Optum™ Claims Manager Professional

Leveraging advanced clinical editing capabilities, Optum™ Claims Manager Professional reviews claims before payer submission to help physician practices improve reimbursement rates, support provider compliance and reduce operating expenses. Using Optum Claims Manager Professional, practices can maximize their revenue potential by reducing denials, identifying unbilled items and shortening accounts receivable cycles.

Optum Claims Manager helps your practice:

- Correct claims at the least costly point — before they leave your hands
- 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

Powerful KnowledgeBase and editing capabilities

Claims Manager is powered by the Optum extensive KnowledgeBase of third-party industry edits to drive rules-based clinical editing that allows for extensive customization. Combined, these features help you receive appropriate and timely reimbursement, and gain financial insights that contribute to better business decisions.

Claims Manager Professional contains a comprehensive Medicare, Medicaid and Commercial Payer KnowledgeBase:

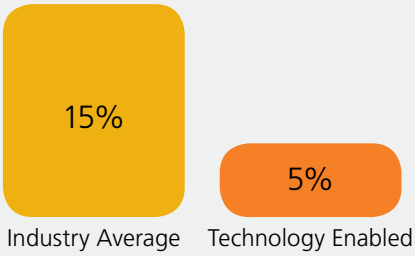
- Contains more than 119 million government and third-party industry edits
- Is sourced at the code relationship level
- Is supported by disclosure statements

The KnowlegeBase is maintained by a diverse team of medical and clinical coding experts:

- Includes more than 60+ experts who support existing and new content development
- Includes a broad range of medical directors, specialty panels, RNs, LPNs, RHITs, RHIAs, CPCs, CCS-P and legal experts
- Provides clinical, technical and end-user customer support

Reducing your resubmission cost

Rejection/denial rates: Up to 15 percent of claims are rejected or denied, necessitating rework and resubmission. Imagine the reductions in your administrative costs if you could reduce this to only five percent.



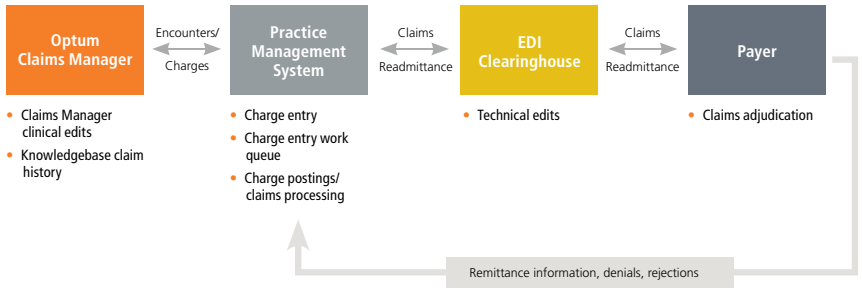
New capabilities allow for timely regulatory updates:

New advanced Data-Driven Rules function allows clients to receive updates to the knowledgebase faster than ever along with a significant increase in new rules to help identify even more coding errors. The solution also makes it extremely easy to upload new and customized rules.

Seamless integration and flexible reporting

Claims Manager can be fully integrated into your practice management system where each edit is individually controlled. In addition, you can run a batch process within your system and send the file to Claims Manager Professional via TCP/IP. Alternatively, users can benefit from Claims Manager functionality while still working within the screens of their third-party solutions, enabling you to release claims to your clearinghouse or payer within your normal workflow.

Flexible reporting also enables managers to view counts of claims and claim lines, display product customizations and audit logs, and schedule reports to run daily, weekly or monthly. Managers can also view data elements from Claims Manager Facility to compare inpatient and outpatient claims, and to identify when inpatient and outpatient claims are billed on the same date of service.



ICD-10 ready

Be prepared for ICD-10 with automatic updates into the solution upon their release. The latest version of Claims Manager allows clients to 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, that 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 patient 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.		

Prevea Health* has gained $2,112,859 by identifying service dollars that were previously not billed and by making substantial use of Claims Manager's positive editing ability.

CPT is a registered trademark of the American Medical Association.

To learn more about how Claims Manager can help your organization, please contact us at 1-800-765-6793 or inform@optum.com

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