Optum

10 hurdles to fast, accurate reimbursement

And how we can help you clear each one

Read the e-book

Denial rates remain high despite providers' extensive efforts

The average denial rate remains elevated from one year ago at 12% of claims denied upon initial submission, up 3% from 2016.* Insights from the 2024 Optum Revenue Cycle Denials Index can help you reduce denials.

Nearly half of denials occur in front-end processes.

Of the almost 32% of denials that are unequivocally avoidable, 40% cannot be recovered. Prevention is the key to averting revenue loss.*

With the Optum portfolio of revenue cycle solutions and services, you can address almost any denial issue you're facing.

Select a hurdle below to see how we can help you clear each one

1. **Ensuring accurate registration**
2. **Verifying eligibility consistently**
3. **Completing timely authorization/precertification**
4. **Demonstrating medical necessity**
5. **Sending attachments efficiently**
6. **Coding claims accurately**
7. **Avoiding missing or invalid claims data denials**
8. **Ensuring timely filing**
9. **Efficiently responding to denials that occur**
10. **Using data to drive decisions**

* The 2024 Revenue Cycle Denials Index

Hurdle #1
Accurate registration

A seemingly simple process often causes denials

- Manual workflows are time-consuming and error-prone
- Patient-supplied info isn't always reliable
- Lack of implemented automated data-quality checks

How to clear this hurdle

Improve accuracy with real-time data and automated quality checks

Use technology to catch errors early and avoid denials down the line

Spot potential errors fast

- Send error warnings to alert registrars to correct issues immediately
- Quickly verify patient demographic data
- Identify missed coverage
- Reduce the need for manual registration audits
- Flag potential fraud or identity theft
- Integrate analytics to determine the root causes of denials and process improvement opportunities

Automatically check registration information

- Automatically check registration information for accuracy and completeness, while highlighting concerning areas for staff to address directly with patients
- Customizable business rules let you tie into any field in the registration record to check for errors, including insurance plans, patient types, financial classes and more
- Utilize programs integrated with the U.S. Postal Service database to verify address accuracy and standardize data formats for clean data

Hurdle #2
Verifying eligibility consistently

24% of denials originate in registration/eligibility due to:*

- Inaccurate coordination of benefits
- Lack of visibility into a patient's benefit maximum
- Inconsistent coverage verification

How to clear this hurdle

Boost process consistency, reliability and timeliness with technology

The more predictable the eligibility verification process, the less chance of error

Identify undisclosed coverage

Identify existing commercial coverage that should be billed prior to Medicaid to:

- Bill the correct payer the first time
- Reduce denials attributed to the coordination of benefits
- Obtain complete and accurate reimbursement
- Manage nuanced eligibility denials and leverage analytics to identify root causes
- Utilize advanced analytics to identify pre-existing coverage
- Suppress unusable coverage to keep billing staff focused on accounts with a high probability of recovery

Connect with payers to verify eligibility

- Use real-time eligibility verification plus benefit mapping with actionable alerts
- Convey the patient's coverage quickly with standardized payer-response screens (e.g., an HMO flag appears on the system dashboard when a patient has a Medicare Advantage plan)
- Utilize patient data validation, identity verification and risk detection tools to instantly confirm consumer and business identities and reduce fraud

Address service-coverage issues by flagging patients seeking a noncovered issue due to:

- The benefit maximum already being reached
- Coverage not extending to the service type
- Lack of medical necessity
- Other issues

This allows staff to work with the patient on secondary coverage, generate ABNs for noncoverage automatically and connect the patient with financial services for payment options.

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Hurdle #3

Completing timely authorization/ pre-certification

Nearly 13% of denials stem from pre-authorization issues*

- Inconsistencies due to process complexity and changing payer requirements
- Poor collaboration between revenue cycle and clinical staff

How to clear this hurdle

Improve pre-authorization consistency and timeliness with technology and expert insights

Automate processes and stay current on changing payer requirements

Automate pre-authorizations requiring a medical review

- Enable faster pre-authorization for complex requests
- Transmit an authorization request directly to a payer from the existing workflow and automatically include a medical review
- Receive near-instant authorization for most requests if the review meets payer criteria

Improve visibility into pre-authorization workflow

- Automatically determine if a pre-authorization is required and on file
- Monitor payers for pending decisions and posts updates in your EHR
- Display payer decisions, including approval and authorization number
- Alert staff to a denied request by displaying a denied status code

Prevent complex authorizations from slipping through the cracks

- Manage pre-certification and authorization needs for inpatient and outpatient diagnostic and therapeutic services
- Provide concurrent or retrospective inpatient authorizations after admission
- Review denied admissions, days and services and complete all necessary steps for appeal requests
- Review each medical record, focusing on payer requirements, to get the proper authorization for all services scheduled and rendered

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Hurdle #4
Demonstrating medical necessity

Documentation doesn't always support care provided

- Clinical findings/documentation does not substantiate need for services
- Insufficient support for level-of-care decisions

How to clear this hurdle

Get real-time insight to facilitate the right care in the right place

Improve documentation, communication and coordination with payer requirements

Automate medical necessity review by extracting data directly from the EHR to complete the medical necessity review, helping ensure all relevant data points are included:

- Provide evidence-based guidance at the point of decision-making
- Automate review to reduce errors linked to manual processes
- Lessen administrative burden

Tighten clinical documentation through services that:

- Reduce denials and compliance risk by ensuring billed codes are accurate and reflect the highest level of specificity
- Identify gaps in diagnosis and procedure coding
- Improve diagnosis capture and accurately record the level of service rendered
- Flag missing or incomplete charts for faster resolution

Facilitate the appropriate care setting by instantly assessing the safest and most efficient care level based on severity of illness, comorbidities, complications and the intensity of services being delivered:

- Enable defensible, medical necessity decision-making for more than 95% of admission reasons
- Cover medical and behavioral health across all care levels, as well as ambulatory care planning

Utilization Management Services aligns care needs with reimbursement requirements. Our team:

- Focuses on length of stay and highly complex cases that need specific clinical expertise
- Applies additional scrutiny when decision-support tools conflict with a physician's clinical judgment, providing additional documentation for medical necessity
- Implements concurrent authorization services for admissions
- Augments existing staff, or trains staff to build a strong internal prospective review program

Hurdle #5
Sending attachments efficiently

Manual processes can increase error and denial risk

- Staff may misinterpret payer requirements
- Payers may not correctly match mailed or faxed attachments to claims submitted electronically
- Errors may lead to multiple mailings, causing delays
- With increasing postage rates and industry-wide labor challenges, organizations can no longer afford the time and expense to manually print and mail attachments

How to clear this hurdle

Reduce reliance on manual processes for sending attachments

Automating workflows helps improve efficiency, while decreasing risk and costs

Automate the attachment process

Send attachments electronically through easy bulk uploading and attaching documentation for many claims. Streamline communication, eliminate costly delays, and save money per attachment.*

- Submit solicited and unsolicited supporting documentation electronically to:
  - Medicare
  - Veterans Affairs
  - Workers' compensation
  - Property and casualty
  - A growing selection of commercial payers
  - Other non-Medicare payers, including Medi-Cal
- Track attachments until the claim reaches final resolution
- Reduce the risk associated with overlooked payer-documentation requests

* Need new source.

Hurdle #6
Coding claims accurately

Errors can lead to denials, delays and compliance issues

- Finding experienced coding staff is challenging
- Tight labor market impacts hiring and retention
- Continuous education needed to stay current on regulatory changes

How to clear this hurdle

Access the necessary tools and expertise to code accurately and consistently

Reduce denials and compliance risks while improving accuracy of reimbursement

Address coding claims challenges with a comprehensive middle-revenue cycle solution.

- Seamless integration into multiple billing systems
- Help address specific coding areas, including inpatient, outpatient, emergency department, ambulatory care, surgery centers and provider-based billing locations
- Help improve coding accuracy with ongoing, periodic or one-time coding assistance
- Clinical intelligence that automates and optimizes hospital coding operations
- Access to a rules-based tool with more than 132 million code-to-code relationships
- Single integrated platform for coding and clinical documentation improvement
- Translation of clinical data into charging and coding terms for emergency departments, hospital-owned clinics, observation, infusion and oncology treatment centers

Audit coding regularly to improve accuracy to avoid recurring denials or compliance issues.

Stay current on regulatory changes to:

- Support appropriate billing for documented procedures
- Optimize front-end and back-end billing to streamline operations and improve overall billing integrity
- Uncover trends and improvement opportunities to achieve financial and data-quality goals
- Promote best-practice coding and documentation compliance standards

Hurdle #7

Avoiding missing or invalid claims data denials

Claim inconsistencies are the second highest cause of denials*

- Missing/invalid EOB
- Invalid provider information
- Missing/invalid drug information

How to clear this hurdle

Make sure your claims are correct and complete before you submit

Avoid rework and denials, which can slow and reduce cash flow

Help increase first-pass claims-acceptance rate

Engage with a strategic partner to access large networks of payers to stay current with changing payer rules and regulations. Discover solutions to help spot new errors and resolve them quickly to avoid denials with capabilities like:

- Automated alerts show staff when and where claims need attention, right in the provider workflow
- Shift-left application of provider-specific rules at the point of billing
- Real-time claim editing capabilities within HIS workflow let staff efficiently complete rework
- Secondary claims and EOBs are automatically generated from the primary remittance advice (especially important for Medicare claims)
- Historical editing capabilities, both standard and custom

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Hurdle #8
Timely filing

Although preventable, this error still occurs*

- Untimely filing denials comprise 4% of all denials
- Interruptions to standard workflows can increase risk

How to clear this hurdle

Use technology and expert services to keep claims on track, regardless of volume

Improve efficiency, reduce risk and better respond to the unexpected

- Improve transparency to spot and resolve issues before they cause major delays
- Track claims throughout their lifecycle via a color-coded dashboard:
  - Shows when each claim has been received, released or accepted
  - Helps troubleshoot issues to keep claims moving
  - Allows use of payer status and claim-assignment rules to assign claims, create work groups and monitor claim volume
  - Helps ensure team members work the claims that leverage their expertise, enabling greater efficiency and preventing bottlenecks that can slow claims and cause missed deadlines
- Address timely filing denials, with additional resources to focus on added inventory or specific payers that have tighter time filing requirements
- Assist with preparation of proof-of-filing documentation to help overturn denials when they do occur

View each patient's financial clearance profile in one dashboard:

- See eligibility details, pre-authorization, medical necessity, bill estimation, point-of-service collection capabilities and more
- Quickly spot where things are being held up or where key information may be missing
- Proactively address issues that could lead to delays and denials

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Hurdle #9

Efficiently responding to denials that occur

Despite best efforts, denials can still happen

- Lack of streamlined workflows
- Limited access to experienced resources, especially for clinical denials
- Lack of actionable insights to prioritize denial management and prevent future denial

How to clear this hurdle

Automation plus expertise yields fast, effective denial response and future prevention

Maximize appeals success while identifying systemic issues

Automate appeals when possible

- Implement fast, effective denial response and future prevention
- Maximize appeals success while identifying systemic issues
- Streamline the appeals process for 3 levels of denied Medicare claims
- Create and track appeals for groups of claims that have been denied by a single payer for the same reason
- Ensure appeals reflect the correct format using built-in, state-by-state filing and processing requirements
- Access standard forms and templates to facilitate a faster response
- Track submitted appeals using a comprehensive, user-friendly dashboard

Leverage skilled resources

Optimize appeals success by managing all details of technical, coding and clinical denials.

- Focus on overturning denials and obtaining payment quickly to reduce A/R days and decrease bad debt
- Leverage AI and robotic process automation to prioritize denial management efforts and automate workflows, including benefit verification and first-level appeal submission
- Employ advanced analytics to identify root causes and provide actionable data regarding each payer's denials

Make data-driven decisions with analytics

Analytics can help you organize which denials to prioritize to improve reimbursement practices. They can help monitor trends and uncover denial root causes to improve team knowledge and process to prevent future denials.

Hurdle #10
Using data to drive decisions

With scarce resources, data and insights are critical to guide prioritization and decisions

- Data and analytics help you identify metrics that matter and measure progress against goals
- Lack of data or siloed data prevents you from gaining valuable insights to drive improvement
- Insights allow you to explore data to identify the root cause or develop a new trend analysis for clinical denials

Identifying trends, spotting issues early and assessing your performance objectively will allow you to make decisions that consistently improve productivity and reimbursement.

How to clear this hurdle

Use analytics and benchmarking to continuously improve performance

Assess your performance against goals and compared to peers

Use tools to derive analytics, identify trends and make benchmark comparisons to enhance performance and evaluate progress

- Use a dashboard to quickly identify problem areas via critical information compiled automatically and in near real time
- Gain ongoing visibility into interdependencies of cross-functional processes and performance against financial goals
- Leverage data-driven performance recommendations and set alerts when thresholds are not met
- Access data across multiple functions, even with various revenue cycle systems in use

Improve visibility into performance with regularly updated comparative analysis data

- Monitor downward trends to proactively address issues before they cause major financial impacts
- Review process effectiveness and gain quick insights into the dollar impact of improvement opportunities
- Benchmark performance against thousands of peer facilities
- Review claim cycle performance in 20 key areas using consistently calculated, near real-time data to compare yourself with peers, the industry average or industry best
- Drill down to detailed analyses to identify root causes if performance starts to decline

Power of a strategic RCM partner

Optum software solutions streamline RCM, enhancing the patient experience and reducing friction between providers and payers. With clinical insights and intelligent automation, Optum delivers superior results and a seamless end-to-end RCM experience.

Front-end solutions

- **Patient Access And Engagement** helps prevent denials by correcting issues within registration and intake forms, confirming patient eligibility prior to appointment and providing direct integration with EHRs to help ensure accurate patient information.
- **Patient Financial Clearance** helps accelerate reimbursement, reduce denials and optimize workflows from registration through point-of-service collections.
- **Coverage Insight™** Helps accurately identify and verify insurance coverage enabling providers to bill the correct payers for reimbursement, leading to reduced denials, accelerated payments and efficient workflows.

Mid-cycle solutions

- **Enterprise CAC & CDI 3D** helps hospitals and health systems with coding, clinical documentation improvement and auditing needs.
- **Professional Computer-Assisted Coding** helps large physician groups and billing companies with automated coding.
- **Lynx Outpatient Charge Capture** helps protect revenue and support compliant, consistent charging across outpatient operations. Our algorithms capture resource use and patient care complexity for consistent charging.
- **InterQual®** helps ensure clinically appropriate medical utilization decisions with evidence-based criteria. InterQual AutoReview automates the creation and population of the medical review with data from the EHR. These solutions mitigate denial risk by delivering accurate and defensible medical necessity reviews.

Back-end solutions

- **Assurance Reimbursement Management™** helps automate workflows to prevent denials and facilitate fast reimbursement, enabling staff to focus on other tasks.
- **Claims Manager** helps lower denial rates and identify unbilled revenue by automatically flagging claims for inaccurate coding and billing documentation prior to payer submission.
- **Provider Communication Gateway** helps prevent unnecessary claim denials and rework by delivering payer-specific edits into the provider workflow at the point of coding.
- **Acuity Revenue Cycle Analytics™** helps determine root causes to reimbursement barriers, and delivers actionable insights to support tactical and strategic decisions.

Contact our experts to overcome your hurdles, and start reducing your denials today

The Optum portfolio of revenue cycle offerings and solutions can guide you over any hurdle with actionable insights and strategies to reduce denials in your organization.

For more information on how denials are impacting the industry, view the **2024 Revenue Cycle Denials Index**.

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