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Optum Releases New Lab Benefit Management System

This summer, UnitedHealth Group's subsidiary, Optum, released a new lab benefit management (LBM) system designed with the aim of reducing clinical lab tests Optum has deemed unnecessary. This system will replace Beacon, the old lab management system used by UnitedHealth.

According to Optum, approximately 30% of lab tests are unnecessary, as determined by criteria developed in a collaborative effort between Optum and Avalon Healthcare Solutions. With nearly 13 billion clinical lab tests being run every year, it is estimated that the reduction in paid lab tests will save health plans between $12-36 per member, or more than $3 billion annually.

The LBM system operates on what Optum claims are evidence-based guidelines and automates much of the process in the hopes of drastically reducing the need for manual assessments and payment denials. Notably, Optum is being marketed to non-United Health plans, including commercial, Medicaid, and Medicare Advantage plans.

A major instigator of these efforts is the rapid rise of genetic tests in recent years. Senior Product Director at Optum, Tanya Hendrickson, claims genetic testing comprises 20% of lab test expenses, as opposed to only 5% a decade ago.

The primary focus of the software will be in the following areas:

- Routine Clinical Lab Testing: Optum claims routine lab tests consistently tack on additional, unnecessary testing or recommend larger test panels when smaller panels would do. The LBM aims to identify these unnecessarily involved panels and only pay for the smaller panel of tests deemed necessary.
- Genetic Testing: Optum is requiring Z-code identifiers on tests with non-specific CPT® codes to obtain payment. This is supposed to assist the automation process and reduce the need for pre-authorizations.
- Anatomic Pathology: Optum is limiting the number of CPT 88305 units that will be reimbursed based on specimen type. For example, only six core biopsies will be reimbursed per prostate biopsy case. Optum claims labs routinely bill for 10-18 in these cases.

One notable issue with this newly implemented system is the difficult spot it puts pathologists in. Pathologists are medically required to analyze samples sent to them, which puts them in a position where they may have to run tests that will be denied payment later on. One potential step pathologists can take to mitigate this risk is to work with referring providers to ensure appropriate diagnosis indications that prove the tests are medically necessary. Hopefully, this will help minimize denials, but issues will still arise in some cases.

APS will continue to monitor the implementation of this new system and report on any new developments as it applies to reimbursement. If you have questions as to how this new lab benefit management system may affect your business and reimbursement, please contact your Practice Manager.

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