UnitedHealth Premium program Patient episode cost

Use this document with the UnitedHealth Premium® program methodology document at **UnitedHealthPremium.uhc.com.** Please review all methodology documents to understand the entire Premium program methodology.

Overview

Patient episode cost reflects a combination of resource utilization, resource mix and unit cost. Episodes include services delivered to a patient related to a specific procedure or treatment of a condition. Services may include those provided by other health care professionals as well as facility, pharmacy and ancillary services (e.g., diagnostic tests). Episodes are categorized as condition or procedure.

Condition episodes

Condition episodes are defined using Symmetry® Episode Treatment Groups® (ETG), which group patients' medically consistent illnesses and severities to the same ETG. ETG builds complete treatment episodes that incorporate inpatient, outpatient, professional and ancillary services, including pharmaceutical services. Once treatment for an episode has begun, ETG continues to collect all clinically relevant information until an absence of treatment is detected. All appropriate cost information is collected and assigned to one complete treatment episode.

Using the claim service line of an individual claim as input, ETG evaluates and assigns each health care service to its appropriate episode, even when more than one illness is treated during a single health care encounter. As a result, ETG separates and identifies concurrent conditions and assigns each health care service to the clinically appropriate episode. ETG tracks and adjusts for changes in a patient's condition during the course of treatment. Once a more serious condition is identified, a patient's entire episode shifts from the initially defined ETG to one for which the definition includes the more serious condition.

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Building condition episodes

The following chart explains the process for building condition episodes.

1 Determine the service category

Service category	Displayed explanation
Management	Claims submitted by a clinician for services related to the evaluation of a patient's condition
Facility	Claims submitted by a facility for room and board services
Surgery/Procedure	Claims submitted by a clinician for surgical or related procedures
Pharmacy	Claims for a prescription drug
Ancillary	Claims submitted by any care provider for laboratory, radiological or similar services

2 Identify anchor records and create episodes from them

Anchor records represent services by a physician engaging in the direct evaluation, management or treatment of a patient. Management, surgery and facility record types are classified as anchors. The identification of an anchor record represents a physician who has evaluated a patient and decided on the types of services required to further identify and treat the patient's condition.

3 Assign the remaining non-anchor records to the open episodes

Non-anchor records represent services that are incidental to the direct evaluation, management and treatment of the patient. Non-anchor records are also identified by pharmacy records and ancillary records (such as laboratory tests, X-rays and the facility component of ambulatory surgery centers and non-inpatient room and board services).

Episode time frames

Each ETG has its own treatment time period per episode. Episodes are defined as complete based on a flexible, rather than fixed, length of time. ETG continues to identify and track all clinical activity for an episode for as long as a condition is actively treated, then identifies the absence of treatment for a specified period of time as the end of the episode. Chronic disease episodes such as hypertension and diabetes, which do not have a clear beginning or end, are assessed using a 1-year episode.

Claims record assignment

Diagnosis codes are the basis for the claims record assignment to an ETG. The ETG methodology considers clinically appropriate diagnosis codes as primary, incidental, complicating or comorbid for any given ETG. Diagnosis codes considered primary establish the initial claims record ETG assignment. Each diagnosis code is mapped as primary to at least one ETG. For example, the ICD-10 diagnosis code J45.20 (mild intermittent asthma, uncomplicated) is primary to the asthma ETG. Incidental diagnosis codes represent an illness or condition that is present during the treatment of another related, but usually more serious illness or condition. For example, if during the course of treatment for acute bronchitis, a patient is treated for throat pain, the throat pain diagnosis is considered incidental to acute bronchitis. Rather than begin a new episode with throat pain, this claim record and the information it contains is considered part of the acute bronchitis episode. Inversely, if a throat pain claim was considered first, it would still group to the acute bronchitis episode. The complicating and comorbid diagnosis codes are not used in the episode assignment but are used to determine episode severity.

Once the diagnosis on the claim record is matched with the ETG, the next step is to review the associated procedure or revenue code for a clinical appropriateness match with the ETG. Only those claim service lines with codes that are mapped to the ETG are assigned to the ETG. For example, if both a chest X-ray and blood glucose test were provided to a patient during the same encounter, and they've had active episodes of both chronic bronchitis and diabetes, the chest X-ray is assigned to the chronic bronchitis episode, while the blood glucose test is assigned to the diabetes episode. The blood glucose test is not eligible for assignment to the chronic bronchitis ETG, as there is not a clinical appropriateness match. If a given code can be valid for several ETGs, ETGs are ranked by clinical relevance to the code. The claim service record would be assigned to the ETG with the highest rank.

National Drug Codes (NDCs) are also used in the grouping process and like procedure codes are matched with one or more ETGs. Just as with the procedure and diagnosis codes, a drug eligibility and ranking identify the ETG for which a drug can be prescribed. This allows ETG to assign the drug claim to the most clinically appropriate episode.

Procedure episodes

Procedure episodes are defined using Symmetry® Procedure Episode Groups® (PEG), which identify a primary "anchor" procedure, as well as claims that have a clinical relationship to the anchor procedure. PEG uses ETGs to identify claims with anchor procedures, as well as identify the clinical relationship between an anchor procedure and other claims that are eligible to group to a procedure episode. Each PEG anchor has a set of clinically related diagnostic and minor treatment procedures, which are known as targets. Procedure episodes include the anchor procedure, target procedures and services from the related ETG episodes.

Inpatient procedure episodes are further classified using All Patients Refined Diagnosis Related Groups (APR DRG). The APR DRG classification system assigns each patient a base class for the underlying condition. The Premium program combines some APR DRGs like chest pain and angina.

Symmetry® Procedure Episode Groups® (PEG) further classifies outpatient episodes based on similar patient and clinical characteristics.

Building procedure episodes

The first step in building a procedure episode is the identification of at least 1 claim line on a given date of service with a procedure CPT® or HCPC or revenue code eligible for PEG anchor procedure status. A single PEG anchor procedure may consist of multiple claims occurring on the same date of service. Once a PEG anchor procedure is identified, non-anchor claims from related ETGs and "target" procedures that are clinically related to the anchor procedure, are grouped to each episode within a time frame specific to each anchor procedure. Certain surgical procedures can be performed on either the left or the right side of the anatomy. When applicable, PEG assigns a flag to a procedure to indicate the laterality of the anchor procedure.

Important notes about the UnitedHealth Premium Program

The information from the UnitedHealth Premium program is not an endorsement of a particular physician or health care professional's suitability for the health care needs of any particular member. UnitedHealthcare does not practice medicine nor provide health care services. Physicians are solely responsible for medical judgments and treatments supplied. A Premium Care Physician designation does not guarantee the quality of health care services members will receive from a physician and does not guarantee the outcome of any health care services members will receive.

The fact that a physician doesn't have a Premium Care Physician designation doesn't mean the physician doesn't provide quality health care services. All physicians in the UnitedHealthcare Network have met certain minimum credentialing requirements. Regardless of whether a physician has received a Premium Care Physician designation, members have access to all physicians in the UnitedHealthcare Network, as further described under the member's benefit plan.

There are various reasons why a physician may not be designated as a Premium Care Physician. A physician may not receive a Premium Care designation because that physician has not been evaluated for a Premium Care designation. This occurs when a physician does not practice in a specialty that is evaluated by the Premium program, or when a physician's evaluation is in process. It also occurs when a physician does not have enough health plan claims data to be evaluated, but it is not an indicator of the total number of patients treated by the physician, or the number of procedures performed by the physician. Rather, it reflects the statistical requirements of the Premium program, which includes only health plan claims associated with specific Premium program measures and relevant to the physician's specialty. In some cases, there may not be enough data to complete the analytic process from a statistical standpoint.

UnitedHealthcare informs members that designations are intended only as a guide when choosing a physician and should not be the sole factor in selecting a physician. As with all programs that evaluate performance based on analysis of a sample, there is a risk of error. There is a risk of error in the claims data used in the evaluation, the calculations used in the evaluation, and the way the Premium program determined that an individual physician was responsible for the treatment of the patient's condition. **Physicians have the opportunity to review this data and submit a reconsideration request.**

UnitedHealthcare uses statistical testing to compare a physician's results to expected or normative results. There is a risk of error in statistical tests when applied to the data and a result based on statistical testing is not a guarantee of correct inference or classification. We inform members that it is important that they consider many factors and information when selecting a physician. **We also inform our members that they may wish to discuss designations with a physician before choosing him or her, or confer with their current physician for advice on selecting other physicians.**

The information contained in this document is subject to change.

Learn more

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