



ADVANCING THE
REVENUE CYCLE
TOWARD A
DENIAL-FREE
FUTURE



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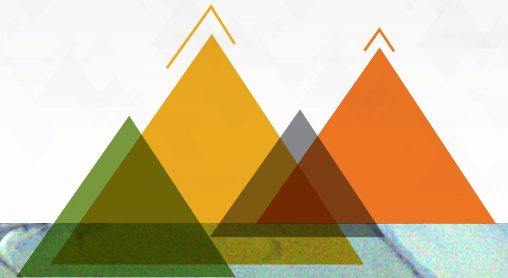
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THE OPTUM360 VISION FOR AN ADVANCED REVENUE CYCLE



Imagine a revenue cycle so seamlessly interconnected that no claim is ever denied.

It's built on a foundation of rich clinical content and payer-informed rule sets and infused with the experience of countless clinical experts.

And it leverages clinically aware artificial intelligence technology. Imagine payers and providers working in a seamless, transparent and collaborative way. In this revenue cycle, processes are fused into a single ecosystem that shares best practices and analytic insights across all stages and functions.

That revenue cycle doesn't have to be a dream. We help our clients approach that vision. Not in five or ten years. **Today.**

A UNIQUE VISION FROM A UNIQUE COMPANY

At Optum, we have a unique perspective about how to transform the revenue cycle because we are strategically situated between payers, providers and consumers.

And we believe that by enabling unprecedented levels of transparency and collaboration between all three we can drive positive financial performance for all stakeholders. Our technologies and methodologies are the industry's most advanced, and our people are the industry's most proficient. This positions us well to identify and seize opportunities to modernize the revenue cycle for collective success. We focus on getting it right up front in the revenue cycle to eliminate denials later.



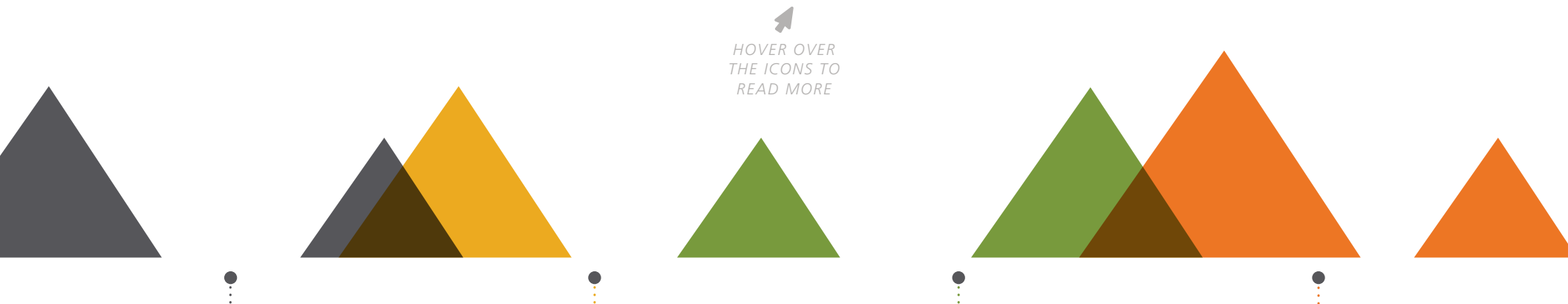
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REVENUE CYCLE PRIORITIES

Advancing the revenue cycle requires a new vision. One that is focused not on managing denials but on preventing them from ever happening.

Achieving this vision requires modernization and a focus on four revenue cycle priorities for improvement. We apply rich content, clinical intelligence and payer-aware rules refined by decades of experience to every priority area to enable your success.

HOVER OVER
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READ MORE



PATIENT FINANCIAL
EXPERIENCE

DOCUMENTATION AND
CODING IMPROVEMENT

CLAIM INTEGRITY
AND PROCESSING

DENIAL MANAGEMENT
AND RECOVERY

PATIENT FINANCIAL EXPERIENCE

While improving efficiency and cash flow are critical to the success of your organization, it's just as important to ensure patient satisfaction in the registration and financial aspects of their experience. Providing a smooth experience for patients will help ease burdens in every stage of the revenue cycle. Addressing eligibility verification, getting prior authorization and providing patients with estimates will not only improve patient collections but also reduce mid-stage errors and prevent avoidable denials.

OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR A PATIENT FINANCIAL EXPERIENCE THAT PURSUES A DENIAL-FREE FUTURE.



PATIENT FINANCIAL EXPERIENCE



Assess Yourself!

THE MEASURE:

Point-of-service collection rate*

WHY IT MATTERS:

HFMA defines patient point-of-service payments as patient cash (self-pay cash) collected prior to or at the time of service and up to seven days after discharge. As patients take on more financial accountability for their health care, hospitals need to assess if their staff is effectively collecting patient payments before overdue bills turn into hospital bad debt.

**Divide the total value of patient point-of-service payments by the total self-pay cash collected.*

TAKE ACTION NOW!

SOME TIPS TO HELP YOU BEGIN ADDRESSING ELIGIBILITY CHALLENGES

ADDRESSING ELIGIBILITY CHALLENGES:

- **Verify eligibility at the right time** — Leverage batch inquiries for groups of patients prior to appointment and re-check eligibility at registration.
- **Leverage real-time medical eligibility verification** — Retrieve eligibility status and benefit information in seconds.
- **Train staff to process prior authorizations** with the right procedures and codes, resulting in faster approvals.
- **Calculate price estimates for patients** — After you verify eligibility, use the information provided by the patient's insurance provider, as well as your practice's contracted rates, to calculate a price estimate for your patients.



DOCUMENTATION AND CODING IMPROVEMENT

Pursuing a denial-free future requires providers to produce complete and accurate clinical documentation and coding — something easier said than done. To succeed, providers must operate from a foundation of rich clinical content and rules — including payer rules and regulatory changes — that are continuously updated to react to the latest trends, developments and guidelines. Automated processes and collaboration are vital to success, but automation must be built on advanced, clinically aware artificial intelligence (AI) technology, expert guidance and best practices that continuously improve. A multifaceted approach to these challenges will enable error prevention throughout the revenue cycle and support revenue integrity under changing payment models.

OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR DOCUMENTATION AND CODING IMPROVEMENT WORTHY OF A DENIAL-FREE FUTURE.





DOCUMENTATION AND CODING IMPROVEMENT

Optum360 provides the breadth and depth of experience, clinically intelligent technology, and market-leading content and services to deliver exceptional results across coding and CDI operations. With over 30 years' experience, we help clients efficiently improve clinical documentation and coding accuracy, support quality initiatives and achieve revenue integrity.

Available as
TARGETED SOLUTIONS,
MANAGED SERVICES or
a **STRATEGIC PARTNERSHIP**



WE DELIVER ON THE FEATURES NEEDED TO IMPROVE DOCUMENTATION AND CODING THROUGH THE FOLLOWING SOLUTIONS:



PHYSICIAN ADVISOR SOLUTIONS

Highly trained regulatory and payer guideline experts who use peer-to-peer collaboration and unmatched evidence-based medical research to resolve utilization review (UR) and CDI issues



ENTERPRISE COMPUTER-ASSISTED CODING (CAC)

Coding and automated workflow technology that harnesses the power of clinically intelligent NLP to support accurate code assignment for timely, appropriate reimbursement



CDI 3D

Clinically intelligent NLP technology that reviews 100 percent of cases and identifies documentation deficiencies, gaps and potential quality events (including HAC and PSI) concurrent to and throughout the patient stay



CODING SERVICES

A broad range of outsourced coding services, including backlog coding and coding review, with experienced clinical and medical records specialists and proprietary applications such as Optum CAC technology and the charging algorithms in Optum LYNX charging applications

ADDITIONAL PRODUCTS

CAC PROFESSIONAL

Technology powered by superior NLP that **AUTOMATES** workflow and performs professional code assignment for consistent, compliant coding, optimal operations, and accurate revenue capture

ENTERPRISE CAC AND CDI 3D PLATFORM

A single integrated platform that **FACILITATES** collaboration across teams to support the common goal of complete and accurate documentation, coding and reimbursement

OPTUM LYNX OUTPATIENT CHARGING APPLICATIONS

Applications that use proprietary algorithms, knowledge of regulatory guidelines and industry experience to **EVALUATE** outpatient charges and code assignment for emergency departments, clinics and infusion centers

DOCUMENTATION AND CODING IMPROVEMENT



Assess Yourself!

THE MEASURE:

Case mix index (CMI)*

WHY IT MATTERS:

CMI reflects the diversity and clinical complexity of patients and the associated resources utilized to care for patients compared with similar facilities within a peer group. It also serves as a trending indicator of patient acuity, clinical documentation and coding. Accurate CMI supports appropriate reimbursement for services performed and accurate clinical reporting.

*CMI is calculated by dividing the sum of all DRG-relative weights by the number of cases (month/year).

CLIENT PERSPECTIVE

Our unbilled A/R has never been lower than it is now. We've also seen an improvement in our coding backlog, case mix index, and ratings for SOI and ROM, which means we're better reflecting the quality of care we're giving to our patients.

— Nancy Cloutier, system director of health information management at Hallmark Health System (using Enterprise CAC, CDI 3D, and consulting and coding services)

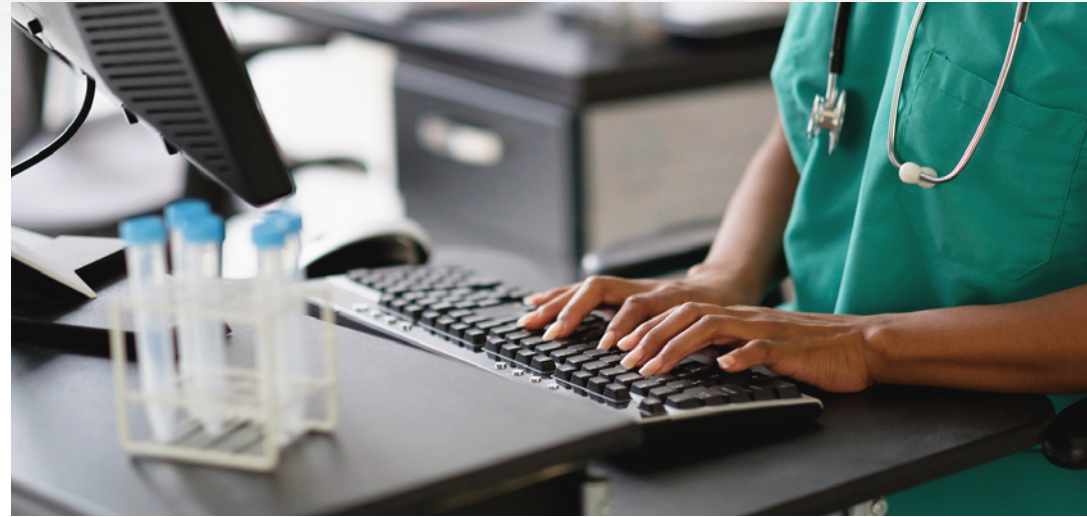
TAKE ACTION NOW!

- **Find physician champions** in each department to help encourage others to strive for complete and accurate clinical documentation. A physician advisor can be a good catalyst for identifying and developing physician champions.
- **Analyze queries and denials for trends** that identify specific areas for process improvement.



CLAIM INTEGRITY AND PROCESSING

A transformative revenue cycle requires careful attention to improving claim integrity and simplifying claim processing. Leveraging payer-specific rules, necessary attachments and prior patient claims data can ensure revenue integrity and prevent denials by identifying certain-to-deny claims prior to submission. Removing unnecessary costs — such as wasting money on claim processing when options to avoid this cost are available — allows you to reallocate that money into other high-value areas of the revenue cycle.



OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR CLAIM INTEGRITY AND PROCESSING THAT ENABLE A DENIAL-FREE FUTURE.



CLAIM INTEGRITY AND PROCESSING

Optum360 removes unnecessary payer-provider feedback loops by using content and rules that support claim accuracy and documentation based on how payers adjudicate claims. Our intelligent clearinghouse and clinical editing capabilities streamline claim processing, identify certain-to-deny claims and help ensure revenue integrity. With these innovative solutions, clients can remove costs from the claim submission process and reduce administrative expenses associated with claim resubmission. This frees up dollars for other critical investments.

WE DELIVER ON THE FEATURES NEEDED FOR EFFECTIVE CLAIM INTEGRITY AND PROCESSING THROUGH THE FOLLOWING SOLUTIONS:



CLAIMS MANAGER

Claims software that identifies certain-to-deny claims by pre-screening for clinical coding and billing errors based on payer adjudication guidelines and standards



INTELLIGENT EDI

Claims clearinghouse that streamlines the claim process, from claim preparation and no- or low-cost claim submission to payer response management

SUPPORTING YOUR CLAIM INTEGRITY WITH OPTUM: BY THE NUMBERS



ELIMINATE the cost of basic claim transactions with free² EDI via Link



\$1.54 MILLION average unbilled revenue identified per client, per year



130 MILLION code-to-code relationships developed and supported by an industry expert research panel of 140+ FTEs



\$3.01 MILLION average cost avoidance per client, per year, based on denial prevention edits



120,521 average claims stopped for repair, per client, per year

2. Select Medicaid payer claims and non-UHC real-time transaction fees apply

Available as
TARGETED SOLUTIONS,
MANAGED SERVICES or
a **STRATEGIC PARTNERSHIP**



CLAIM INTEGRITY AND PROCESSING



Assess Yourself!

THE MEASURE:

Clean claims rate*

WHY IT MATTERS:

Clean claims rates identify the quality of data being collected upstream as well as the amount of labor going into error resolution. Improving clean claims rates reduces the labor costs and AR days required to generate payment.

**Divide the number of claims that pass all edits by the total number of claims accepted into the claim processing tool for billing.*

TAKE ACTION NOW!

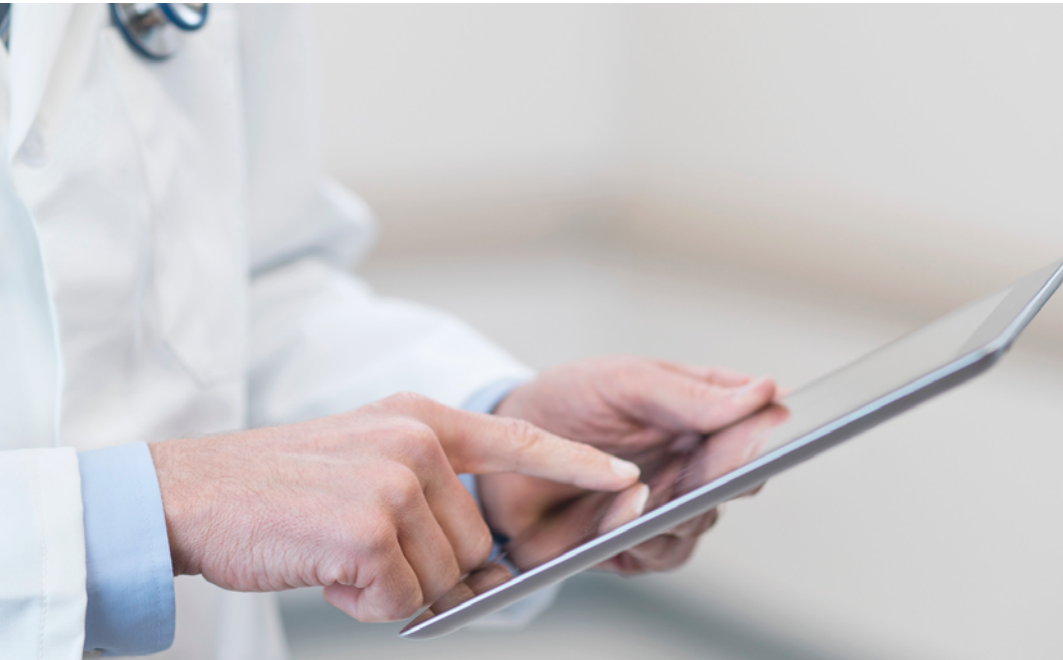
- **Scrub claims for all major payers** for compliance issues, diagnosis issues, and other possible coding and billing errors.
- **Review all electronic claim rejection reports daily** in order to determine where in the continuum the claim was rejected.
- **Reduce the number of claims** hitting an edit by tracking the root causes of your most frequent errors.
- **Implement system-wide workflows** that efficiently sort pre-billed claims and denials for rework.



DENIAL MANAGEMENT AND RECOVERY

While we pursue a denial-free future, providers must still face the current denial challenge. Appeals and recovery are the necessary last mile in the cycle. By analyzing root causes of denials, providers can chip away at denial contributors. Where are denials originating, and why are they occurring? Are the hot spots in patient access and registration, documentation, coding/billing or utilization/case management? But, no matter how successful an organization is at correcting the causes of denials, some will still slip through. A well-tuned denial management and recovery approach can quickly and effectively minimize the impact of denials on the revenue cycle.

OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR BEST-IN-CLASS DENIAL MANAGEMENT AND RECOVERY EFFORTS.





DENIAL MANAGEMENT AND RECOVERY

Optum360 denials prevention and recovery solutions harmonize the revenue cycle for payers and providers alike, enabling collaboration and transparency. Our solutions provide intelligent, automated denials recovery approaches and ongoing prevention through denial root cause analysis as well as elimination of inefficiencies and inaccuracies.

WE HELP CLIENTS EFFECTIVELY MANAGE DENIALS AND RECOVER REVENUE THROUGH THE FOLLOWING SOLUTIONS:



DENIALS RECOVERY SERVICE

Technology-enabled denied claim recovery, including root cause analysis and trending of outcomes to create a solid denials prevention strategy for acute and ambulatory settings



PAYMENT INTEGRITY COMPASS

Automated contract management solution that pinpoints underpayments, identifies trends in reimbursement discrepancies and bundles denials rework by payer



DENIAL MANAGEMENT

An intelligent, automated denials workflow technology that enables providers to capture, identify and correct the root causes of denied claims while improving productivity

OPTUM HAS UNMATCHED EXPERTISE IN DENIAL MANAGEMENT AND RECOVERY:



1 MILLION+ complex denial appeals completed by Optum



\$5 MILLION average denied claim resubmission expenses avoided per Optum client, per year



85% Optum overturn rate for Medicare clinical denial appeals



\$2.2 MILLION contract underpayment dollars recovered in one year for a Wisconsin-based health system

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DENIAL MANAGEMENT AND RECOVERY



Assess Yourself!

THE MEASURE:

Percentage of A/R over 60 days*

WHY IT MATTERS:

Many providers struggle to collect A/R after the 60-day mark. Having a high rate of A/R over 60 days reflects a propensity for declining recovery rates, an increase in likely write-offs and bad debt, and problems with the rest of your revenue cycle policies leading to denials.

**Divide the amount of A/R over 60 days by the total outstanding A/R.*

SEE HOW SOME BASIC ANALYTICS AND PRIORITIZING CAN HELP YOU IDENTIFY THE FIRST STEPS OF YOUR UNIQUE DENIALS CHALLENGE.

TAKE ACTION NOW!

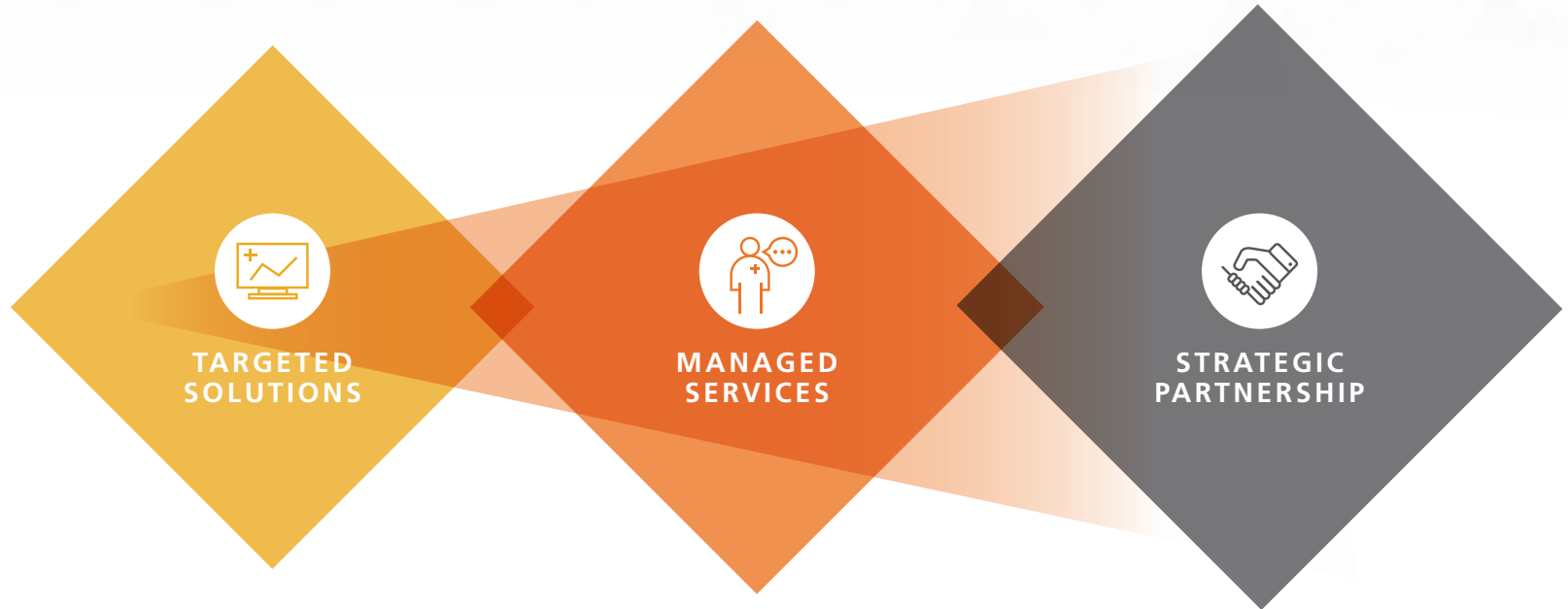
You can begin rebuilding your denial management and recovery strategy today from an organization-specific foundation of metrics, priorities and insights.

- **Identify trends.** Identify trends in denials and conduct root cause analysis. Your existing analytic tools may pinpoint trends. For instance, if a significant portion of your denials are prior-authorization denials, scrutinize your front-end authorization process.
- **Prioritize.** Systematically prioritize denials and related workflow. Assess the business impact of each kind of denial and address those denials that either represent the greatest challenge or offer the opportunity for quick revenue recovery. Earmark more complex denials for third-party assistance or additional technological investment.
- **Communicate.** Feed intelligence upstream for best-practice realignment. Sharing learnings and insights about the reasons for denials with front-end and middle-stage revenue cycle teams can help reduce the flow of denials by addressing issues further upstream.



OPTUM CAN HELP.

The path to a denial-free future is possible with the right partner.
Our flexible engagement model can meet you where you are.



Advance the revenue cycle with our industry-leading technology solutions

- Complement core system investments
- Clinically aware artificial intelligence
- Payer-centric clinical and administrative content
- Reduce EDI transaction cost

Modernize key functional areas of the revenue cycle with technology-enabled managed services

- Our expert teams understand operations and workflow intricacies to drive performance and process improvement
- Services powered by our industry-leading technology solutions
- Avoid technology deployment and support costs

Achieve long-term revenue and savings with full operating transformation

- Risk-sharing partnership model
- We manage every claim and dollar in the revenue cycle
- Achieve more accurate and appropriate payment and savings

WHAT'S NEXT?

CONTACT US TODAY

to learn how we can help strengthen each of these four revenue cycle priorities in your pursuit of a denial-free future.

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