

Optum Claims Manager plays pivotal role in reducing claims resubmission rates and improving A/R days for University of Vermont Medical Center



## Challenges

Founded in the late 1800s, the University of Vermont Medical Center in Burlington, Vermont, is today the most comprehensive not-for-profit hospital in the state. One of only 138 academic medical centers in the country, the hospital is also the state's largest private employer, with more than 7,000 employees, an annual payroll of \$492 million and annual revenues of more than \$1 billion. Formally known as Fletcher Allen Health Care, it is one of four affiliate hospitals in the University of Vermont Health Network, which serves the Vermont and northern New York State region.

Steeped in the traditions of medical, nursing and health sciences, the hospital has been able to provide the highest quality care, informed by ongoing academic research and innovation, to patients throughout its region. This commitment to quality and innovation has taken many forms, foremost among them the application of new technologies within several departments of the hospital.

When originally researching for clinical editing solutions, one area in particular needed improvement. Payer claims, containing a large number of errors, were being submitted by the hospital's clinical charge entry and coding staff to the billing department, which in turn sent the claims out to Medicare, Medicaid and four commercial carriers. Subsequently, a large number of payer denials and rejections were returned to the billing staff, requiring them to sort out, research and, if possible, correct the errors made by the clinical staff before resubmitting the claims to payers for payment. As a result, accounts receivable cycles became extended, billing staff were underutilized, and, in many cases, revenue was lost.

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## Highlights

Using Optum<sup>®</sup> Claims Manager, the University of Vermont Medical Center achieved an ROI of 18.65:1 for 2014.

- Current payer claim denial rate – **5.1%**
  - **31.5** A/R days
  - **\$3.5 million** in administrative savings and additional reimbursements:
    - Commercial: **\$2,455,518**
    - Medicaid: **\$38,001**
    - Medicare: **\$1,090,702**
  - ICD-10 fully integrated into Claims Manager
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Coincidentally, the hospital was converting its professional billing system. An option offered during the time was a powerful claims management system — Optum Claims Manager Professional. Upon careful review, it was determined that Claims Manager would provide a solution to the charge entry and coding errors that were quickly becoming a challenge to correct.

“We knew we had a problem with errors in clinical coding. This created extra work for our billing and follow-up teams, who were required to go back to sites, pull documentation and correct mistakes after the fact,” says Michael Barewicz, Director of Professional Revenue. “Our intent was to provide a way for the clinical side of the house to code things correctly in the first place.”

## Solutions

### Correcting claims before payer submission

Claims Manager is powered by the comprehensive Optum KnowledgeBase™ of more than 119 million Medicare, Medicaid and commercial payer industry edits to drive rule-based clinical editing. The KnowledgeBase is maintained and constantly updated by a team of more than 140 medical and clinical coding experts, and includes clinicians, developers and engineers, as well as a broad range of medical personnel.

Claims Manager also allows employees to use the fully integrated Rules Creation Manager feature to customize the system with local rules, including clinical guidelines, practice policies and procedural follow-up on patient histories.

Each claim entering the revenue management system flows automatically into Claims Manager. Optum automatically checks each charge against its built-in set of rules and any additional local rules created by University of Vermont Medical Center personnel. Claims, including local coverage determinations (LCD), that are documented accurately and error free are published to the billing and accounts receivable system as invoices. Then, and only then, they are sent out for collection. This unique clinical editing ability enables the hospital’s clinical team to correct claims before sending them to billing, automatically catching any errors and making edits upfront rather than later in the claims process.

“This ability to review claims before submission using the rules engine was very attractive to us,” Barewicz explains. “Our charge entry and coding staff were able to see and quickly correct errors themselves. We were now able to educate and empower our clinical staff to compress the cycle time and improve the accuracy of the claims coded the first time.”

As is normal with innovative technology, there was some skepticism within the clinical charge entry and coding department regarding error capture at the front end. Staff voiced concerns that the system might, in fact, slow down the process and adversely further impact cash flow and revenue. As a result, they decided that Claims Manager edits should be gradually turned on. This approach lasted for quite a few months, with the staff becoming accustomed to the types and volume of edits that the system identified. Ultimately, all edits were turned on.

“We probably should have turned everything on at the beginning,” Barewicz admits.

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The unique clinical editing ability enables the University of Vermont Medical Center to correct claims before sending them to billing.

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### Charge-to-charge comparison

Claims Manager's charge-to-charge comparison or cross-encounter review was a necessary function that gave billing a claims history and checked for both OGP and NGP global periods.

"Global period frequency edits are important for us to have in order to figure out what we did wrong," states Kelly Murdock, applications support analyst. University of Vermont Medical Center. "This potentially catches typos and various other errors, such as a clinician putting in 1,000 units instead of 1."

### Applications support analyst

Optum Claims Manager has proven to be a truly flexible system. Rather than centralizing charge capture, the University of Vermont Medical Center chose to distribute it at every front desk. Charges and copays are input at or near the time of service in the clinics, enabling the providers to see the types of edits that result. In that way, the providers themselves best learn the system and how to use it to accurately input claims.

In this distributed charge capture configuration, historical editing is crucial to maintaining compliance. For example, Medicare guidelines require a hospital to bill for a new patient only if the patient hasn't been seen in a particular specialty within three years. Otherwise, the patient is billed at a lower rate, as an established patient. The historical edit in Claims Manager controls new patient versus established patient — something Medicare is scrutinizing.

"If a patient visits a specialty clinic with several surgeons and meets with one surgeon, and then returns to the clinic within three years to see another surgeon in that clinic, Claims Manager tells us that is an established patient," explains Erica Morse, applications support analyst, University of Vermont Medical Center.

The compliance department also reviews the edits and helps catch issues that might create concern with various government payers. Claims Manager is one of the tools the hospital uses to maintain compliance throughout the organization, supporting correct coding and patient categorization required by various payers.

"This is very critical now with mid-level providers," said Barewicz. "Medicare looks at PAs and NPs as their own specialties. If a patient goes to the emergency room and sees a PA, and is then referred to orthopedics and sees a PA, that is an established patient, and without Claims Manager telling us that, orthopedics would have to look at the entire patient record to figure this out — or wait for a denial from Medicare. A recovery audit contractor (RAC), working on behalf of Medicare, recently took a look at our patient classifications, and we did not have issues. Historical editing keeps us in compliance with Medicare."

### ICD-10

Several years after the implementation of Claims Manager, the specter of ICD-10 and a quintupled increase in diagnoses codes over ICD-9 in late 2014 threatened to complicate the future of denial management at the University of Vermont Medical Center. Now, however, with the ICD-10 code set fully integrated into Claims Manager, concerns over the exponential increase in information that coders must handle, and fears over a soaring number of denied claims, have waned.

"The expectation is that ICD-10 won't be much of an issue for us, because we have the Claims Manager product," Morse affirms.

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— **Michael Barewicz**  
Director of Professional Revenue

## Results

The latest 2014 financial statistics compiled by Optum on behalf of the University of Vermont Medical Center are impressive:

- **1.3 million** claims for **750,000** office visits
- Current payer denial rate — **5.1%**
- \$3.5 million in administrative savings and additional reimbursements based on a \$25 resubmission cost for each denied claim:
  - Commercial: **\$2,455,518** using the commercial ruleset
  - Medicaid: **\$38,001**, including CMS Correct Coding Initiative (CCI) unbundle edits and commercial unbundle edits
  - Medicare: **\$1,090,702**, including LCD edits for Vermont
- Return on investment (ROI) — **18.65:1**

As an academic medical center, the University of Vermont Medical Center is a member of the University Health Consortium (UHC). This membership enables the hospital to benchmark against other academic medical centers in several different areas.

The UHC Faculty Practice Solution Center survey focuses on revenue cycle and compares revenue cycles of 60 academic medical centers, including the University of Vermont Medical Center:

A/R days were reduced to 31.5, compared to the median of 40.8 for all academics.

The health care industry continues to evolve with increased government regulations and scrutiny of provider claims. Not-for-profit hospitals are especially vulnerable to the increased costs of operation, and many hospitals are perilously close to falling behind. Optum Claims Manager can be pivotal in improving financial and administrative performance, enabling personnel to be more productive, and increasing the odds that a hospital can meet these challenges not only today, but in the coming years as well.

"I think the value of the product is as a cash accelerator. I am not waiting 30–45 days for a denial before I can fix something," Barewicz concludes. "In terms of clean claims, and in terms of getting it right before we bill it — that is where the value of Claims Manager shines."

## About Optum

Optum is a leading health services and innovation company dedicated to helping make the health system work better for everyone. With more than 85,000 people collaborating worldwide, Optum combines technology, data and expertise to improve the delivery, quality and efficiency of health care.

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