39th Annual Educational Conference & Exposition

leading the way

a brave new world of patient access

National Association of Healthcare Access Management NAHAM™

Eligibility Verification

Advanced Techniques to reduce denials and improve flow

Objectives

- Understand that minimum levels of Eligibility Verification - are no longer acceptable.
- Develop a roadmap for using advanced techniques to reduce denials, increase POS collections, create custom edits and rules to drive complex multi-insured/Medicare HMO accounts.
- Develop a reporting strategy to address various issues around Medicare HMO, self-pay/Medicaid etc.

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Objectives – Contd.

- Develop an Advanced Usage Framework
  - Understand advanced techniques and how to apply them to meet strategic objectives
- Implementation Framework
  - Identify pre-authorization accounts - by using notification features.
  - Identify accounts where Medicare HMO is found.
  - Run self-pay accounts through state Medicaid to identify patients with Medicaid coverage.
  - Increase cash collections based off of copay and deductibles

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Prior to service

- Patient scheduled & registered
- Insurance Eligibility coverage verified
- Any necessary Auths obtained & tracked throughout the visit
- Patient obligation collected
- Financial assistance options presented to those unable to pay
- All forms signed and scanned

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Challenges in achieving that goal

- Is patient eligible?
- Are plan specifics available?
- Does the procedure need authorization?
- Has the authorization been received?
- What is the annual deductible and max OOP?
- How much has patient met?
- What is the current patient obligation?
- Does the patient qualify for Medicaid and/or any other assistance program?
- Which forms to file for assistance program?

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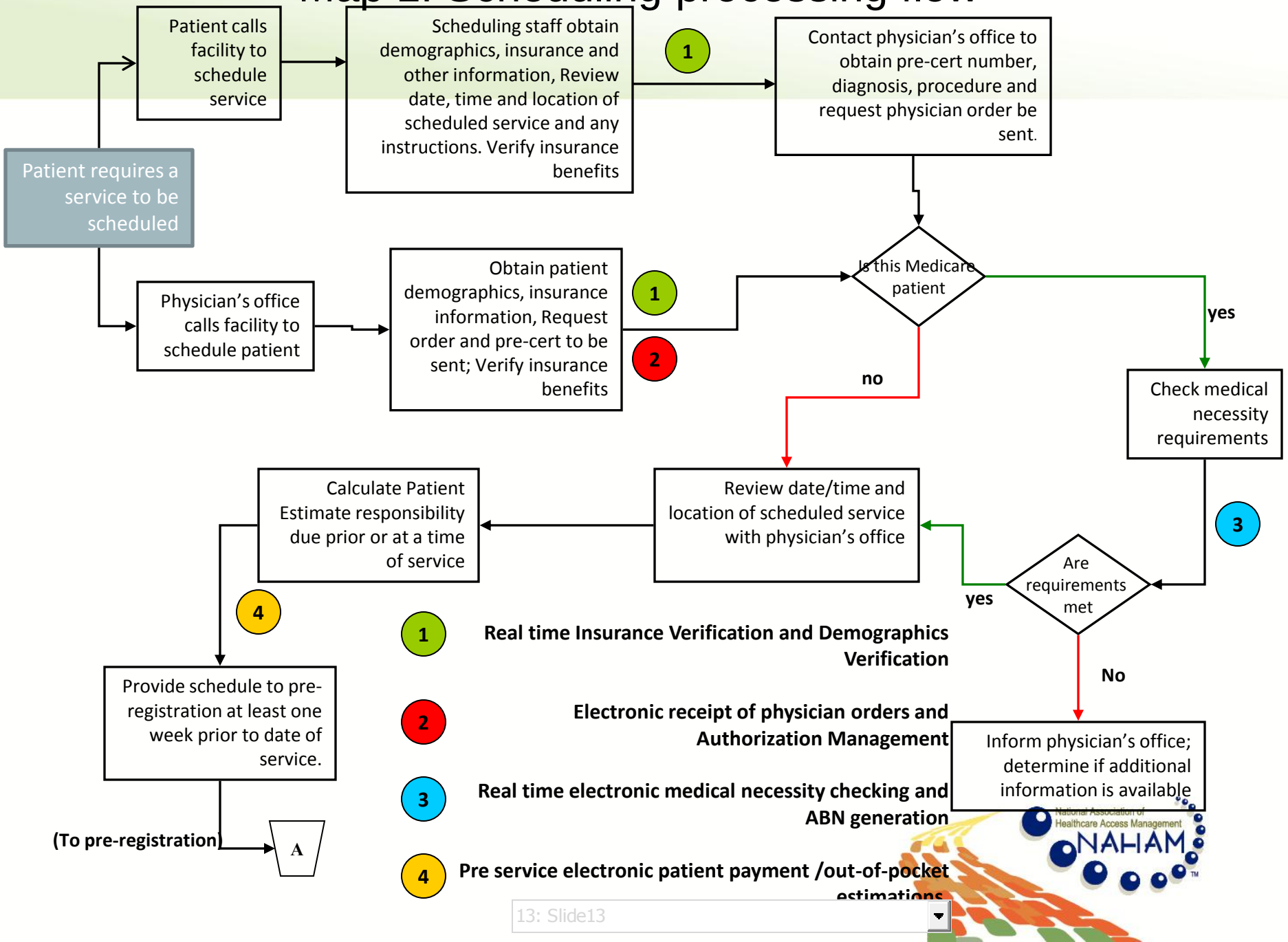
Multiple Entry Points - Process Maps

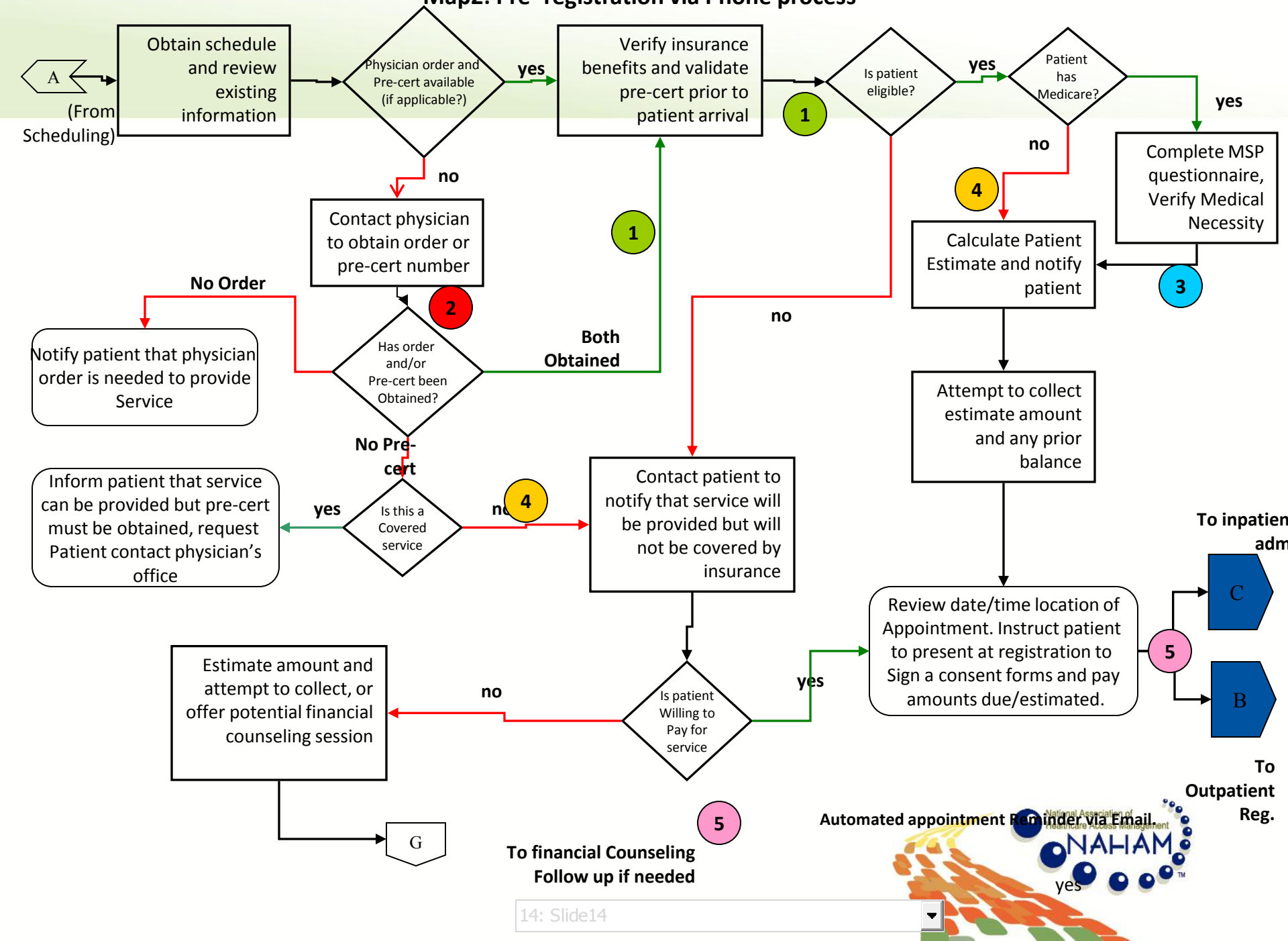
- Scheduling processing flow
- Pre- registration via Phone process
- Pre-Registration on site Process
- Emergency room registration process
- Inpatient admission process
- Outpatient registration process
- Financial Counseling/Discharge Process

PROCESS MAPS

Map 1: Scheduling processing flow



Map2: Pre- registration via Phone process



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The Problem

- Eligibility accounts for about 20% of denials encountered in patient access
- Over 100+ industry standard benefit codes
- Non standard and inconsistent responses from payor
- Facility needs benefits rather than “YES” or “NO”
- Easy to read

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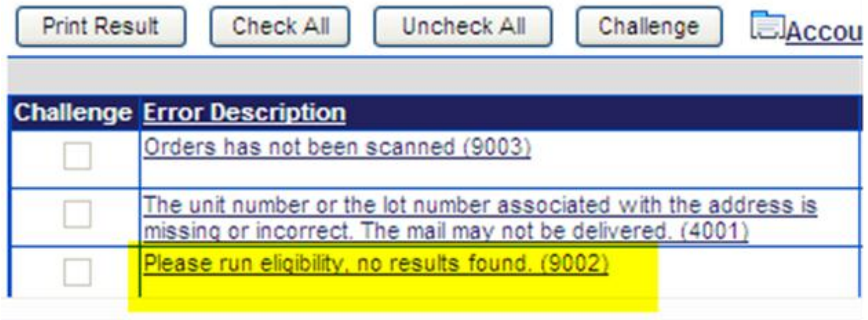
Eligibility– Successful approaches

- Available On-demand
- Integrated to work automatically when the patient is registered
- Run Automatically as batches 2-3 days prior to date of admission
- Exception worklist shows on a daily basis what is pending
- Self Pay validation
- Dynamic Searches based on patient demographics
- Query multiple payors and cascading for one account across multiple payors
- Results via 270/271 or screen Scrape



Medicare 271 Output / Response

- Part A / B entitlement term dates
- Deductible part A
- Deductible part B
- ESRD
- MCO Data
- MSP Data
- Home Health Data
- Hospice
- Hospital days remaining
- Hospital coinsurance days remaining
- Lifetime reserve days
- Skilled Nursing Facility Days Remaining
- Skilled Nursing Facility Coinsurance Days Remaining

Detailed Medicare Results

- Medicare Information most required
  - # of days remaining
  - Lifetime limitations/remaining
  - Reserves
  - Remaining deductibles
  - MSP enrollment
  - PPO enrollment
  - HMO’s
  - Home Health Care
  - Hospice
  - Procedure Limitations based off of CPT codes

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Industry requires MORE in the 271

- Specifies what must be included in the 271 response to a Generic 270 inquiry
- Response must include
  - The status of coverage (active, inactive)
  - The health plan coverage start date
  - The name of the health plan covering the individual (if the name is available)
  - The status of nine required service types (benefits) in addition to the *HIPAA required Code 30*
    - 1-Medical Care
    - 33 - Chiropractic
    - 35 - Dental Care
    - 47 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

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271 Output cont'd

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 -Chiropractic
  - 47 -Hospital Inpatient
  - 50 -Hospital Outpatient
  - 86 -Emergency Services
  - 98 -Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
  - 1-Medical Care
  - 35 -Dental Care
  - 88 -Pharmacy
  - AL -Vision (optometry)
  - 30 -Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

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Daily Eligibility Exception List

ADMIT DATE : 09/22/2009 - 09/22/2009
PAYOR CATEGORY : Blue Shield of California

pat hosp code	Pat first name	Pat last name	Rel.Code	pri plan	pri stat	sec plan	sec stat	ter plan	ter stat	eligibility run date
00027 I	V	AN	A	4000	N 71	8600	N 67	0002	S	
00027 I	R		A	8610	S	8780	N 75	0002	S	9/22/2009 8:50:00 AM
00027 I	D		A	4000	S	8610	N 6	0002	S	9/22/2009 2:55:00 PM
00027 I	D	R	A	8600	N 67	0002	S			9/22/2009 2:15:00 PM
00027 I	M		A	4000	S	8600		0002	S	9/22/2009 5:41:00 PM
Total Accounts	5			5	2	4	4	0	0	

No Results | Never Ran | Not Mapped/ Self Pay

LEGEND
Total Accounts showing under Pat First Name column is the total Errors or Not runs for the given Admit Date
Total Number showing under Pri Plan column is the total number of Pri Plan codes excluding selfpay (0000,0001,0002,0004,0005,0006,0050)

Code	Description
71	Patient Birth Date Does Not Match That for the Patient on
6	In-Active Coverage
72	Invalid subscriber ID

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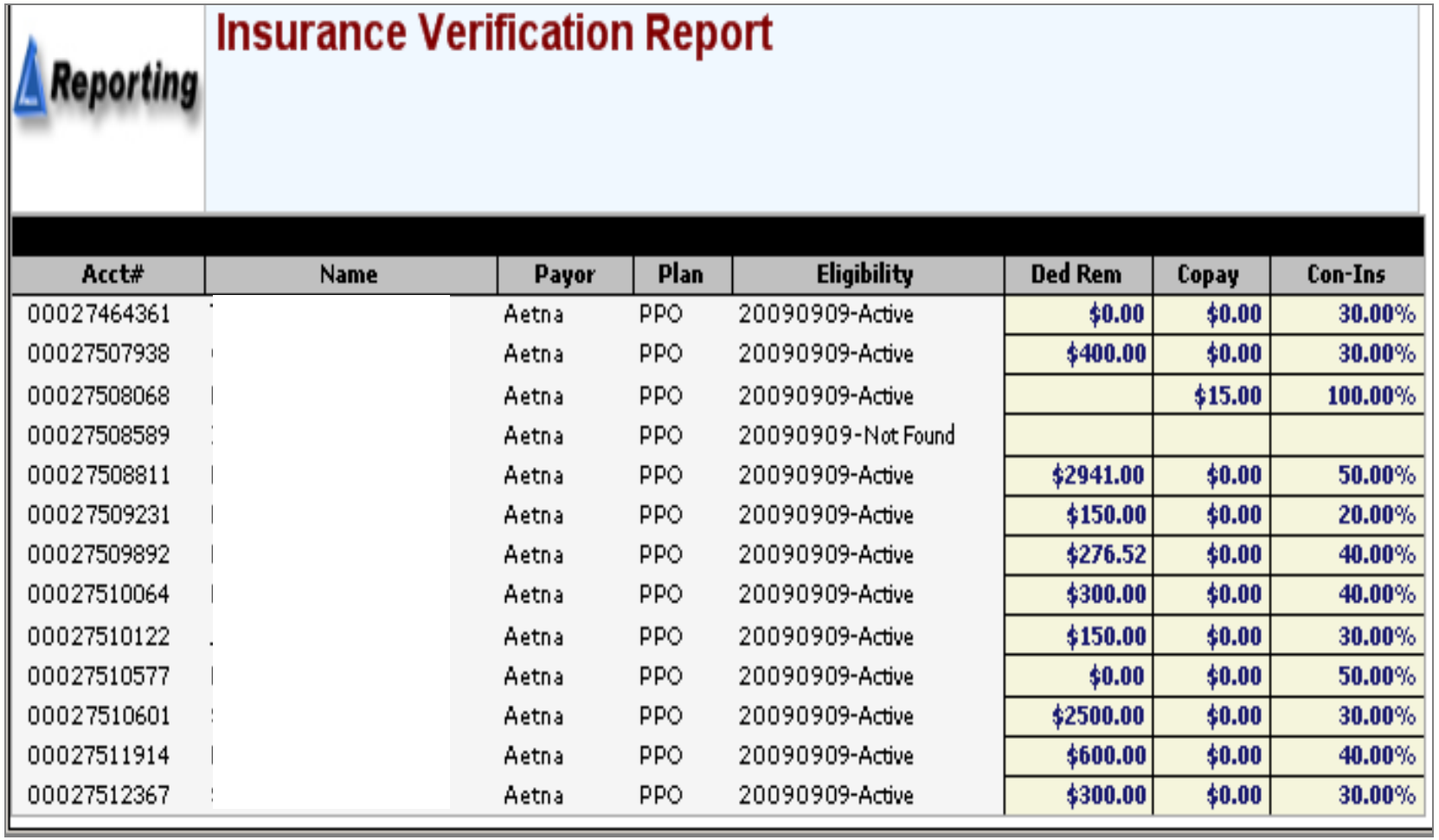
Co-pay by Service Type



Reporting

Insurance Verification Report

Acct#	Name	Payor	Plan	Eligibility	Ded Rem	Copay	Con-Ins
00027464361		Aetna	PPO	20090909-Active	$0.00	$0.00	30.00%
00027507938		Aetna	PPO	20090909-Active	$400.00	$0.00	30.00%
00027508068		Aetna	PPO	20090909-Active		$15.00	100.00%
00027508589		Aetna	PPO	20090909-Not Found			
00027508811		Aetna	PPO	20090909-Active	$2941.00	$0.00	50.00%
00027509231		Aetna	PPO	20090909-Active	$150.00	$0.00	20.00%
00027509892		Aetna	PPO	20090909-Active	$276.52	$0.00	40.00%
00027510064		Aetna	PPO	20090909-Active	$300.00	$0.00	40.00%
00027510122		Aetna	PPO	20090909-Active	$150.00	$0.00	30.00%
00027510577		Aetna	PPO	20090909-Active	$0.00	$0.00	50.00%
00027510601		Aetna	PPO	20090909-Active	$2500.00	$0.00	30.00%
00027511914		Aetna	PPO	20090909-Active	$600.00	$0.00	40.00%
00027512367		Aetna	PPO	20090909-Active	$300.00	$0.00	30.00%

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Pre/Post Eligibility Edits

- What's the plan code?
- Is the plan code mapped back to host ADT system?
- When was the last mammogram done?
- Do we need to print an ABN?
- Should Medical Necessity be integrated with Eligibility?
- Should ABN be generated automatically and be paperless?

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Labor Cost Analysis of Manual vs Automated Eligibility

Manual Eligibility Labor Costs			
Average Registrar @ $15.00			
Cost of Registrar per minute	$	0.75	
Average time to input eligibilibility into payors website		1	minutes
Labor Cost of manual eligibility data entry	$	0.75	
Average # of patients per registrar per day		50	
Daily labor cost for manual eligibility data entry	$	37.50	
Automated Eligibility Labor Costs			
Average Registrar @ $15.00			
Cost of Registrar per minute	$	-	
Average time to input eligibilibility into payors website		1	
Labor Cost of manual eligibility data entry	$	-	
Average # of patients per registrar per day		50	
Daily labor cost for manual eligibility data entry	$	-	

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Daily Labor Costs Analysis

Analysis of 400 transactions per day
Labor Costs for these 400 transactions manually processing eligibility would be as follows:

Daily labor cost for manual eligibility data entry if 400 transactions were processed in a day			
Average Registrar @ $15.00			
Cost of Registrar per minute	$	0.75	
Average time to input eligibilibility into payors website		1	minutes
Labor Cost of manual eligibility data entry	$	0.75	
Average # of eligibility transactions per day		400	
Daily labor cost for manual eligibility data entry	$	300.00	

Daily labor cost for Automated eligibility @ 400 transactions per day		
Average Registrar @ $15.00		
Cost of Registrar per minute	$	-
Average time to input eligibilibility into payors website		1
Labor Cost of manual eligibility data entry	$	-
Average # of eligibility transactions per day		400
Daily labor cost for manual eligibility data entry	$	-

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Monthly Labor Cost Analysis Savings

- The savings in one month could cover 1-2 FTE's monthly salaries.

In one month the savings of labor hours just counting weekdays would be as follows:

Daily labor costs of manual eligibility data entry	$ 300.00
# of work days in month	20
Labor Cost Savings in one month	**$ 6,000.00**

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Results Expected from an Automated Eligibility System

- Reduction in Claim Denials
- Increase in Staff Productivity
- Increase in Upfront Collections

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Vendor Selection

- When choosing an Eligibility solution, vendor selection is **vital**.
  - Partnership with your Hospital/Health system
  - Ability to develop new features
  - Knowledgeable of processes, product lines and industry standards
  - Pre and post go-live support
  - Continued support for current areas as well as future rollouts
  - Capital vs. operational budget

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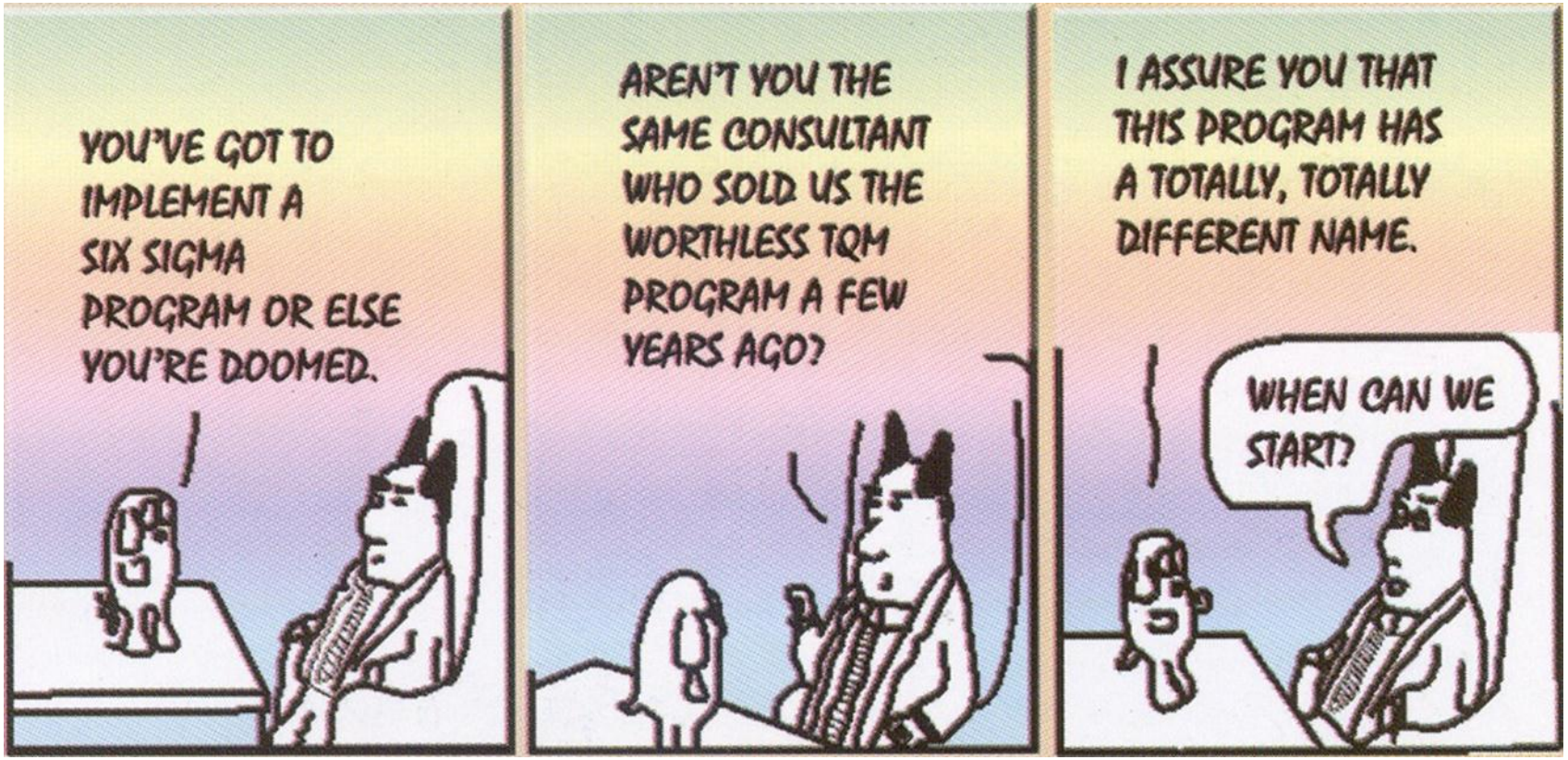
Vendor Selection



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Thank you!

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