Advanced Claim Management for Hospitals
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Director, Sales Product Consulting
Agenda

• Optum Overview
• Traditional hospital claim workflow
• A better way
  – Claims Manager Facility
  – Knowledgebase edits
• Deployment Options
Optum Businesses

**OPTUM Insight™**
(Formerly Known as Ingenix)

One of the largest health information, technology and consulting companies in the world

**OPTUM Health™**

The leader in population health management serving the physical, mental and financial needs of both individuals and organizations

**OPTUM Rx™**

Pharmacy Management leader in service, affordability and clinical quality

Market leaders within a dynamic health services market
Breadth of Offerings

OPTUMInsight™
MARKET GROUPS
Payer | Government | Life Sciences | Provider
## Provider Division “Pillars”

<table>
<thead>
<tr>
<th>Cost &amp; Operational Improvement</th>
<th>Compliance</th>
<th>Financial Performance</th>
<th>Clinical Performance</th>
<th>Community &amp; Connectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solution Summary</strong></td>
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</tr>
<tr>
<td>A new approach to creating sustained cost advantage.</td>
<td>Ensure compliance and revenue integrity at the point of care for hospitals and physicians.</td>
<td>Industry-leading tools and operational excellence to accelerate sustainable financial results.</td>
<td>Drive improved outcomes in the hospital high-acuity and ambulatory care settings.</td>
<td>Empower all Stakeholders with a Platform to Transform Claim and Clinical Information Flow</td>
</tr>
</tbody>
</table>

### Key Capabilities
- Picis Workflow Solutions
- EHR Medical Necessity Compliance
- ICD-10 Compliance
- CareMedic eFR® and Revenue Cycle Management
- Actuarial consulting services
- LYNX revenue management solutions
- A-Life CAC
- Picis High-Acuity Solutions
- Impact Suite to measure clinical performance
- Clinical data services
- Claim Integrity
  - Claims Manager
  - Contract Manager
- Connectivity
  - Intelligent EDI
  - Validation Suite
- Axolotl HIE solutions
- CareTracker PM/EMR

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Claims Manager
Facility Overview
The Problem

Lack of Transparency in Current Hospital Workflow*

**Code, click submit, then wait for...**
- Rejections and denials
  - Manually edit claims and resubmit
  - Then entire process starts over
- Reimbursement

**While all of this is taking place...**
- Cash flow is unpredictable
- Rejections and denials increase A/R days
- Productivity suffers and costs escalate

*$25 ▶ The average cost per claim for rework and resubmission

$521 ▶ Average dollar value of an automated denial

$5,839 ▶ Average dollar value of a complex denial

50,395 ▶ The number of automated denials compared to 30,295 two quarters ago.

741 million ▶ Amount of denials reported in the first quarter of 2012

96% ▶ Of all the denied dollars involving RACs, 96% were complex denials

$25 ▶ The average cost per claim for rework and resubmission

The Solution — Claims Manager by Optum

Reviews claims before submission to payers to reduce claim denial rates, shorten accounts receivable cycles, and increase the rate of collection.

Helps Hospitals:
- Reduce claim denials by pre-screening for billing and coding errors
- Stay current with new and changing guidelines
- Comply more easily with Medicare, Medicaid and commercial regulations
- Realize ROI through intelligent automation

Unparalleled Clinical Content
- Commercial editing
- Over 1 million facility coding relationships
- Medicare editing (including LCD and NCD)
- Over 15 million Part A coding relationships

Continuous Investment
- Resource and financial investments are made annually to help gather and maintain the content used in our editing and billing products
- Quarterly knowledgebase update/bi-weekly NCD/LCD updates
- Yearly/bi-annual software new feature releases
- Medicaid unbundling and MUE edits

Industry Leader
- Industry leader in 5010 and ICD-10 preparation
The Power Behind Claims Manager

Comprehensive Commercial and Medicare Knowledgebase

- 16+ million industry sourced coding relationships
  - Contains 1 million Facility knowledgebase edits
  - Contain more than 15 million Part A, Sourced at the code relationship level
- Supported by disclosure statements
- Date sensitivity at the code relationship level
- Quarterly knowledgebase update / bi-weekly NCD/ LCD updates
- ICD-10 Ready

Diverse Team of Medical and Clinical Coding Experts

- Team of over 40 experts supporting content development
- Team of Medical Directors, Specialty Panels, RN's, LPN's, RHIT's, RHIA's, CPC's, CCS-P and Legal Support
- Methodology reflects clinical research, comprehensive coding expertise and claims data analysis
- Clinical, technical and end user customer support
Clinical Editing Knowledgebase — Specific Types of Editing (not all inclusive)

Historical-Based Clinical Editing

- Invalid use of Modifiers
  - Modifier 25 may be required
  - Modifier 27 may be required
  - Modifier not appropriate with CPT code
- Unbundling across claims
  - Medicare Unbundle (CCI/OCE)
  - Medicaid Unbundle
  - Will a modifier override an unbundle?
  - Should component codes be transferred to a different code such as a lab panel?
- Frequency
  - Medicaid MUE
  - Medicare MUE
- New vs. Established patient
  - Should an Established Patient be billed vs. New?
- Duplicate Line/Claim

Historical-Based Clinical Editing

- LCD/NCD Part A edits
  - CPT to Diagnosis appropriateness
  - Sequencing of Diagnosis Codes
  - Frequency allowed for Procedures
  - Age/Gender Requirements
  - POS or Modifier Requirements
- Condition codes
  - Appropriate condition code billed with TOB
  - Appropriate condition code billed with Modifiers
- Observation services allowed only on bill types 13X
- Overlapping Observation Periods
- Partial Hospitalizations

Edits That Accurately Capture Services

- Complete services were not billed for
  - Were both the Injection and Injectable material billed?
  - Device codes missing
  - Is Patient really considered a New Patient?
## Appropriate Use and Sequencing of Diagnoses Codes — Example

### Diagnoses Code Based on Medical Necessity

<table>
<thead>
<tr>
<th>Chronic Airway Obstruction</th>
<th>Definition</th>
<th>Edit Type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COPD Code 496 <em>Chronic airway obstruction not elsewhere classified</em> is one of the few three-digit codes in the ICD-9-CM manual. The code includes a subcategory listing of &quot;chronic obstructive pulmonary disease (COPD) NOS&quot; and is both a not otherwise specified (NOS) and not elsewhere classified (NEC) diagnosis. Code 496 is a legitimate diagnosis but it lacks specificity.</td>
<td>Diagnosis Sequencing</td>
<td>According to ICD-9-CM instructions, Code 496 should not be reported with chronic bronchitis (491.xx), emphysema (492.x) or asthma (493.xx). Just as shortness of breath normally should be integrated in the coding for pneumonia, COPD should be incorporated into categories 491-493 for other lung diseases listed.</td>
</tr>
</tbody>
</table>
Analysis Results within CM FE-LCD DX Inappropriate

### Optum Claims Manager

**Claim Results (UB)**

<table>
<thead>
<tr>
<th>Claim ID:</th>
<th>Facility ID:</th>
<th>Org ID:</th>
<th>Org Group ID:</th>
<th>Error Level: AK</th>
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<tbody>
<tr>
<td>1</td>
<td>LCI</td>
<td></td>
<td></td>
<td></td>
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</table>

#### Analysis Results

<table>
<thead>
<tr>
<th>Line ID</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td>1</td>
<td>LCI</td>
<td>For LCD or NCD guidelines, CMF ID(s) L21279, a diagnosis code(s), which meets medical necessity for procedure code 19544, is missing or invalid.</td>
</tr>
</tbody>
</table>

**Patient #1:**

**Statement Covered Period:** From 10/20/2011 through 10/20/2011

**Type of Bill:** 101

**Patient ID:** 1

**Patient Name:** Test John

**Patient DOB:** 12/31/1970

**Patient Gender:** M

**Patient Status:** E1

**Point of Origin:** 1

### Condition Codes

<table>
<thead>
<tr>
<th>Occurrences Code</th>
<th>Occurrence Spans Code</th>
<th>Date</th>
<th>Date From</th>
<th>Date To</th>
<th>Value Codes Code</th>
<th>Amount</th>
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<tbody>
<tr>
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#### Lines

<table>
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<tr>
<th>Line</th>
<th>Line Status</th>
<th>Revenue Code</th>
<th>HCPCS/HCPCS Code</th>
<th>Rate</th>
<th>Healthcare</th>
<th>Service Date</th>
<th>Work</th>
<th>Total Charge</th>
<th>Non-Covered Charge</th>
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<tbody>
<tr>
<td>1</td>
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#### Payers

**Order:**

- **Primary:** MCR
- **Secondary:**
- **Tertiary:**

#### Diagnoses

**Principal Code:**

**Reason(s) for Visit:**

- Diagnosis Code 24900
- Others
- Others

### Attending ID:

### Operating ID:

### Other Physician IDs:
Data That is Used for Analysis — Viewable to Customers

### Optum Claims Manager

#### Procedure 15341

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Subset</th>
<th>Sequencing</th>
<th>Support</th>
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<th>Expiration</th>
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</tbody>
</table>

All data points used in analysis for Med Necessity.
Claims Manager Facility Technology
Claims Manager Deployment Models

**Installed**
- Client maintains the server and manages disk space, backup procedures
- Client maintains the software set-up and software data updates

**Hosted**
- Connect to Claims Manager online through a secure hosted environment for a subscription fee
- Includes standard database management, disk space monitoring, backup procedures, Oracle maintenance, security, and product upgrades performed by our IT staff

**SaaS**
- 24/7/365 access from anywhere in the world via the web-based platform
- The same robust content and functionality as the traditional models with no software or download to install
- Reduce costs with no large upfront capital investment by eliminating the need for hardware, software, or IT support staff — pricing is subscription based
- Automatic updates as Optum manages the infrastructure, upgrades, updates, and availability to ensure access to the most current content
Claims Manager Facility Recap

Claims Manager Facility Can Help Your Organization. . .

- Identify partially billed or missed charges
- Reduce administrative expenses and avoid the delays associated with incorrect coding
- Comply with National Medicare, Medicaid, and commercial regulations with a consistent, automated standard
- Comply with Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs); load and view updated LCD/NCD policy relationships as they become available to ensure that the claims are in compliance with Medicare policy
- Develop your own edits and customize system edits to meet your facility’s billing and reimbursement needs
- Review current claim or claim line history, allowing for a better view of patient history

Reduce your RAC vulnerabilities

The number of medical necessity errors a hospital triggers could point to overpayment and result in RAC audits. Claims Manager Facility provides Part A guidelines resulting in for claims that include complete and accurate documentation, which may reduce the risk of an audit.
For more information
or for a detailed, technical demo please contact Optum at:
800.765.6705
or
inform@optum.com