Authorizations: A Race Against the Clock

THIS PRESENTATION
WAS EXCLUSIVELY CREATED FOR:

Florida Sunshine Chapter
AAHAM
American Association of Healthcare Administrative Management

certified WBENC WOMEN'S BUSINESS ENTERPRISE

AGENDA

What is Financial Clearance?

Why is Financial Clearance Important?

Financial Clearance Challenges

Financial Clearance Models

Scheduling vs. Financial Clearance

HR Considerations

COVID Concerns

What is Financial Clearance?

Five Pillars of Financial Clearance:

- Insurance Verification
- Ensure Service is a Covered Benefit
- Obtain Authorization or Referral
- Calculate Out-of-pocket Responsibility
- Discuss responsibility with patient / family

1. Insurance Eligibility

- Coverage should be verified using real-time eligibility (RTE) when available
- Verification should take place as close to the beginning of the process as possible (e.g., at time of scheduling)
- Medicaid should be reverified at the beginning of every month
- Exception-based workflow should be used when coverage has lapsed

2. Validating Coverage

- This step is commonly missed during the financial clearance process
- Each plan has specific services they cover and “carve-outs” for services that may be covered by a different insurance (e.g., mental health)
- Employer groups often have services they exclude from an employees benefit package
- It’s important to understand what benefits the plan will cover in order to communicate effectively with the patient

3. Obtaining Authorization or Referral

- Determining whether an authorization or referral is needed for a specific CPT code and payor
- Submit request for authorization via web-portal or fax (with relevant clinical documentation)
- Follow-up on the request and enter approvals in the system
- Arrange peer-to-peer calls, when necessary
- Have a process to handle denied requests
- It’s also important to check medical necessity for patients with Medicare or those who don’t require authorization

4. Calculate Out-of-Pocket Responsibility

There are mandates at the federal and state levels that require pricing transparency. These regulations are aimed at assisting consumers choose the best value for care, but often create more confusion.

Pros of Price Estimation:

- Calculating out-of-pocket responsibility prior to service can reduce your bad debt by collecting upfront – once service is rendered, collectability decreases significantly
- Increases customer satisfaction by giving patients different options if they're unable to pay their bill (e.g., payment plan, charity, elective self pay rate)

Challenges of Price Estimation:

- Healthcare costs are hard to predict and generally based on an order. The price can vary drastically if the physician adds/changes the order at the time of service
- Even though staff are trained to emphasize the quote is only an estimate, many patients still complain if the estimate isn't correct
- Maintaining the contacts and the rates within the pricing tool can be very tedious

5. Discuss Responsibility with Patient

- Staff must fully understand how the estimate is calculated in order to articulate it to the patient
- Customer service training is critical before launching a pre-service collection program
- Emphasize that the calculation is an estimate and may change if the physician adds or changes a procedure
- Some tools calculate the total cost (physician and hospital) and others only calculate one

Why is Financial Clearance Important?

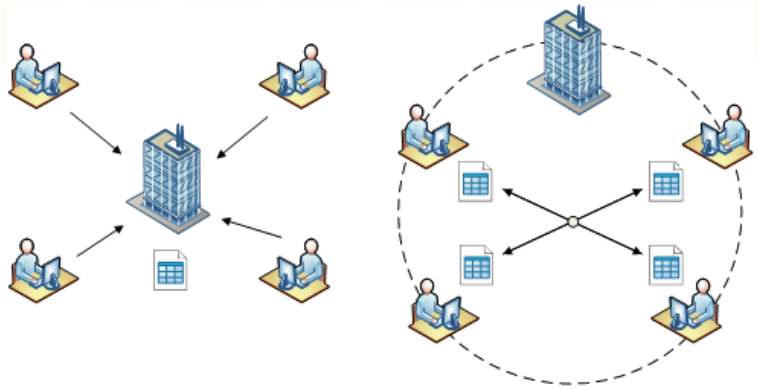
- The rise of managed care plans has increased the number of services that require authorization
- Denials can occur when financial clearance team members are not trained to read specific plan benefits and are not able to determine medical necessity (e.g., no authorization is required if the service meets medical necessity)
- Many insurance companies will no longer issue retro-authorizations for medically necessary services provided without authorization
- Pricing Transparency regulations have increased consumer expectations of knowing what their service will cost

Financial Clearance Challenges:

- PAYORS!!
- Rescheduling / Canceling cases without authorization
- Obtaining clinicals to support the need for service
- Finding staff with the right skill set

What issues do you have?

Centralized vs. Decentralized:



Centralized

Pros:

- Career Ladder
- Coverage
- Formal Infrastructure
- Tools/Workflow

Cons

- Physician Communication

Decentralized

Pros:

- Physician Communication
- Understanding of Medical Treatment

Cons:

- No Coverage
- No Formal Training
- No Career Ladder

HR Considerations

- According to a study performed by Becker's, "registration/eligibility" is the leading cause of denials (23.9%).
- Patient Access employees are typically paid below employees in other areas of the revenue cycle.
- The role of the financial clearance specialist has grown over the past few years to require critical thinking, clinical experience, and effective negotiation and communication skills.
- It's important to partner with HR and revenue cycle leadership to realign the pay grades to the reflect the additional tasks handled by these employees.
- Align the most complex financial clearance roles with a level II collector or denials specialist

Pay Scale Alignment of Access Employees (Example)

Job Title	Pay Grade	Pay Rate	Number of Employees
Registration Specialist	Grade 8	$14.96- $19.50 ($31,115 - $38,500)	42
Scheduler / Financial Counselor	Grade 9	$15.71-$21.39 ($32,677-$44,491)	32
Financial Clearance Specialist I	Grade 10	$16.48-$23.65 ($34,278-49,192)	15
Financial Clearance Specialist II	Grade 11	$17.50-$26.06 ($36,400-$54,205)	17
Financial Clearance Supervisor	Grade 13	$20.51-$31.80 ($42,661-$66,144)	2
Financial Clearance Manager	Grade 15	$24.61-$39.59 ($51,189-$82,347)	1

Scheduling Goals vs. Financial Clearance Goals

Scheduling Goals and Financial Clearance Goals are often in conflict. For example:

Scheduling Goals	Financial Clearance Goals	Conflict
Schedule the patient within 7 days of call	90% of patients are financially cleared 5 days in advance of their visit / procedure	NCQA (accredits health plans) allows payers 15 days to process non-urgent authorization requests and 72-hours for urgent requests.
Call abandonment rate is < 5%	99% of patient's insurance is verified prior to their visit/procedure	Inaccurate or incomplete insurance and demographic information delays the FC process.
Percent of appointments cancelled is < 10%	Patients must be financially cleared 48 hours before appointment or appointment is rescheduled	Patients scheduled without enough time to obtain auth will result in a cancellation.

Aligning Scheduling and Financial Clearance Goals

Working and communicating across departments will ensure a seamless patient experience and reduce rework and denials.

Conflict	Alignment
Schedule patients within 7 days of call	Gather payor-specific data on auth turnaround times and create scheduling tools based on payor / procedure type.
Call abandonment rate is < 5%	Allow scheduling staff enough time to gather all relevant insurance and demographic information at time of scheduling. Run RTE while patient is on the phone and ask patient for different information if insurance comes back inactive.
Percent of appointments cancelled is < 10%	Ensure financial clearance is staffed appropriately to handle the workload and patients are scheduled with enough time for a payor auth decision.

COVID Concerns

- Many payors are waiving co-pays for services – make sure to develop a plan and communicate frequently with staff
- Double check eligibility – some patients may have lost coverage due to layoffs
- Ensure all face-to-face registration components are captured for telehealth services
- Build on remote-access capabilities established during the pandemic – use this opportunity to move healthcare forward

We’re here to help!

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