Optum

Claims Edit System EDI Messaging

Achieve payment accuracy early in the value stream

Claims Edit System (CES) EDI Messaging harnesses the scalable, fully automated technology and robust content of CES and brings it into the electronic data interchange (EDI) workflow. By shifting edits into EDI workflows for early editing transparency, CES EDI Messaging helps ensure higher first-pass billing accuracy.

Identify claims prior to submission

Editing in EDI workflows empowers providers to submit accurate, complete claims with higher first-pass adjudication rates through transparent and actionable messaging. This type of editing directly impacts administrative savings, provider network satisfaction and allows health plans to introduce new policies and editing programs more seamlessly.

CES EDI Messaging advantages

- Notify providers to self-repair — at the speed of EDI — to reduce denied claims requiring rework.

- Reduce administrative expenses associated with appeals, resubmissions and manual rework.

- Introduce incremental medical cost-savings opportunities where traditional mid-adjudication claim editing may be abrasive to providers.

- Improve provider satisfaction by delivering clear, efficient claims feedback that doesn't disrupt work.

- Avoid "rip-and-replace" of existing technology by leveraging CES and industry-standard EDI workflows and 277CA to provide alerts.

- Increase your savings and ROI with a dedicated Application Managed Services support team that provides ongoing assistance.

1. Medical Group Management Association.
2. CMS data, Oct. 1–Dec. 31, 2019.

Prevent coding errors from entering your system

$31

Average additional costs for health plans and providers to manage a denied claim[1]

Avoid claim errors and related expense with proactive and collaborative identification from CES EDI Messaging.

Results from MAC A[2]

24%

Reduction in resubmitted claims, totaling $66.5M in total charges

76%

Of claims resubmitted with changes, yielding a decrease of $22.7M in charges

Results from MAC B[2]

18%

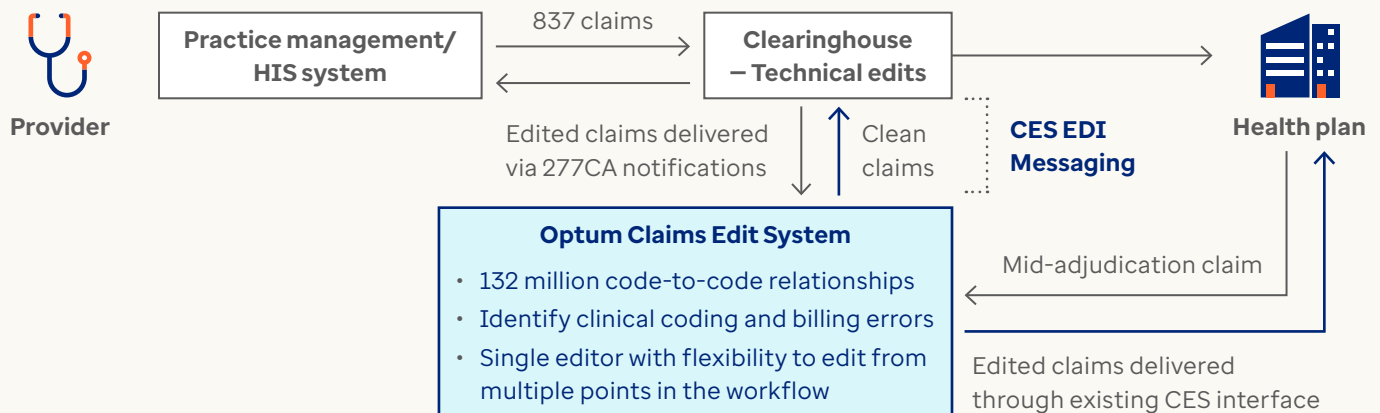Reduction in resubmitted claims, totaling $50.7M in total charges

74%

Of claims resubmitted with changes, yielding a decrease of $41.8M in charges

How it works

CES EDI Messaging can be configured in as few as 90 days, and is supported through your existing CES technology investment. Edits are provided to submitters via industry trading partners using the standard 277CA transaction, so there's no need for you or your provider networks to change current workflows or replace existing technologies.

Provider → **Practice management/ HIS system** → 837 claims → **Clearinghouse – Technical edits** → **Health plan**

Edited claims delivered via 277CA notifications

Clean claims

CES EDI Messaging

Mid-adjudication claim

Optum Claims Edit System
- 132 million code-to-code relationships
- Identify clinical coding and billing errors
- Single editor with flexibility to edit from multiple points in the workflow

Edited claims delivered through existing CES interface

CES EDI Messaging includes nine categories of edits that can be deployed into the EDI stream

1. **Standard CES edits:** 132 million editing combinations maintained by Optum, including professional and facility edits, commercial and Medicare, national and state-level Medicaid, and custom edits

   Benefit: Leverage the industry's largest code-to-code database — the Optum KnowledgeBase — to ensure claims accuracy for all lines of business.

2. **Eligibility verification:** Member eligibility, plan and line-of-business routing and flexible matching criteria

   Benefit: Get reliable validation of patient eligibility and accurate answers to coverage queries.

3. **Duplicate edits:** Line- and claim-level checks, flexible criteria, historical claim upload, organically built history and multi-factor logic

   Benefit: Review each service and immediately identify if the same service is already on record.

4. **Prior authorization edits:** Clinical scenarios requiring prior authorization are identified in addition to verifying that claims include a prior authorization number

   Benefit: Prevent unnecessary denials due to missing prior authorization numbers.

5. **Operational edits:** Provider credentialing

   Benefit: Further prevent denials by proactively alerting providers of upcoming expiration of health plan credentialing.

6. **Attachment edits:** Attachment notification

   Benefit: Promptly reminds providers to attach supporting documentation for medical necessity for accurate documentation.

7. **Administrative edits:** HIPAA and ICD-10 validation, WEDI SNIP Types 1–7 and NDC code check

   Benefit: Validate, route, report and track all X12 transaction types.

8. **Pattern detection:** Provider patterns, prospective notification and profile reporting; can operate at notification level or hard reject, based on client preference and settings

   Benefit: Break the cycle of pay-and-chase with prepayment detection. Identify overpayments.

9. **Quality analytics:** Gaps in care identified

   Benefit: Improve member health outcomes by forewarning providers of critical patient needs. Proactively identify care needs via a 271–eligibility transaction, prior to care delivery.

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