OPTUM™

Optum™ Claims Manager Professional

Integration with Epic

Optum™ Claims Manager Professional is a proven system that leverages advanced clinical editing and reviews claims prior to submission to third party payers to improve reimbursement rates, support provider compliance, and reduce operating expenses. This clinical editing solution helps physicians identify inappropriately coded charges prior to claim submission.

In collaboration with Epic, we have created seamless integration and connectivity via a real-time, two-way interface that allows users of Epic to stay within their screens, providing enhanced productivity with a minimal learning curve. Currently, Claims Manager has integration points with Resolute Professional Billing.

Review claims at the least costly point in the claims workflow

Imagine the possibilities if clinical claims editing were conducted before claims were submitted, regulatory and payer rules were automatically updated, and missed revenue opportunities were proactively identified.

Claims Manager Professional replicates the Medicare and Medicaid payment process and emulates the commercial payer adjudication process at the least costly point in the claims continuum — before the claims leave your hands. Its intelligent automation can help you attain financial insights that contribute to better business decisions and help you realize significant return on investment.

Optum Claims Manager Professional can help your organization:

- Identify partially billed or missed charges
- Reduce administrative expenses and avoid the delays associated with incorrect coding.
- Comply with Medicare, Medicaid and commercial regulations with a consistent, automated standard
- Develop your own edits and customize system edits to meet your organization's billing and reimbursement needs

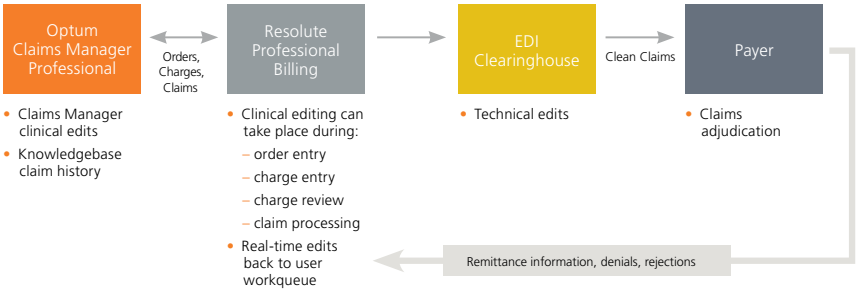
Claims Manager can assist your organization in curtailing administrative costs associated with denied claims.

With so many complexities in the claim workflow of today's physician practices, it's a Herculean task to stay on top of changing regulatory and commercial payer reimbursement requirements without devoting a large staff to manage the process.

Furthermore, an average of 19 percent of claims are rejected or denied, necessitating rework and resubmission; and physicians spend an average of 20 hours each week dealing with claim edits.* If a claim has to be resubmitted through the claims management process, your organization's administrative costs and A/R days escalate — resulting in unpredictable cash flow.

* 2011 AMA National Health Insurer Report Card

Claims Manager workflow with Epic



- Multiple integration points within Resolute Professional Billing
  - Order entry
  - Charge entry / charge review
  - Claims processing / claims edit
- Edits routed via charge router logic (Resolute Professional Billing workqueues)
- Each Claims Manager edit is individually controlled in Epic
- Front-end edits return immediately after the user presses accept
  - Can be worked right away or pended to an Epic workqueue for further research
- Back-end edits appear during charge review processing
  - Automatically routed to specified Epic workqueues

Optum ClaimsManager — the power behind the knowledgebase

Claims Manager is powered by an extensive knowledgebase of third-party industry edits. The increased accuracy helps you receive appropriate and timely reimbursement. In addition, this solution features:

Comprehensive Medicare, Medicaid and Commercial knowledgebase

- Contains more than 119 million government and third party industry edits
- Sourced at the code relationship level
- Supported by disclosure statements

A diverse team of medical and clinical coding experts

- Team of more than 60+ experts supporting content development
- Team of medical directors, specialty panels, RNs, LPNs, RHITs, RHIAs, CPCs, CCS-P and legal support
- Methodology that reflects clinical research, comprehensive coding expertise and claims data analysis
- Clinical, technical, and client support

ICD-10 Ready

- Final ICD-10 regulations are automatically incorporated into Claims Manager upon their release, and clients can test claims using ICD-9 and ICD-10 code sets

Increased revenue potential

Identifying partially billed procedures before claims submission results in complete payment for all services delivered. For example, see the family practice scenario below, which illustrates what happens when a patient is billed for a prolonged service.

Scenario: Patient is billed for a prolonged service		
Code	**CPT® Description**	**Reimbursement**
99354	Prolonged physician service in office or other outpatient facility; face to face, first hour	$115.57
Edit	Per CPT® guidelines, codes 99354–99357 are used when a physician provides prolonged services involving direct patent contact that is beyond the usual service. This contact is reported including other services, including E&M services at any level.	
99215	The edit indicates additional CPT code(s) to be reviewed and considered. High-level office visit	$143.17
By adding the additional code, the total reimbursement increases by $143.17, for a total of $258.74.		

Lower Your Administrative Costs and Maximize Your Revenue. To learn more about how Claims Manager can help your organization, please contact us at 1-800-765-6793 or inform@optum.com

OPTUM™ optum.com

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