Optum

Optum Claims Manager Professional

Align clinical and revenue cycle workflows for faster and more accurate reimbursement

Optum® Claims Manager Professional identifies certain-to-deny claims and unbilled services by pre-screening for clinical coding relationships and billing errors, based on payer adjudication. Practices using Claims Manager leverage a collaborative, unified platform with advanced clinical editing capabilities to help shorten accounts receivable cycles and ensure proper payment.

Optum Claims Manager Professional helps your organization:

- Correct claims at the least costly point – before they leave your system
- Proactively identify missed revenue for unbilled services
- Reduce denial rates and administrative expenses due to incorrect coding
- Take advantage of a consistent, automated standard to comply with government and commercial regulations
- Configure current system rules and create your own custom edits in minutes to meet billing and reimbursement needs

Powerful content and rules-based editing

The Optum KnowledgeBase powers Claims Manager with more than 132 million code-to-code relationships, to pre-screen claims. Combined with your custom edits, this rules-based tool helps ensure your organization has the content and insights to receive timely reimbursement and make better business decisions.

The KnowledgeBase is maintained by a team of clinical and technical experts who ensure clients receive precise regulatory updates related to Medicare, national and state-specific Medicaid and commercial guidelines.

23:1

average ROI

For every dollar spent on Claims Manager, organizations receive an average of $23 in return.[1]

Example content sources[2]

- AMA guidelines and consulting
- CPT® Assistant[3]
- CMS program memoranda
- Correct Coding Initiative (CCI)
- Medicare Physician Fee Schedule Database (MPFSDB)
- Local medical review policy
- Physician specialty panel
- Medical societies

1. Based on client claims reviews run for non-billed and resubmission errors in 2018–2020.
2. Not a complete list of edit sources.
3. CPT® is a registered trademark of the American Medical Association..

Client success story

Through Claims Manager, a health network in the Northeast avoided $5.2M in administrative rework and re-submission costs in one year. This organization also identified an additional $1.9M in annual revenue.

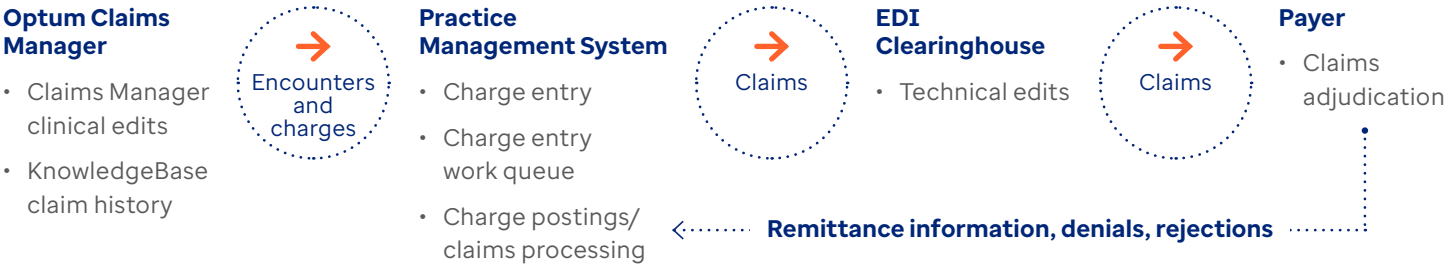
Scenario: Patient received a prolonged service

The chart below is an example of revenue found and more than doubled, when a patient received a prolonged service. Adding the additional code increases total reimbursement by $143.17, to $258.74.

Code	CPT® description	Reimbursement
99354	Prolonged physician service in office or other outpatient facility; face-to-face, first hour.	$115.57
Edit	Per CPT® guidelines, codes 99354-99357 are used when a physician provides prolonged services involving direct patient contact beyond the usual service. This contact is reported with other services, including E&M services at any level.	
99215	Edit indicates additional CPT® code(s) to be reviewed and considered. High-level office visit.	$143.17

Seamless integration

Claims Manager can fully integrate with your practice management system. This means users can work within existing solutions and workflows, and managers can view information and create and schedule periodic reports.



Leverage the collaborative, consistent and unified platform relied upon by both provider and payer audiences. Claims Manager Professional provides flexibility to support the way your organization processes and manages claims data.

Identify claims processing and management improvements

See the difference Claims Manager can make for your organization. Request your Claims Opportunity Assessment and uncover ways to improve denial rates and earn revenue for all delivered services.

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