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I. HIPAA 5010 EDI Changes
The Centers for Medicare & Medicaid Services (CMS) mandates that all physicians/hospitals and payers exchange key business transactional data using the HIPAA 5010 format via Electronic Data Exchange (EDI) by 1/1/2012.

Transition from HIPAA 4010 to HIPAA 5010
- Adds functionality to the enrollment, eligibility, inquiry, claim, claim inquiry, remittance, referral/authorization and premium payment transactions
- Eliminates redundancy and ambiguity in the usage of transaction standards
- Clarifies NPI instructions and provide a structure for better usage
- Establishes a platform for the adoption of International Classification of Diseases, 10th Edition (ICD-10) codes
- Reduces reliance on trading partner Companion Guides for Electronic Data Interchange (EDI) transactions
- Calls for HIPAA 5010 Trading Partner Testing by January 1, 2011 and adoption by January 1, 2012

Opportunities
- Drive the administrative simplification and transparency agenda
  - Consistent use of transaction sets
  - Consistent communication and testing approach with trading partners including UnitedHealthcare
  - Consistent data and data context across all health plans easing complexity for practice management systems and vendors
- Reduce variation and cost of infrastructure and support of EDI transactions across the industry
Transactions Affected

- HIPAA 5010 is focused on administrative simplification and transparency.
- Over 800 changes from 4010 version to 5010.
- HIPAA 5010 incorporates support for ICD-10.
- NCPDP changes have the same timeline as HIPAA 5010.

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Change Summary</th>
<th>Transaction</th>
<th>Change Summary</th>
</tr>
</thead>
</table>
| 834 - Healthcare Enrollment | • Semantic notes more clearly define codes  
• Clarified differences and methods used for:  
• Change Updates versus Full File Replacements  
• Full File Audits  
• Added C1Y segment: transaction set control totals  
• Subtotals by: Employee, Dependents and Total  
• Added member policy amount qualifiers  
• Added new Maintenance Reason Codes  
• Added support for ICD-10  
• Added privacy options for subscriber  
• Designation of confidentiality and drop off locations |
| 837 - Healthcare Claims     | • Added diagnosis codes to the Dental Guide  
• Greatly improved_front matter explanation of COB Reporting and balancing  
• Section added to explain allowed and approved amounts reporting calculations  
• Added COB crosswalk — and examples  
• Subscriber/patient hierarchy modified  
• Greatly improved rules and instructions for reporting provider roles and use of NPI  
• NPI and proprietary identifiers will still be supported for a typical provider  
• Added support for ICD-10 |
| 820-Premium Payments     | • Added Premium Receiver’s Remittance Delivery Method  
• Added Outer Adjustment Loop  
• Organizational summary  
• Individual remittance detail tables  
• Added Service, Promotion, Allowance, or Charge Information Loop  
• Changed usage of RMR (Organization Summary Remittance Detail) to required |
| 276/277-Healthcare Claim Status | • Subscriber and Dependent loops were made more consistent  
• Eliminated sensitive patient information that was unnecessary for business purpose  
• Inquire by prescription number pharmacy claims  
• Modified STC01-04 to be situation for prescription reporting  
• Added NCPDP Payment/Reject codes  
• Added more examples to clarify instructions  
• Added Patient control number  
• Added Claim ID for clearinghouse and other intermediaries  
• Claim level status Information, segment repeat now greater than 1 allows for multiple status codes per claim |
| 270/271-Eligibility | • Clarified instructions for sending inquiries  
• Required alternate search options  
• Nine categories have been made mandatory for reporting  
• Explained E001 repeating data element  
• EE situational rules have been updated  
• Added support for ICD-10 |
| 835-Claim Payment/Remittance | • Tighter business rules to eliminate options  
• Eliminated codes marked “Not Advised”  
• Added another PER segments to loop 1000A  
• Health care medical policy — via payer URL  
• Added Remittance Delivery Method (RDM) segment to loop 100B payment options  
• Claim status has clearer guidance to report how a claim was adjudicated  
• Better instructions for handling reversals and corrections, interest payments and prompt pay discounts  
• Limits use of denial claim status to specific business case  
• Advanced payments and reconciliation  
• Secondary payment reporting considerations section revised  
• Reporting encounters |
| 276-Healthcare Services | • Request for review and response  
• Enable service level to support institutional, professional and dental detail consistent with claim transaction by adding segments  
• Medical services reservation (Medicare)  
• Added PVM segment to support attachments  
• Added support for ICD-10 |
| NCPDP: Retail Pharmacy | • Adopting NCPDP Telecommunication version D.0 and batch standard 1.2  
• Enhanced guidance for COB  
• Processing of Medicare Part D claims  
• Specific COB for Medicare Part D  
• Enhanced eligibility checking  
• Streamlined processing for compounded drugs  
• New transaction — Medicaid subrogation for pharmacy (NCPDP version 3.0) |
CAQH CORE Certification Overview

• Holds Payers to a higher standard of requirements for EDI eligibility and claim transactions.
• Increases the information available and ease of EDI use, leading to increased adoption.
• Entities that create, transmit or use the covered transactions in daily business are required to submit to third-party certification testing.

UnitedHealthcare signed the CORE pledge and is committed to achieving 5010 certification
II. ICD-10 Challenges & Benefits
ICD-10 Executive Summary

Summary
January 15, 2009 – Department of Health and Human Services (DHHS) published a final rule requiring covered entities (providers, health plans & clearinghouses) to comply with new code set regulations for: International Classification of Diseases, 10th Edition (ICD-10)
- Clinical Modifications (ICD-10-CM) Diagnosis Code Set
- Procedure Coding System (ICD-10-PCS) Inpatient Hospital Procedure Coding System.

DHHS Required Compliance Date: October 2013
UnitedHealthcare will be code-ready by October 2012 to allow for business process changes, training, contract renewals, and trading partner testing.

Background
ICD diagnosis and procedure codes are fundamental to UnitedHealthcare’s business operations. Significant changes to the coding structure will have major impacts on many business processes and systems. This in turn will require extensive training and updates to medical policies and contracts.

Industry analysts and advocacy organizations have prioritized ICD-10 and HIPAA 5010 as the top two initiatives for health care organizations’ focus for the next three years.

Problem Statement
Implementation costs: Compliance with ICD-10 will require significant information technology (IT) and other resources and capital expenditure.

Operational costs: Due to the “Date of Service” implementation requirement, simultaneous support of ICD-9 and ICD-10 will increase operation costs after implementation in 2013.

Organizations will be challenged on how to mitigate the implementation and operational costs of this mandate.
ICD-10 Snapshot

ICD-10 Quick Reference Guide

Comparison of ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format</td>
<td>3–5 characters</td>
<td>3–7 characters</td>
</tr>
<tr>
<td># of codes</td>
<td>approx 13,000</td>
<td>approx 68,000</td>
</tr>
<tr>
<td>Adding new codes</td>
<td>limited space</td>
<td>flexible</td>
</tr>
<tr>
<td>Level of detail</td>
<td>minimal</td>
<td>extensive</td>
</tr>
<tr>
<td>Laterality</td>
<td>lacking</td>
<td>present</td>
</tr>
<tr>
<td>Specificity</td>
<td>limited</td>
<td>extensive</td>
</tr>
<tr>
<td>Interoperability</td>
<td>US only</td>
<td>US &amp; most international</td>
</tr>
</tbody>
</table>

Why ICD-10?

ICD-9 Limitations:
- Outdated, with limited ability to accommodate new procedures and diagnoses
- Lacks the precision needed for a number of emerging uses such as pay-for-performance and biosurveillance
- Limits the precision of diagnosis-related groups (DRGs)
- Lacks specificity and detail, uses terminology inconsistently, cannot capture new technology, and lacks codes for preventive services
- Will eventually run out of space, particularly for procedure codes

ICD-10 Advantages:
- Supports value-based purchasing and Medicare's anti-fraud and abuse activities by accurately defining services and providing specific diagnosis and treatment information
- Supports comprehensive reporting of quality data
- Ensures more accurate payments for new procedures, fewer rejected claims, improved disease management, and harmonization of disease monitoring and reporting worldwide
- Allows the United States to compare its data with international data to track the incidence and spread of disease and treatment outcomes

October 1, 2013: ICD-10 Implementation Deadline

Source Code Format

ICD-10-CM

ICD-10-PCS

ICD-10-PCS
The ICD-10 Challenge

• ICD-10 requires a more complex business approach than HIPAA 5010.
  – HIPAA 5010 changes were specified by CMS by prescriptive EDI technical specifications. CMS recommended health care payers’ use of new and modified HIPAA 5010 data elements.
  – ICD-10, on the other hand, requires health care payers to interpret the new ICD-10 code set and determine how to modify business processes so that efficiencies can be gained to drive organizational value and competitive differentiation.
  – ICD-10 process changes will impact all physician practices and hospitals but there are benefits too:

  • Medical Management
    – Medical Policy changes made to align with ICD-10 may impact business process
    – Opportunity: richer code set allows for more focused Care Mgmt & Wellness Programs
  
  • Contracting
    – Updating contracts containing ICD-9 codes & references may impact business process
    – Opportunity: additional detail allows for a more precise pricing structure
  
  • Fraud & Abuse
    – Richer data set available for Fraud & Abuse analytics may impact business processes
    – Opportunity: greater specificity of code sets allows for more automation in reviews
ICD-10 Impact Map

In both Physician and Payer settings, ICD-10 represents a major impact to all business and technology areas that utilize medical codes.
ICD-10-CM Diagnosis Code Example

Diagnostic Code Set - Broad Impacts

ICD-10-CM provides 50 different codes for “complications of foreign body accidentally left in body following a procedure,” compared to only one code in ICD-9-CM.

- T81 category for complications due to foreign body show how specific these ICD-10-CM codes are compared to the one general ICD-9-CM.
- ICD-10-CM codes describe the actual complication, e.g. perforation, obstruction, adhesions, as well as the actual procedure that had been done that resulted in the foreign body being left behind.

- T81.530, Perforation due to foreign body accidentally left in body following surgical operation
- T81.524, Obstruction due to foreign body accidentally left in body following endoscopic examination
- T81.516, Adhesions due to foreign body accidentally left in body following aspiration, puncture or other catheterization
ICD-10-PCS Procedure Code Example

Procedure Code Set - Heavily Impacts Inpatient Procedures

ICD-10-PCS provides dozens of combinations of codes for Coronary Artery Bypass Grafts compared to only 7 codes in ICD-9-CM.

- Specificity of an ICD-10-PCS code compared to the more general ICD-9-CM code
- ICD-9-CM codes 36.14 and 36.16 would be reported for this same procedure
- Each ICD-10-PCS character has a specific meaning, and there is no decimal point used in ICD-10-PCS procedure codes

- **02100Z8** Bypass, One Coronary Artery to Right Internal Mammary Artery, Open
  - 0 stands for the medical-surgical section
  - 2 is the heart and great vessels body system
  - 1 is the root operation of bypass
  - 0 is the body part – one coronary artery
  - 0 is the approach, which is open for this case
  - Z indicates no device was used
  - 8 is a qualifier for right internal mammary artery
What Are Crosswalks?

• Crosswalks are a translation tool used to assign an ICD-9 code to the best possible match in ICD-10 (and potentially the reverse as well).
• Crosswalks will be created based on the CMS-created General Equivalency Mapping (GEM) files
  – GEMs are more than crosswalks
  – GEMs are more of 2 way translation dictionaries for diagnosis and procedure codes from which crosswalks will be developed.
  – Interpretation of the GEMs will impact everything from medical necessity to reimbursement.
• The development of a crosswalk ideally should be a temporary measure used for specific purposes.
• Crosswalks should not alter the meaning of a code; rather represent the facts as accurately as possible.
• Creating a crosswalk from “scratch” will incur significant costs.

Crosswalks are not the solution to ICD-10 deployment for the industry, rather a tool to be used in creating the solution.
The Mapping Problem

• Development of a single “official” mapping between ICD-9 and ICD-10 is a major industry concern:
  – Only about 5% of all codes will map accurately 1:1
  – All other codes will either lose information or assume information that may not be true
  – Imperfect mapping will affect processing and analytics in a way that impacts revenue, costs, risks and relationships
  – The level of impact is directly related to the quality of translation
  – The anticipated quality of translation is currently an unknown
  – GEMs does not provide a definitive match
  – There may be multiple translation alternatives for a source system code, all of which are equally plausible
  – Some translation projects will require selection of a “best alternative”
# Example ICD-9 to ICD-10 changes

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,000 Procedure Codes</td>
<td>68,000 Procedure Codes</td>
</tr>
<tr>
<td>3,000 Diagnosis Codes</td>
<td>87,000 Diagnosis Codes</td>
</tr>
<tr>
<td><strong>Angioplasty (procedure codes)</strong></td>
<td><strong>Angioplasty (procedure codes)</strong></td>
</tr>
<tr>
<td>1 code</td>
<td>854 different codes</td>
</tr>
<tr>
<td>39.50</td>
<td><strong>047K047</strong></td>
</tr>
<tr>
<td></td>
<td>Specifying body part, approach and device</td>
</tr>
<tr>
<td><strong>Pressure Ulcer Codes (diagnosis codes)</strong></td>
<td><strong>Pressure Ulcer Codes (diagnosis codes)</strong></td>
</tr>
<tr>
<td>7 codes</td>
<td>125 different codes</td>
</tr>
<tr>
<td><strong>707.00-707.99</strong></td>
<td><strong>L89.131</strong></td>
</tr>
<tr>
<td>Show location, but not depth</td>
<td>Specific location, depth, severity, occurrence</td>
</tr>
<tr>
<td><strong>No equivalent ICD 9 Code</strong></td>
<td><strong>Y71.3</strong></td>
</tr>
<tr>
<td>-Indicated through notes and</td>
<td>Surgical instruments, materials and cardiovascular devices associated with adverse incidents</td>
</tr>
<tr>
<td>other methods</td>
<td></td>
</tr>
<tr>
<td><strong>Autopsy</strong></td>
<td><strong>No ICD 10 code</strong></td>
</tr>
</tbody>
</table>
ICD-10 Crosswalk Example

- There may be multiple translation alternatives for a source system code, all of which are equally plausible
- Some translation projects require selection of a “best alternative”

Clinical Example

A provider sees a patient in a [subsequent encounter] for a [non-union] of an [open] [fracture] of the [right] [distal] [radius] with [intra-articular extension] and a [minimal opening] with [minimal tissue damage].

**ICD-9 Code:** 81352 - *Other Open Fracture of Distal End of Radius (Alone)*

**ICD-10 Code:** S52571M - *Other intra-articular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with nonunion*

*Note* For all codes related to fractures of the radius:
- ICD-9 codes = 32
- ICD-10 codes = 1731
Example of Change Impact & Sensitivity – Diagnosis Related Groups (DRG) Based

- **ICD-9**
  - 96.05
  - CMS ICD-10 to ICD-9 to DRG grouping

- **ICD-10**
  - 96.05
  - Other Intubation Respiratory Tract
  - 31.99
  - Other operations on trachea

- **CMS’s ICD-10-PCS to MS-DRG v25.0 grouping**

- **Non-Surgical procedure code and requires an appropriate DX to group to DRG203**

- **Current DRG grouping for “dilation of trachea” ICD-9 procedure code**

- **validation of code set translation requires human judgment to achieve revenue neutrality**
Why Should Physicians and Practices Care About Crosswalks?

• Before technology analysis and design can begin payers must make strategic decisions about the use of the ICD-10 codes
  – Without standardization it is likely that affected physicians, facilities and payers will come up with different versions of mappings and crosswalks

• Usage of the ICD-10 codes in a consistent, transparent manner will impact every aspect of the industry, from policy to claim submission to revenue and reporting
  – Practice revenue will be dependent on reasonable and appropriate interpretation of the ICD-10 code set

• Without guidance there is potential for multiple versions of mappings across the industry
  – Collaboration, standardization, consistency and transparency are key in successful code, data and revenue mapping
### Benefits of ICD-10 Implementation

Transitioning to ICD-10 can result in significant value realization.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic imperative</strong></td>
<td>• ICD-10 transition should be viewed more broadly than “complying with a government regulation”; it serves as an opportunity to create differentiation and new and incremental value for the organization.</td>
</tr>
</tbody>
</table>
| **Positive impact to Case Mix / Quality Reporting** | • More specific diagnosis reporting  
• Case mix adjustments  
• More specific quality monitoring / reporting; e.g., Stent Insertion (specific codes for open vs. subcutaneous stent insertions) |
| **Reduced cycle time**                      | • Fewer claim rejections and denials due to non-specific diagnoses  
• Fewer requests for clinical information  
• Expectations of fewer denials from payers could result in significant reduction of rework / administrative expense for both physicians and payers |
| **Positively affect patient / community health** | • More specific disease management programs |
| **Enhanced reimbursement**                  | • Targeted reimbursement based on revised diagnoses and procedure coding |
III. HIPAA 5010/ICD-10 Readiness at UnitedHealthcare
HIPAA 5010 Program Objectives

The HIPAA 5010 program at UnitedHealthcare has three main objectives:

1) Achieve compliance with the Centers for Medicare & Medicaid Services (CMS) mandate for all physicians/hospitals and payers to exchange key business transactional data using the HIPAA 5010 format via Electronic Data Exchange (EDI) by 1/1/2012.

   - The HIPAA 5010 mandate is an enhancement of HIPAA 4010 with the objective to reduce the administrative burden of healthcare by ensuring that facilities, physicians, and payers utilize complete and consistent data electronically. The Healthcare industry recommends that all trading partners are ready to perform trading partner testing on 1/1/2011.

   - UnitedHealthcare is committed to achieving readiness for trading partner testing by 1/1/2011.

2) Achieve Phases I and II Certification of Committee on Operating Rules for Information Exchange (CORE) from the Council for Affordable Quality Healthcare (CAQH) organization by 1/1/2011.

   - CORE Phase I is focused the administrative tasks associated with eligibility and benefit inquiries by providing access to a patient’s eligibility information at the time of service (or before) using the preferred electronic means. CORE Phase II includes rules around the claim status transaction to enable checking the status of a claim electronically, without manual intervention, or confirming claims receipt.

   - UnitedHealthcare is committed to achieving CORE Phase 1 and Phase 2 Certification by 1/1/2011.

3) Consolidate key EDI platforms (hubs) on an Enterprise Strategic EDI hub.
UnitedHealthcare Principles for ICD-10

We are committed to:

– Full Regulatory Compliance
  • UnitedHealthcare will fully comply with the regulatory mandate as described in the Final Rule published January, 2009
  • UnitedHealthcare will fully comply with all Medicare (CMS) requirements for ICD-10 code set usage
  • UnitedHealthcare will meet any performance guarantee requirements defined in customer contracts regarding regulatory compliance

– Cost Neutrality
  • UnitedHealthcare will position itself to ensure payment rates for services in an ICD-9 environment equal payment rates in an expanded ICD-10 diagnosis code set.
  • UnitedHealthcare will ensure cost neutrality in benefit design with the expanded ICD-10 diagnosis code set.
  • UnitedHealthcare will evolve its payment methodologies to support healthcare quality as it gains experience and data with the ICD-10 code set.

– Full Systems Remediation
  • Any system not scheduled for decommissioning must be remediated to natively accept, process and output results for all transactions using compliant ICD-10 code sets
We have requested America’s Health Insurance Plans (AHIP) take action on:

- **Standardized Industry Guidelines for Crosswalk Development**
- **Standardized Industry Guidelines for Implementation Date Issues**
- **Basic Training & Communication Plan**
  - AHIP with Deloitte has developed 9 webinars on readiness
  - AHIP is scheduling intensive educational opportunities at the June Institute and November Business Forum
  - Anticipate a more detailed education and outreach plan as Crosswalk Workgroup and Stakeholder Coalition make progress
- **Standardized Set of Basic Fraud and Abuse Edits**
  - AHIP has a Fraud & Abuse workgroup which is looking at ICD-10 based recommendations
- **Others**
  - AHIP providing strong support on CMS freezing code sets effective October 2011
• SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.
  – (c) ICD CODING CROSSWALKS.—
  • (1) ICD–9 TO ICD–10 CROSSWALK.—The Secretary shall task the ICD–9–CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care facilities, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD–9 and ICD–10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

• Includes GEMs, reimbursement mappings & industry crosswalk issues

• Below is the AHIP schedule to align with this mandate:
IV. Physician, Hospital, Office staff and Medical Society Readiness

A Call to Action…
ICD-10 Impacts on Physicians

Different types of physician practices will experience different impacts:

- Private practice physicians (solo, small group)
- Large physician groups
- Employed & academic physicians (all models)
- Government, Researchers and other types

Physician practices are highly cost sensitive, and are already contending with:

- HIPPA Changes
- American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health (HITECH) meaningful use incentive drivers and penalty avoidance
- e-Prescribing incentives/penalties
- Physician Quality Reporting Initiative (PQRI) Incentives & penalties

Bottom line: physicians will have to increase level of medical record documentation across all places of service
Considerations - People

• **Physician:**
  – ICD-10 requires detailed documentation of surgical procedures; more time to document

• **Coding staff:**
  – Will require increased anatomy and surgical procedure knowledge; more time to document
  – Potential increase in coding staff to support transition and minimize productivity losses.

• **Entire practice:**
  – Extensive retraining for physicians, coding and revenue cycle staff
  – Productivity losses should be expected during the initial 3-6 months due to steep learning curve associated with use of ICD-10-CM/PCS
Considerations - Processes

• Office billing/coding work flow
  – Increased coding queries to physicians for further documentation

• Contracting code crosswalks reexamined
  – Medical management program requirements

• Prior Authorization/Notification changes
  – Increased complexity/requirements

• Billing & Reimbursement Accounting
  – Analysis and trending by payer, changes in coding and data trends
  – Previous data analysis obsolete
  – Extensive remapping required (i.e. comparing healthcare outcomes from ICD-9 to ICD-10)
  – Develop a plan for monitoring revenue impact and responses
Considerations - Technology

• **Practice Management System**
  – Code field type/size increase to 3 - 7 alphanumeric characters in all applications using ICD codes (including all clinical and financial applications where codes are entered/ reported)

• **Redesign System Interfaces**

• **Software Changes**
  – Code editing programs (Example: Encoder) will need to be analyzed, redesigned and tested
  – Recalculation of DRG groupers and case mix indexes – inpatient billing

• **Electronic Data Exchanges**
  – Reporting to federal, state, and other regulatory agencies / authorities will need to be analyzed, redesigned to accommodate new data and tested
ICD-10 and the Physician Practice

• Practitioners will look to specialty societies for leadership in areas of:
  – Code comprehension of specialty specific changes
  – Documentation guidance to satisfy medical necessity requirements and increased granularity of the ICD-10 code set
  – Training/Education that is specialty specific
  – Communication of regulations, guidelines and updates
  – Practice Management issues

• Specialty societies have a unique opportunity to strengthen their presence in the industry and lead an ICD-10 call to action within the medical community
UnitedHealthcare Is Ready to Face the Challenges…

• UnitedHealthcare wants to foster open communication with physicians, facilities, office staff, trading partners, and medical societies

• UnitedHealthcare is ready to face the challenges associated with implementing HIPAA 5010 and ICD-10
  – We have well established project teams devoted to HIPAA 5010 and ICD-10 implementation

• UnitedHealthcare would like to work with you as you begin the implementation process – your success is our success

We are all in this together!