

Advanced Claims Editing for payers



Gain greater control over your administrative costs by providing more transparency to your provider network on incorrectly coded claims. According to the AMA, \$777.6 million in unnecessary administrative costs could be saved if the health insurance industry improved claims processing accuracy by one percent. Incorrectly coded claims can lead to wasted processing cycles, printing and postage fees, phone calls from providers and members, and an increase in managing appeals. As a result, payer organizations are faced with higher administrative costs, along with a decrease in stakeholder satisfaction, if providers face an uptick in A/R days.

Avoid the pitfalls and complexities of today's current claim workflow environment with Optum™ Advanced Claims Editing for payers. This front-end claims editing solution is integrated directly into your gateway or transaction workflow, helping push certain-to-deny claim errors back to the provider, to repair before they get denied in your system. This level of prevention helps reduce overall administrative costs tied to **manual re-work**, resubmission of denied claims, appeal management, and the back-and-forth communication between stakeholders.

The power of Advanced Claims Editing knowledgebase

Advanced Claims Editing for payers workflow can be customized by payer line of business, provider TIN, or claim type. In addition, rules can be modified to precisely reflect your unique program design and tailor the application with date-sensitive auditing logic to help you automatically catch errors, omissions and questionable coding. The Advanced Claims Editing solution is sourced from a comprehensive Medicare, Medicaid and commercial knowledgebase that contains more than 119 million government and third-party industry edits, and is updated quarterly and biweekly with NCD/ LCD updates. In addition, we employ a diverse team of 140+ medical and clinical coding experts that support content development and claims data analysis to help you:

- Significantly reduce administrative costs by preventing manual re-work of claims — allowing organizations to reallocate resources as needed
- Improve overall efficiency with reduced requests for re-openings and appeals
- Improve transparency and set correct expectations with providers at the time of submission
- Improve medical loss ratio and bolster relationships with your network providers
- Alert providers upfront regarding non-eligibility patient and duplicate claims issues

A minor coding error or duplicative claim leads to increases costs. Help move coding edits forward into the Electronic Data Interchange (EDI) stream and alert providers to repair their own errors without any additional administrative effort on your end. Imagine how this would impact your administrative costs and improve your operating margin.

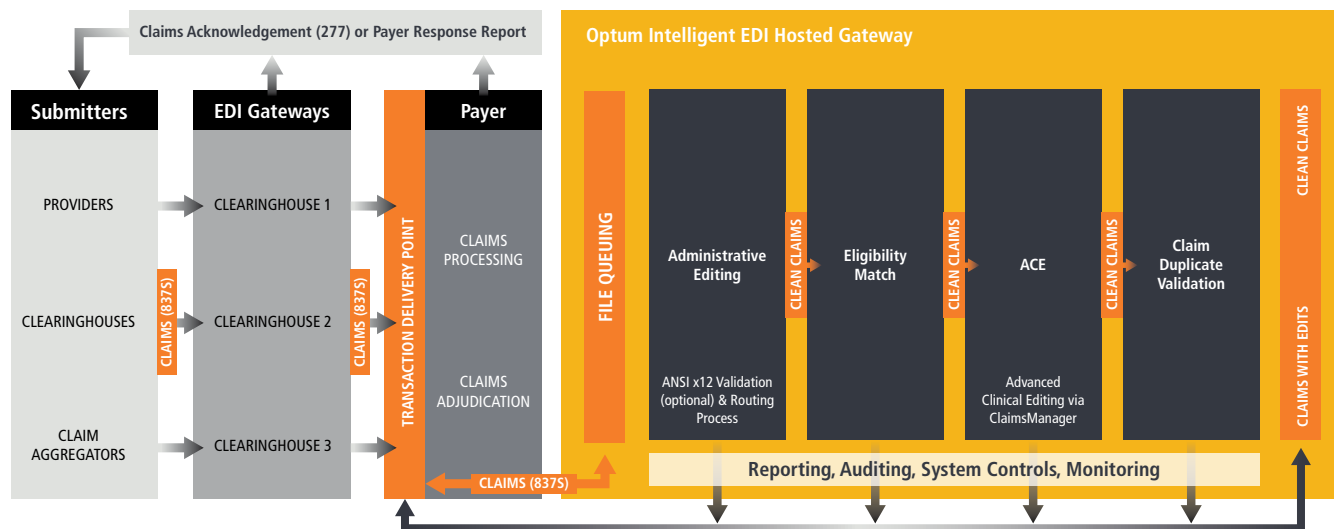
Advanced Claims Editing

- Medicare unbundle (CCI)
- NCD/LCD
- Medicare edits (MUE, globals, reductions)
- Commercial unbundle edits
- CPT® codes to DX to modifier relationships
- Sequencing of DX codes
- Appropriate use of modifiers
- Age, gender, frequency relationships
- Eligibility (member eligibility on DOS)
- Duplicate claim checking (90+ days of claim history)

Advantages of Advanced Claims Editing within your current gateway or transaction workflow

Advanced Claims Editing is implemented within your existing gateway, so there is no need for payers and providers to make changes to current workflow or processes. Edits are provided to submitters via either a standard 277 CA acknowledgment response file format or via the speed if EDI.

Advanced Claims Editing workflow



Balance value to all stakeholders

Advanced Claims Editing for payers can help reduce costs and increase performance and satisfaction for all stakeholders by ensuring timely and accurate claim payments and reducing administrative burdens. Providers are alerted to coding errors prior to full adjudication. Payers increase auto-adjudication rates by receiving correctly coded claims, help manage the impact of ICD-10 and reduce provider abrasion. Fewer phone calls, fewer appeals, and fewer delays. It's a true win-win for both parties.

ICD-10 ready

Be prepared for ICD-10 with automatic updates into the solution upon their release. Advanced Claims Editing is architecturally prepared for ICD-10 and allows clients to test claims using ICD-9 and ICD-10 code sets.

The cost to generate and send paper check, EOB and remittance advice is between \$0.50¹ (paper-based best practice) — \$2.00² (less efficient paper-based) vs. \$0.12³ (electronic process). Total savings per transaction via electronic method is between **\$0.38 to \$1.88**.

1, 2. Optum figure based on customer experience.

3. Milliman, Inc. "Electronic Transaction Savings Opportunities for Physician Practices." January 2006.



11000 Optum Circle, Eden Prairie, MN 55344

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Advanced Claims Editing helps ease administrative burdens by preventing erroneous coding claims from entering your system by empowering providers to self-repair mistakes. For more information:

Call: 1-800-765-6705

Email: inform@optum.com

Visit: optum.com