of your business partners.</td>
<td>Collaborative testing with a few strategically selected business partners</td>
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<td>provides a view of common production risks or issues that may be extensible to</td>
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<td>other partners.</td>
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<td>Share test findings and other key ICD-10 remediation information with other</td>
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<td>business partners via portals and other communication methods.</td>
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<tr>
<td>Not all payers, providers and other claim service vendors will be able to conduct</td>
<td>Recommend a multiple-phase approach to cover different test objectives and</td>
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<tr>
<td>external end-to-end testing (due to partner availability, resources or other</td>
<td>ensure high quality, predictable results.</td>
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A Multi-Dimensional Provider-Payer Test Approach

- UnitedHealth Group recommends a multi-dimensional test approach based on collaboration with selected external business partners (including payers, providers, vendors and other claim intermediaries).
- Each test phase is designed to identify and mitigate a unique dimension of ICD-10 business risk.

1. Validate Clinical Coding Accuracy
   - Providers are encouraged to practice natively coding ICD-10 claims using a standard set of medical scenarios to reduce risk of assigning incorrect, incomplete or invalid codes in production.
   - A few regional, national and other organizations are establishing and validating coding for a suite of suggested ICD-10 claim scenarios.

2. DRG Comparison & Revenue Shift Analysis
   - Early Partnership between Payers and high volume Hospitals to identify, evaluate and predict the impact of coding conditions that generate an ICD-9 to ICD-10 DRG shift.
   - Based on selected high volume, high risk ICD-9 codes from adjudicated claims compared to ICD-10 claims natively coded by the facility.

3. Trading Partner /EDI Transaction Tests
   - Collaborative testing with a selection of high volume direct trading partners/EDI submitters to verify vendor system readiness, transaction compliance, and processing through clearinghouse edits, where applicable.

4. Selected Test Claim Processing
   - Testing between a Payer and a limited number of facilities, physicians and other providers to verify accurate, expected processing results for selected high volume claim scenarios.
   - Compare processing results from ICD-9 adjudicated claims to those recoded by providers in ICD-10 to identify any processing result variations from benefit plans or medical management policies.

5. “End-to-End” Claim Process Flow
   - Similar to other payers, UnitedHealth Group is currently evaluating benefits and challenges to determine to what extent external “end-to-end” testing is required and to define scope.

Share findings and recommendations from test efforts with all providers and business partners via provider portals and other communication channels.
ICD-10: END-TO-END TESTING CHALLENGES
About Blue Cross Blue Shield of Michigan

A non-profit corporation and independent licensee of the Blue Cross and Blue Shield Association

Covers 4.4 million people in Michigan and 1.1 million people outside the state

Network of over 40,000 physicians and other professional providers and over 150 hospitals

Includes all of the major teaching hospitals, university-based hospitals and trauma centers in the state
Today’s Objectives

- Look at testing from the perspective of a single-state payer
- Discuss the opportunities available within the ICD-10 testing space

Share findings and recommendations from test efforts with all providers and business partners via provider portals and other communication channels.
Claim Cycle

- Office visit
- Information to biller/coder
- Claim to clearinghouse
- Payer processes and responds
- Clearinghouse to payer
Transactional testing – Does the claim go through?

Transaction and compliance testing – does the claim go through? Is it compliant?

Traditional response: Yes/no on transaction, payment and compliance

Black box environment
With ICD-10…We Need More Information

● It’s not enough to know that a claim was accepted, was compliant and paid…we need to know more about the code
  — Which code was chosen
  — Why it was chosen
  — What effect it will have on claim processing/benefit application
Give physicians pre-defined clinically based medical scenarios and have them determine the ICD-10 codes they would use on the claim ...then let them know the effects of their selection.

BCBSM would still run its claims adjudication process but would be transparent and minimally invasive to participating providers.
Benefits and Challenges

- Benefits
  - Gives you an idea of what will actually come in on and after the compliance date
  - Easier for the providers than traditional testing
  - Increases the possibility of engagement
  - Properly defined medical scenarios should stand the test of time
  - Avoids risk associated with using PHI during testing
  - Minimizes resources required for provider/payer testing
Benefits and Challenges (cont.)

- Challenges
  - Scenario development is resource intensive
  - Scenarios must be clinically ‘air tight’
  - Defining the scenario ‘universe’ must be managed
  - Not an end to end test
  - Does not test customized clearinghouse edits (when applicable)
Opportunities

– Health Care Reform may offer additional opportunities to utilize medical scenario based testing
– Medical scenarios of interest for one set of payers and/or providers may not have the same degree of interest to others
– Specific medical scenarios may be universally applicable or may only be of regional or local interest
– Given the medical scenario concept, is there an opportunity for payers and providers to define a set of medical scenarios of mutual interest?