



Evolving your revenue cycle to  
embrace modern challenges

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# THE OPTUM360 VISION FOR AN ADVANCED REVENUE CYCLE



Modern health care challenges  
require a reinvented revenue cycle.

Value-based care, the rise of consumerism and shifting payer trends have fundamentally altered the provider health care landscape. Yet most providers are still operating under antiquated revenue cycle models.

At Optum360, we have a new vision for the revenue cycle to address these new challenges. In this revenue cycle, processes are fused into a single ecosystem that shares best practices and analytic insights across all stages and functions.

It's built on rich clinical content, payer-informed rule sets and the experience of countless clinical experts. It leverages clinically aware artificial intelligence. And it involves payers and providers working together in a transparent and collaborative way.

That revenue cycle doesn't have to be a dream. We help our clients approach that vision. Not in five or ten years. **Today.**

# A UNIQUE VISION FROM A UNIQUE COMPANY

At Optum, we have a unique perspective about how to transform the revenue cycle because we are strategically situated between payers, providers and consumers.

And we believe that by enabling unprecedented levels of transparency and collaboration between all three we can drive positive financial performance for all stakeholders. Our technologies and methodologies are the industry's most advanced, and our people are the industry's most proficient. This positions us well to identify and seize opportunities to modernize the revenue cycle for collective success. We focus on getting it right up front in the revenue cycle to eliminate denials later.

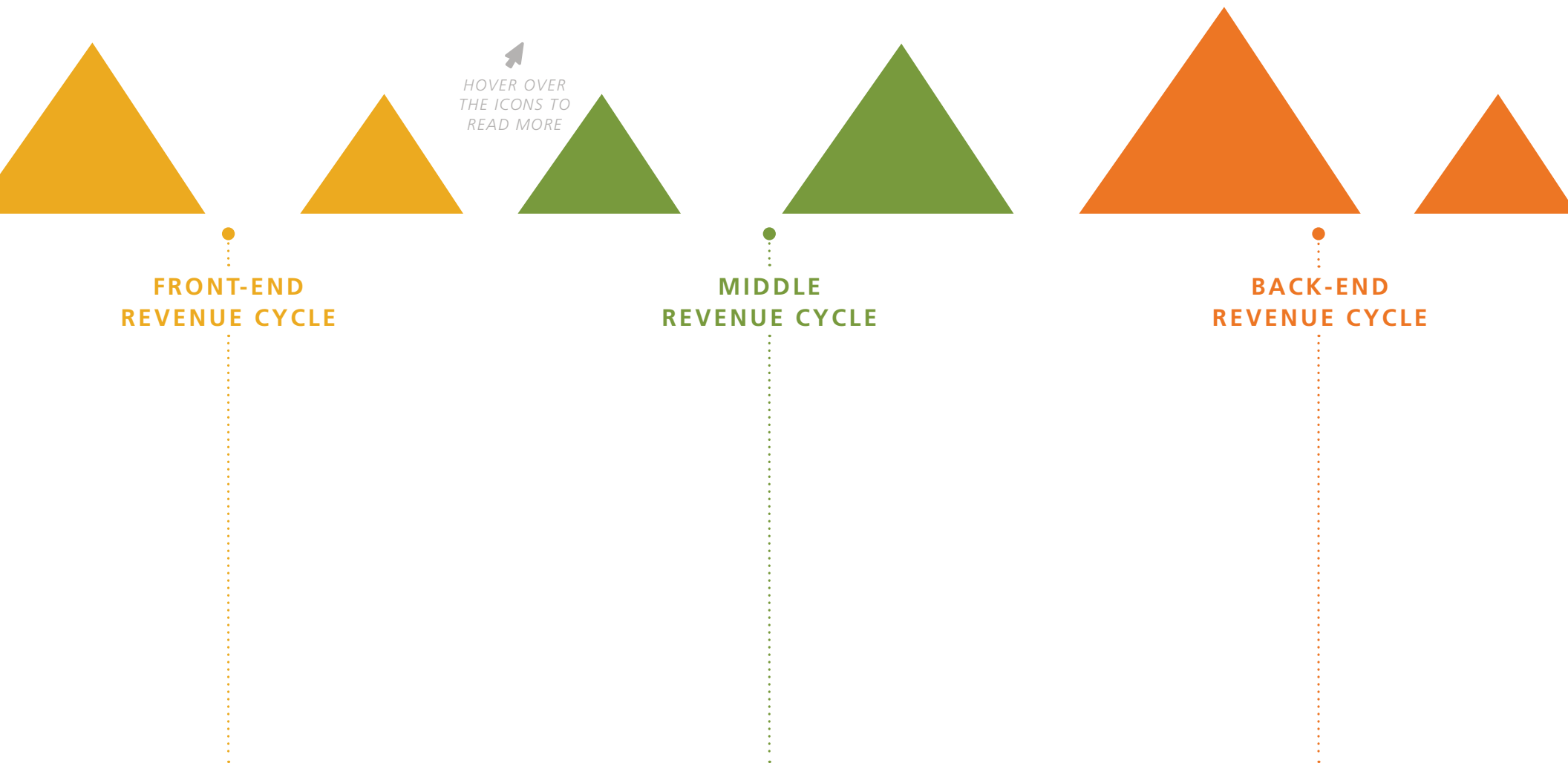


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THE ICONS TO  
READ MORE*

# REVENUE CYCLE PRIORITIES

Advancing the revenue cycle requires a new vision.

Achieving this vision requires modernization of all stages of the revenue cycle. We apply rich content, clinical intelligence and payer-aware rules refined by decades of experience to every priority area to enable your success.



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FRONT-END  
REVENUE CYCLE

MIDDLE  
REVENUE CYCLE

BACK-END  
REVENUE CYCLE

# FRONT-END REVENUE CYCLE

While improving efficiency and cash flow is critical to the success of your organization, it's just as important to ensure patient satisfaction in the registration and financial aspects of their experience. Providing a smooth experience for patients will help ease burdens in every stage of the revenue cycle. Addressing eligibility verification, getting prior authorization and providing patients with estimates will not only improve patient collections but also reduce mid-stage errors and prevent avoidable denials.

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**OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR A BEST-IN-CLASS FRONT-END REVENUE CYCLE.**



# FRONT-END REVENUE CYCLE



## Assess Yourself!

### THE MEASURE:

Point-of-service collection rate\*

### WHY IT MATTERS:

HFMA defines patient point-of-service payments as patient cash (self-pay cash) collected prior to or at the time of service and up to seven days after discharge. As patients take on more financial accountability for their health care, hospitals need to assess if their staff is effectively collecting patient payments before overdue bills turn into hospital bad debt.

*\*Divide the total value of patient point-of-service payments by the total self-pay cash collected.*

## TAKE ACTION NOW!

*SOME TIPS TO HELP YOU BEGIN ADDRESSING ELIGIBILITY CHALLENGES*

### ADDRESSING ELIGIBILITY CHALLENGES:

- **Verify eligibility at the right time** — Leverage batch inquiries for groups of patients prior to appointment and recheck eligibility at registration.
- **Leverage real-time medical eligibility verification** — Retrieve eligibility status and benefit information in seconds.
- **Train staff to process prior authorizations** with the right procedures and codes, resulting in faster approvals.
- **Calculate price estimates for patients** — After you verify eligibility, use the information provided by the patient's insurance provider, as well as your practice's contracted rates, to calculate a price estimate for your patients.

# FRONT-END REVENUE CYCLE

Consumers are responsible for more of their health care costs than ever before. Unsurprisingly, they expect more for their money. They're seeking a smoother, simpler experience of transparent costs, flexibility and easily accessible information. In order to compete successfully, both medical practices and hospitals must offer patients an easy, integrated solution for all patient touchpoints, including appointment scheduling, clinical triage, referral management, care coordination and payment. The benefits for successfully delivering on these expectations are significant: improved patient loyalty, competitiveness and collections, as well as reduced bad debt and cost to collect.

## WE HELP ENHANCE THE FRONT-END REVENUE CYCLE WITH THE FOLLOWING SOLUTIONS:



### PATIENT EXPERIENCE SUITE

A comprehensive set of solutions delivering patient-centric self-service tools to empower patients from the point of recognizing the need for care through final payment for care.



### CONTACT CENTER

Technology-enabled contact center services that centralize patient access and scheduling, deliver convenience through a consumer-centric digital approach, and apply clinical insights to proactively address care improvement.

## OPTUM HAS UNMATCHED EXPERTISE IN THE FRONT END OF THE REVENUE CYCLE:



**60%** of loyalty drivers for primary care physicians are related to their experience with health care services



**PROVIDERS** that deliver a "superior" patient experience gained net margins that were 50% higher, on average, than those that deliver an "average" customer experience<sup>1</sup>



**AS FEW AS 14%** of Medicare patients receive an annual wellness visit; proactive outreach to schedule can increase utilization by 70%



**65%** of callers are directed to a more appropriate care setting



**<5%** no-show appointment rate<sup>2</sup>



**6.4%** of net patient revenue in POS collections with expansive financial clearance<sup>3</sup>

1. Accenture, May 2016

2. Optum book of business January 2017–2019

3. Optum book of business January 2017–2019



# MIDDLE REVENUE CYCLE

Successful middle revenue cycle operations require a foundation of accurate, clinically validated documentation to support appropriate coding, billing, reimbursement and medical necessity determinations. Automated processes and collaboration are vital to success, but automation must be built on advanced, clinically aware artificial intelligence (AI), along with a combination of expert guidance and continuously updated clinical content, rules and guidelines. This multifaceted approach will enable optimal staff efficiency, error prevention and revenue integrity under changing payment models.

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OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR BEST-IN-CLASS DOCUMENTATION AND CODING.



# MIDDLE REVENUE CYCLE

Optum360 provides the breadth and depth of experience, clinically intelligent technology, and market-leading content and services to deliver exceptional results across coding and CDI operations. With over 30 years' experience, we help clients efficiently improve clinical documentation and coding accuracy, support quality initiatives and achieve revenue integrity.

Available as  
**TARGETED SOLUTIONS,**  
**MANAGED SERVICES** or  
a **STRATEGIC PARTNERSHIP**



WE DELIVER ENHANCED DOCUMENTATION AND CODING THROUGH THE FOLLOWING MIDDLE REVENUE CYCLE SOLUTIONS:



## PHYSICIAN ADVISOR SOLUTIONS

Highly trained regulatory and payer guideline experts who use unmatched evidence-based medical research and clinically aware artificial intelligence to deliver utilization review (UR) and CDI excellence



## ENTERPRISE COMPUTER-ASSISTED CODING (CAC)

Coding and automated workflow technology that harnesses the power of clinically intelligent NLP to support accurate code assignment for timely, appropriate reimbursement



## CLINICAL DOCUMENTATION IMPROVEMENT

Clinically intelligent NLP technology that reviews 100% of cases and identifies documentation deficiencies, gaps and potential quality events (including HAC and PSI) concurrent with and throughout the patient stay



## CODING SERVICES

A broad range of outsourced coding services, including backlog coding and coding review, with experienced clinical and medical records specialists and proprietary applications such as Optum CAC technology and the charging algorithms in Optum LYNX charging applications

## ADDITIONAL CAPABILITIES

### CAC PROFESSIONAL

Technology powered by superior NLP that **AUTOMATES** workflow and performs professional code assignment for consistent, compliant coding, optimal operations and accurate revenue capture

### ENTERPRISE CAC AND CDI 3D PLATFORM

A single integrated platform that **FACILITATES** collaboration across teams to support the common goal of complete and accurate documentation, coding and reimbursement

### OUTPATIENT CHARGE CAPTURE

Applications that use proprietary algorithms, knowledge of regulatory guidelines and industry experience to **EVALUATE** outpatient charges and code assignment for emergency departments, clinics and infusion centers

# MIDDLE REVENUE CYCLE



## Assess Yourself!

### THE MEASURE:

Case mix index  
(CMI)\*

### WHY IT MATTERS:

CMI reflects the diversity and clinical complexity of patients and the associated resources utilized to care for patients compared with similar facilities within a peer group. It also serves as a trending indicator of patient acuity, clinical documentation and coding. Accurate CMI supports appropriate reimbursement for services performed and accurate clinical reporting.

*\*CMI is calculated by dividing the sum of all DRG-relative weights by the number of cases (month/year).*

### CLIENT PERSPECTIVE

Our case mix has gone up because we aren't missing diagnoses that are hidden in a big chart with 30 or 40 codes. The NLP-powered code suggestions ensure high accuracy and reflect the quality of care we're providing.

— Susan Weidler, Coding and Data Quality Manager, Trinity Health (using Enterprise CAC)

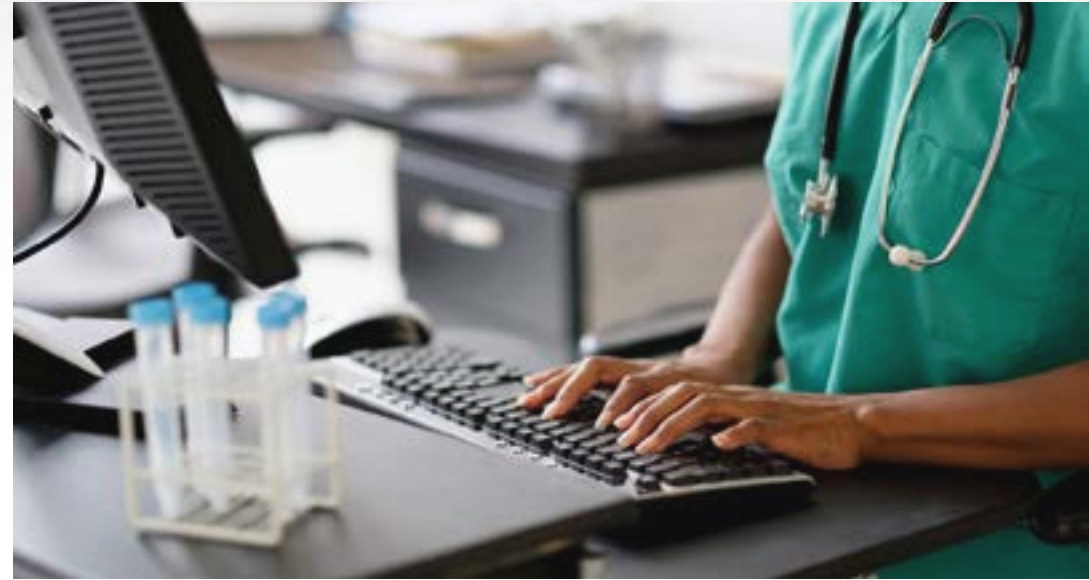
### TAKE ACTION NOW!

- **Find physician champions** in each department to help encourage others to strive for complete and accurate clinical documentation. A physician advisor can be a good catalyst for identifying and developing physician champions.
- **Analyze queries and denials for trends** that identify specific areas for process improvement.

# BACK-END REVENUE CYCLE

## FOCUS: Claim Integrity

A transformative revenue cycle requires careful attention to improving claim integrity and simplifying claim processing. Leveraging payer-specific rules, necessary attachments and prior patient claims data can ensure revenue integrity by identifying certain-to-deny claims prior to submission. Removing unnecessary costs — such as wasting money on claim processing when options to avoid this cost are available — allows you to reallocate that money into other high-value areas of the revenue cycle.



OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR BEST-IN-CLASS CLAIM INTEGRITY AND PROCESSING.

# BACK-END REVENUE CYCLE

## FOCUS: Claim Integrity

Optum360 removes unnecessary payer-provider feedback loops by using content and rules that support claim accuracy and documentation based on how payers adjudicate claims. Our intelligent clearinghouse and clinical editing capabilities streamline claim processing, identify certain-to-deny claims and help ensure revenue integrity. With these innovative solutions, clients can remove costs from the claim submission process and reduce administrative expenses associated with claim resubmission. This frees up dollars for other critical investments.

### WE HELP TO ENHANCE CLAIM INTEGRITY THROUGH THE FOLLOWING CLAIM INTEGRITY SOLUTIONS:



#### CLINICAL CLAIMS EDITING

Claims software that identifies certain-to-deny claims by prescreening for clinical coding and billing errors based on payer adjudication guidelines and standards



#### INTELLIGENT EDI

Claims clearinghouse that streamlines the claim process, from claim preparation and no- or low-cost claim submission to payer response management

### SUPPORTING YOUR CLAIM INTEGRITY WITH OPTUM: BY THE NUMBERS



**ELIMINATE** the cost of basic claim transactions with free<sup>4</sup> EDI via Link



**\$1.54 MILLION** average unbilled revenue identified per client, per year



**130 MILLION** code-to-code relationships developed and supported by an industry expert research panel of 140+ FTEs



**\$3.01 MILLION** average cost avoidance per client per year, based on denial prevention edits



**120,521** average claims stopped for repair per client per year

4. Select Medicaid payer claims and non-UHC real-time transaction fees apply

Available as  
**TARGETED SOLUTIONS,**  
**MANAGED SERVICES** or  
 a **STRATEGIC PARTNERSHIP**

# BACK-END REVENUE CYCLE

FOCUS: Claim Integrity



## Assess Yourself!

### THE MEASURE:

Clean claims rate\*

### WHY IT MATTERS:

Clean claims rates identify the quality of data being collected upstream as well as the amount of labor going into error resolution. Improving clean claims rates reduces the labor costs and AR days required to generate payment.

*\*Divide the number of claims that pass all edits by the total number of claims accepted into the claim processing tool for billing.*

## CLIENT PERSPECTIVE

Our substantial return on investment in Claims Manager is clear. When you've found a technology that consistently delivers results, it's important to consider that new, overarching solutions may not contain the specific functionality and benefits you've come to expect.

— Vice President of Revenue Systems, East Coast Medical Center (using Claims Manager)

## TAKE ACTION NOW!

- **Scrub claims for all major payers** for compliance issues, diagnosis issues, and other possible coding and billing errors.
- **Review all electronic claim rejection reports daily** in order to determine where in the continuum the claim was rejected.
- **Reduce the number of claims** hitting an edit by tracking the root causes of your most frequent errors.
- **Implement system-wide workflows** that efficiently sort pre-billed claims and denials for rework.

# BACK-END REVENUE CYCLE

## FOCUS: Denial Management

Appeals and recovery are the necessary last mile in the revenue cycle. By analyzing root causes of denials, providers can chip away at denial contributors. Where are denials originating, and why are they occurring? Are the hot spots in patient access and registration, documentation, coding/billing or utilization/case management? But, no matter how successful an organization is at correcting the causes of denials, some will still slip through. A well-tuned denial management and recovery approach can quickly and effectively minimize the impact of denials on the revenue cycle.

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OPTUM BELIEVES THE FOLLOWING CHARACTERISTICS ARE ESSENTIAL FOR A BEST-IN-CLASS BACK-END REVENUE CYCLE



# BACK-END REVENUE CYCLE

## FOCUS: Denial Management

Optum360 denials prevention and recovery solutions harmonize the revenue cycle for payers and providers alike, enabling collaboration and transparency. Our solutions provide intelligent, automated denials recovery approaches and ongoing prevention through denial root cause analysis as well as elimination of inefficiencies and inaccuracies.

### WE HELP CLIENTS THROUGH THE FOLLOWING BACK-END REVENUE CYCLE SOLUTIONS:



#### DENIALS RECOVERY SERVICE

Technology-enabled denied claim recovery, including root cause analysis and trending of outcomes to create a solid denials prevention strategy for acute and ambulatory settings



#### PAYMENT INTEGRITY COMPASS

Automated contract management solution that pinpoints underpayments, identifies trends in reimbursement discrepancies and bundles denials rework by payer



#### DENIAL MANAGEMENT

An intelligent, automated denials workflow technology that enables providers to capture, identify and correct the root causes of denied claims while improving productivity

### OPTUM HAS UNMATCHED BACK-END REVENUE CYCLE EXPERTISE:



**1 MILLION+** complex denial appeals completed by Optum



**\$5 MILLION** average denied claim resubmission expenses avoided per Optum client per year



**85%** Optum overturn rate for Medicare clinical denial appeals



**\$2.2 MILLION** contract underpayment dollars recovered in one year for a Wisconsin-based health system

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# BACK-END REVENUE CYCLE

FOCUS: Denial Management



## Assess Yourself!

### THE MEASURE:

Percentage of A/R  
over 60 days\*

### WHY IT MATTERS:

Many providers struggle to collect A/R after the 60-day mark. Having a high rate of A/R over 60 days reflects a propensity for declining recovery rates, an increase in likely write-offs and bad debt, and problems with the rest of your revenue cycle policies leading to denials.

*\*Divide the amount of A/R over 60 days by the total outstanding A/R.*

IDENTIFY THE FIRST STEPS OF YOUR UNIQUE DENIALS CHALLENGE WITH SOME BASIC ANALYTICS AND PRIORITIZATION.

## TAKE ACTION NOW!

You can begin rebuilding your denial management and recovery strategy today from an organization-specific foundation of metrics, priorities and insights.

- **Identify trends.** Identify trends in denials and conduct root cause analysis. Your existing analytic tools may pinpoint trends. For instance, if a significant portion of your denials are prior-authorization denials, scrutinize your front-end authorization process.
- **Prioritize.** Systematically prioritize denials and related workflow. Assess the business impact of each kind of denial and address those denials that either represent the greatest challenge or offer the opportunity for quick revenue recovery. Earmark more complex denials for third-party assistance or additional technological investment.
- **Communicate.** Feed intelligence upstream for best-practice realignment. Sharing learnings and insights about the reasons for denials with front-end and middle-revenue cycle teams can help reduce the flow of denials by addressing issues further upstream.



# OPTUM CAN HELP.

The right partner can enhance interconnectivity and supply extensive expertise and innovative technology. Our flexible engagement model can meet you where you are.



## Advance the revenue cycle with our industry-leading technology solutions

- Complementary core system investments
- Clinically aware artificial intelligence
- Payer-centric clinical and administrative content
- Reduced EDI transaction cost

## Modernize key functional areas of the revenue cycle with technology-enabled managed services

- Expert teams that understand operations and workflow intricacies to drive performance and process improvement
- Services powered by our industry-leading technology solutions
- Help avoiding technology deployment and support costs

## Achieve long-term revenue and savings with full operating transformation

- Risk-sharing partnership model
- Management of every claim and dollar in the revenue cycle
- Achievement of more accurate and appropriate payment and savings

# WHAT'S NEXT?

## CONTACT US TODAY

to learn how we can empower each stage of your revenue cycle to meet modern health care challenges.

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