Optum

10 hurdles to fast, accurate reimbursement

And how we can help you clear each one

Read the e-book

Denials continue to rise despite providers' exhaustive efforts

The average denial rate is up 3% since 2016, hitting 12% of claims denied upon initial submission in 2022. Insights from our 2022 Revenue Cycle Denials Index can help reduce your denial rates.

Nearly half of denials are occurring in front-end processes. Start here to help gain control of the problem.

Of the almost 31% of denials that are unequivocally avoidable, 43% 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.

The 2022 Revenue Cycle Denials Index; internal data, 2016–2022. Percentages have been rounded.

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/pre-certification**
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**

Hurdle #1
Ensuring accurate registration

A seemingly simple process often causes denials

- Manual workflows are error prone.
- Patient-supplied info isn't always reliable.
- Automatic data-quality checks aren't in place.

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
- Verify patients' demographic data quickly
- 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

Learn more

Quality-check registration information automatically

- You can automatically check registration information for accuracy and completeness and highlight concerning areas for staff to address directly with patients.
- Customizable business rules let you tie to any field in the registration record to check for errors, including insurance plans, patient types, financial classes and more.
- Programs are integrated with the U.S. Postal Service database, so you can verify address accuracy and standardize data formats to keep your data clean.

Learn more

Hurdle #2
Verifying eligibility consistently

22% 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

Bolster process consistency, reliability and timeliness with technology

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

Identify undisclosed coverage

Our module's insight helps identify existing commercial coverage that should be billed prior to Medicaid to help you:

- Bill the correct payer the first time
- Reduce denials attributed to the coordination of benefits
- Obtain maximum reimbursement

Manage nuanced eligibility denials and leverage those analytics to identify root causes

Learn more

Connect with 1,000+ payers to verify eligibility

- Ensure you're using up-to-date patient benefits information
- 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)

Learn more

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

* The 2022 Revenue Cycle Denials Index

Hurdle #3
Completing timely authorization/ pre-certification

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 insight

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 an InterQual® medical review
- Receive instant authorization for most requests if the review meets payer criteria

Learn more

Improve visibility into pre-authorization workflow

- Automatically determines if a pre-authorization is required and on file
- Monitors payers for pending decisions and posts updates in your HIS
- Displays payer decisions, including approval and authorization number
- Alerts staff to a denied request by displaying a denied status code

Learn more

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

Learn more

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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:

- Provides evidence-based guidance at the point of decision-making
- Automates review to reduce errors linked to manual processes
- Lessens the administrative burden

Learn more

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

Learn more

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:

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

Learn more

Utilization Management Services align 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 your staff to build a strong internal prospective review program

Learn more

Hurdle #5
Sending attachments efficiently

Manual processes can increase error and denial risk

- Staff can 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 workflow helps improve efficiency, reduce risk and reduce costs

Automate the attachment process

Send attachments electronically through easy bulk uploading and attaching documentation for many claims. Streamline communication, eliminate a 30-minute delay per attachment in sending and save $4.50 per attachment.*

- Submit solicited and unsolicited supporting documentation electronically to:
  - Medicare
  - Veterans Affairs (VA)
  - 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

Learn more

* 2019 CAQH Index®. Conducting electronic business transactions: Why greater harmonization across the industry is needed. 2020.

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 expertise to code accurately and consistently

Reduce denials and compliance risks while improving accuracy of reimbursement

Partner with an outsourced coding expert with deep ICD-10 expertise and knowledge in 25+ specialties.

- 1,100+ certified coders exceed industry standards of excellence
- Can easily work in multiple software billing systems
- Help address specific coding areas, including inpatient, outpatient, emergency department, ambulatory care, surgery centers and provider-based billing locations
- Help you improve coding accuracy with ongoing, periodic or one-time coding assistance

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

Our team stays current on regulatory changes to help you:

- Ensure 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 so you can achieve financial and data-quality goals
- Ensure your team establishes best-practice coding and documentation compliance standards

Learn more

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 your first-pass claims-acceptance rate.

Access one of the industry’s largest networks of payers to stay current with changing payer rules and regulations. Our solution also helps you spot new errors that may not have been a problem before, resolve them quickly and avoid denials:

- Automated alerts show staff when and where claims need attention
- Real-time claim editing capabilities within your HIS workflow let staff efficiently complete rework
- Secondary claims and EOBs are automatically generated from the primary remittance advice (especially important for Medicare claims)

Learn more

* The 2022 Revenue Cycle Denials Index

Hurdle #8
Ensuring timely filing

Although preventable, this error still occurs*

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

How to clear this hurdle

Use technology and expert services to keep claims on track, even during a crisis

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 life cycle via a color-coded dashboard:
  - Shows when each claim has been received, released or accepted
  - Helps you troubleshoot issues to keep claims moving
  - Allows you to use 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 you to miss important deadlines

Learn more

- Address timely filing denials, with additional resources to focus on added inventory or specific payers that have tighter timely filing requirements
- Our teams can also prepare proof of filing documentation to help overturn denials when they do occur.

Learn more

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

Learn more

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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 three 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 your 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

Learn more

Leverage skilled resources

Optimize appeals success by managing all details of technical, coding and clinical denials. Using our extensive reimbursement knowledge and advanced technologies, we can help address the denial backlog and improve the denial recovery rate to accelerate cash. Our team:

- Focuses on overturning denials and obtaining payment quickly to reduce A/R days and decrease bad debt
- Leverages AI and robotic process automation to prioritize denial management efforts and automate workflows, including benefit verification and first-level appeal submission
- Employs advanced analytics to identify root causes and provide actionable data regarding each payer's denials
- Works with you to create best practice processes for denial prevention and resolution

Learn more

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.

Learn more

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

Leverage tools to derive analytics, trending and benchmark comparisons to continuously improve performance and assess your performance against goals and in comparison to peers.

- 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

Learn more

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 to peers, the industry average or industry best
- Drill down to detailed analyses to identify root causes if performance starts to decline

Learn more

Be proactive about underpayment recovery by identifying and correcting underpayments, which includes looking at charges that were denied. The team also identifies claims that were underpaid due to contractual variances and pursues additional reimbursement. You can use our detailed denial and underpayment reports during payer contract negotiations.

Learn more

If you're ready to start tackling your denials rate, we're ready to help

We'll listen to your challenges and help you determine the best approach with revenue cycle solutions that help create downward denials trends for your organization.

Learn more

For more information on how denials are impacting the industry, view the **2022 Revenue Cycle Denials Index**.

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