Optum

A data-driven strategy to decrease denials

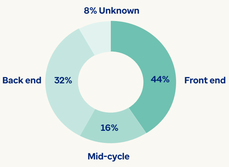


Gaining insight into the root causes of claims denials is the first step to preventing them in the future. In fact, 84% of denials are potentially avoidable.[1] Learn how the Optum 2024 Revenue Cycle Denials Index results shown below can help you prevent future claims denials and rework. Plus, explore solutions to help address the top denials trends across all stages of the revenue cycle.

The Optum 2024 Revenue Cycle Denials Index[1] shows nearly half of all denials occur in front-end processes.

Understanding where, when and why claim denials occur is crucial to preventing them.

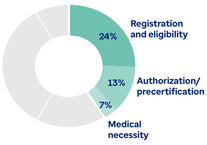
Fortunately the Optum portfolio of solutions offers denial prevention support across the revenue cycle, regardless of stage and cause.



Start here to begin reducing your denials rate:

1 Fighting front-end denials

Front-end denials make up the bulk of revenue cycle denials overall. Registration and eligibility and authorization/precertification make up the first and third largest denial categories, respectively. Combining the front end of your revenue cycle with digital patient intake and engagement helps create a seamless, intuitive experience for patients and staff. It's a crucial starting point to avoiding denials.



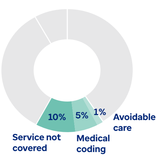
Front-end solutions

Patient Access and Engagement	Patient Financial Clearance	Coverage Insight

• Improved acquisition and retention using omnichannel points of entry
• Enhanced search and scheduling, featuring self-guided 24/7 availability, self-service or agent-assisted scheduling and EHR integration
• Accuracy and transparency in estimates and payment
  – Self-service, accurate cost estimates
  – Omnichannel payment options
  – Payment options and plans
• Digitized patient intake
• Frictionless patient communication
	• Quality-assurance registration data
	• Real-time eligibility verification plus, benefit mapping with actionable alerts to payment risks
	• Price estimation and transparency
	• Automated authorization and medical necessity management to reduce administrative burden, costs and denials
	• Patient data validation, identity verification and risk detection tools to instantly confirm consumer and business identities and reduce fraud
	• Improved patient financial experience through financial screenings for charity care or other financial assistance programs
	• Propensity to pay screenings for increased collections and improved patient financial experience
		• Enhanced provider data to create robust patient profiles
		• Advanced analytics to identify pre-existing coverage
		• Analyzing patient profiles to pinpoint funding sources
		• Targeted collection approach to support CMS and anti-phishing rule compliance
		• Comprehensive coverage checks
		• Fast, reliable access to net-new insurance data
		• Improved efficiency while reducing self-pay volumes
		• Suppression of unusable coverage to keep billing staff focused on accounts with a high probability of recovery

2 Mitigating the mid-cycle denials

Patient care is becoming increasingly complex. Ensure that your middle revenue cycle management can help navigate the ever-evolving charges and coding language, and your care teams feel supported in their clinical decisions to achieve optimal patient care.



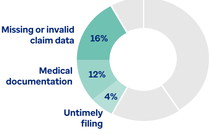
Mid-cycle solutions

Enterprise CAC and CDI 3D	Professional Computer-Assisted Coding	Lynx Outpatient Charge Capture	InterQual

• Reduced clinical validation denials by identifying coding specificity, quality and risk events, and clinical clarification opportunities
• Supports timely and accurate reimbursement
• Clinical intelligence automates and optimizes hospital coding operations and increases efficiency
• Single integrated platform for coding and CDI
	• Increased efficiency by automating manual coding processes
	• Improved compliance through traceable audit trails
	• Supports timely, accurate and consistent coding
	• Built-in LCD and CCI edits and information needed to apply appropriate evaluation and management levels
		• Enables translation of clinical data into charging and coding terms for emergency departments, hospital-owned clinics, observation, infusion, and oncology treatment centers
		• Assigns same charge for identical services across an integrated delivery network
			• Provides evidence-based criteria supporting clinically appropriate medical-utilization decisions
			• Provides criteria for medical and behavioral health across all levels of care, ambulatory care planning and industry content
			• Medical review automation that:
			  – Alleviates administrative burden
			  – Supports review accuracy
			  – Provides transparent and defensible documentation

3 Blocking those back-end denials

Missing or invalid claim data is the second-leading cause of denials across the revenue cycle, with medical documentation requested the fourth overall cause of denials. A clear understanding of payers' reimbursement rules is critical to submitting a clean claim that processes with a reduced likelihood of denial.



Back-end solutions

Assurance Reimbursement Management	Claims Manager	Provider Communication Gateway	Acuity Revenue Cycle Analytics
• Configurable automations to ensure claims take fastest path to reimbursement • Automated secondary claim creation capabilities based on 835 remittance received • Exception-based workflow, resulting in time savings and staff workload re-prioritization • World-class payer-specific edits that reduce denials and A/R days • Access to extensive report library for generation of actionable, detailed financial reports	• Access to KnowledgeBase, a rules-based tool with more than 132 million code-to-code relationships • Match claims against clinically sourced claim submission guidelines • Proactive identification of unbilled revenue • Historical editing capabilities, both standard and custom • Automatic date sensitivity editing • Access to commercial editing, developed by clinical experts.	• Application of provider-specific rules at point of billing, leading to reduced provider/payer friction • API capability to shift payer-specific editing directly into existing provider workflow • Increased provider adoption/utilization • Payment transparency and predictability • Additional preventive capabilities in reduction of denial rework, administrative cost and A/R days	• Identification of denial root causes across revenue cycle stages • Actionable insights to prevent avoidable denials and recover unavoidable denials • Monitoring of denial trends to prioritize and quantify denial prevention and recovery efforts • Standard and ad-hoc analytic reports across patient access, services rendered, billing efficiencies, reimbursement, denial analysis and payer relations

The key to decreasing denials is a prevention strategy.



Download the e-book 2024 Optum Denials Index, to begin your strategy planning with a deep dive into the latest industry denials trends and root-cause breakdowns.

* Percentages have been rounded

1. The Optum 2024 Revenue Cycle Denials Index is based on an internal analysis of 441 million hospital claim remits valued at $500 billion in total charges across more than 1,500 U.S. hospitals.

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