

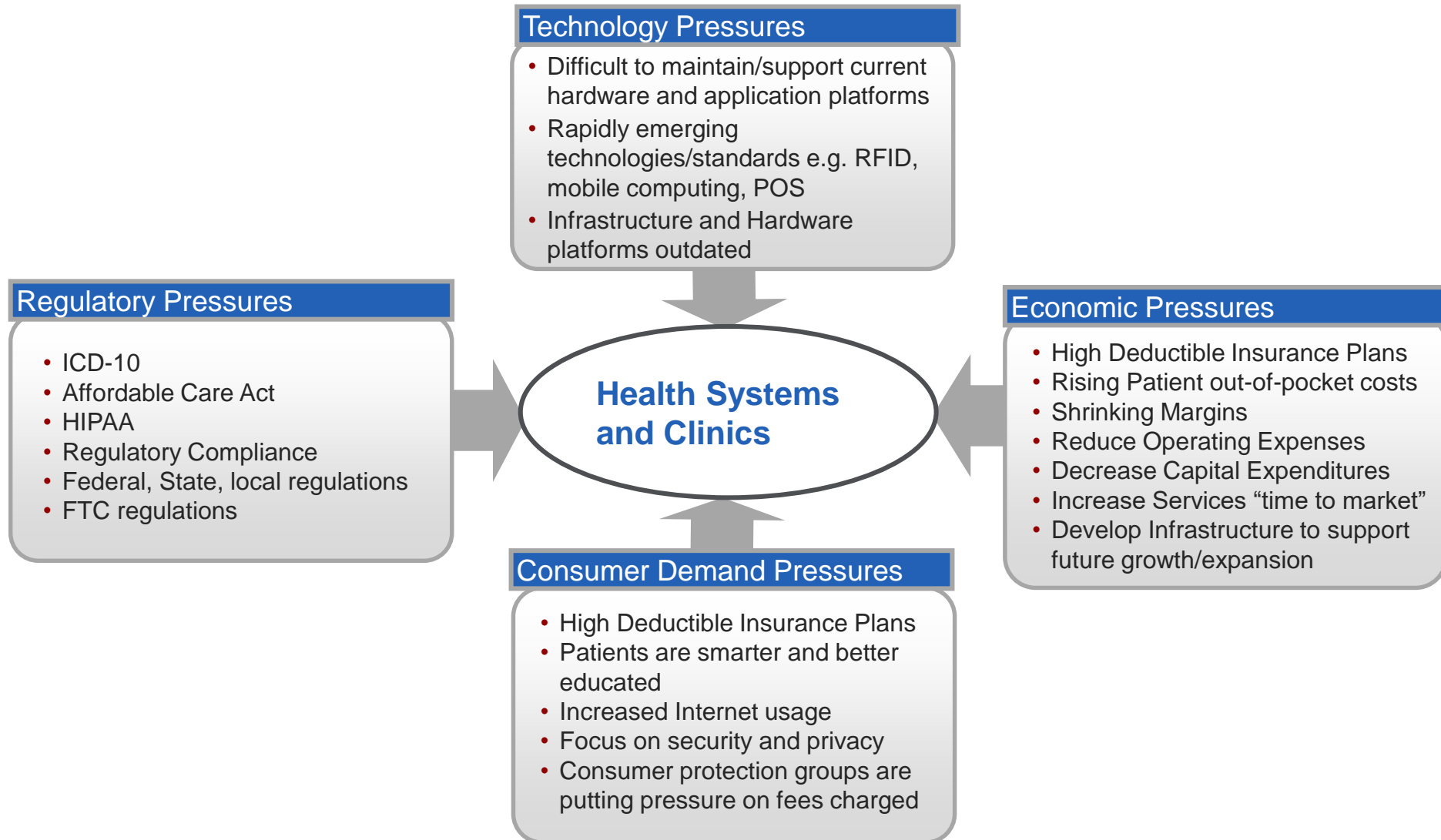


STOP WAITING DAYS GET ANSWERS IN MINUTES

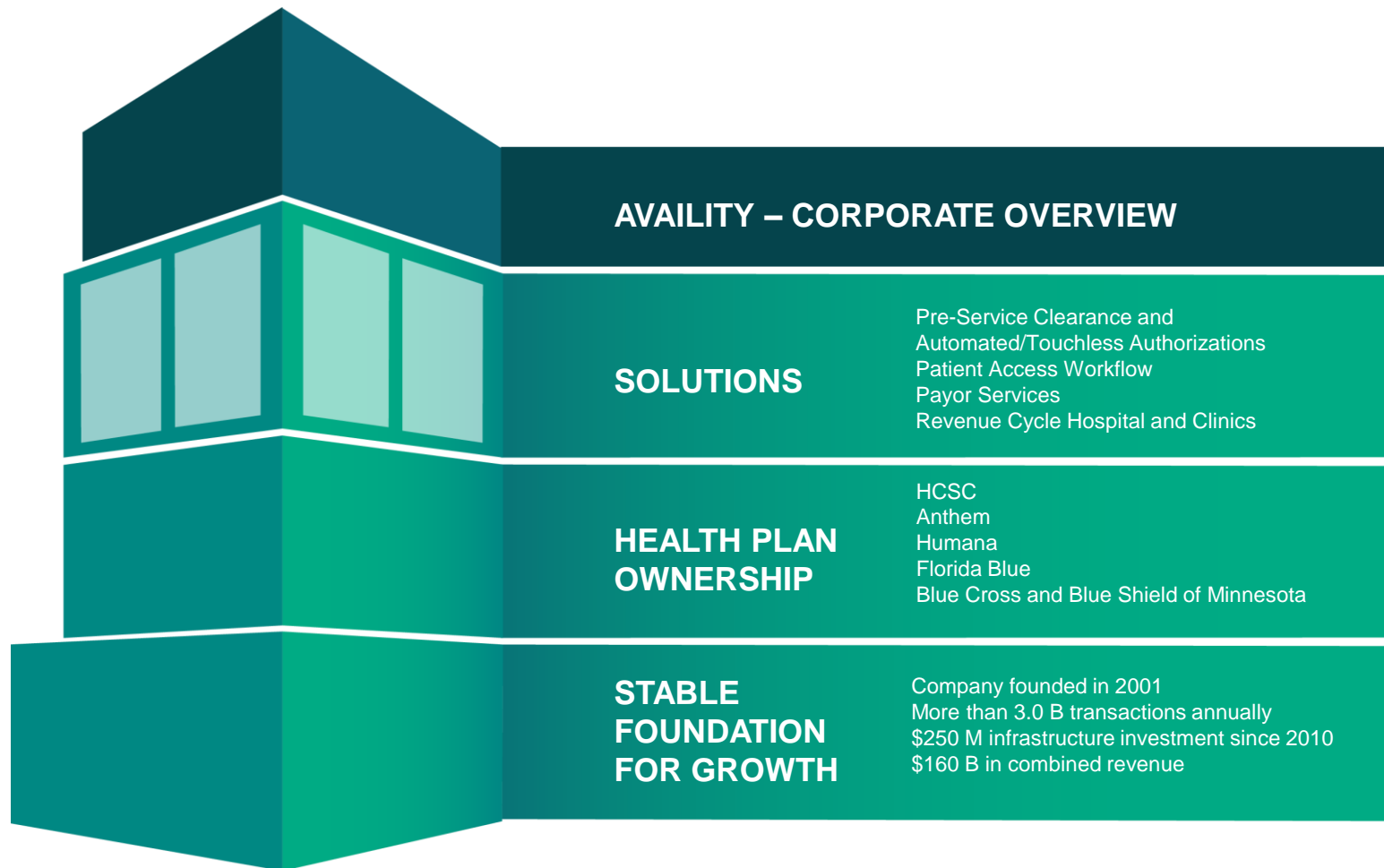
Automation of the pre-authorization process

better information. better insights. better outcomes.


OUR INDUSTRY IS UNDER PRESSURE



FLEXIBILITY TO PROVIDE STRATEGIC SOLUTIONS



INDUSTRY ANALYSIS

 82% of people say price is the most important factor when making a healthcare purchasing decision*

 The costliest 1% of patients in the US consume 20% of the nations healthcare*

 11-20% of Americans think healthcare is affordable*

 Percentage of covered workers enrolled in a plan with a deductible of \$1000 or more is on the rise* (i.e., 46.0%)

 43% of patients in fair or poor health found medical treatment unaffordable**

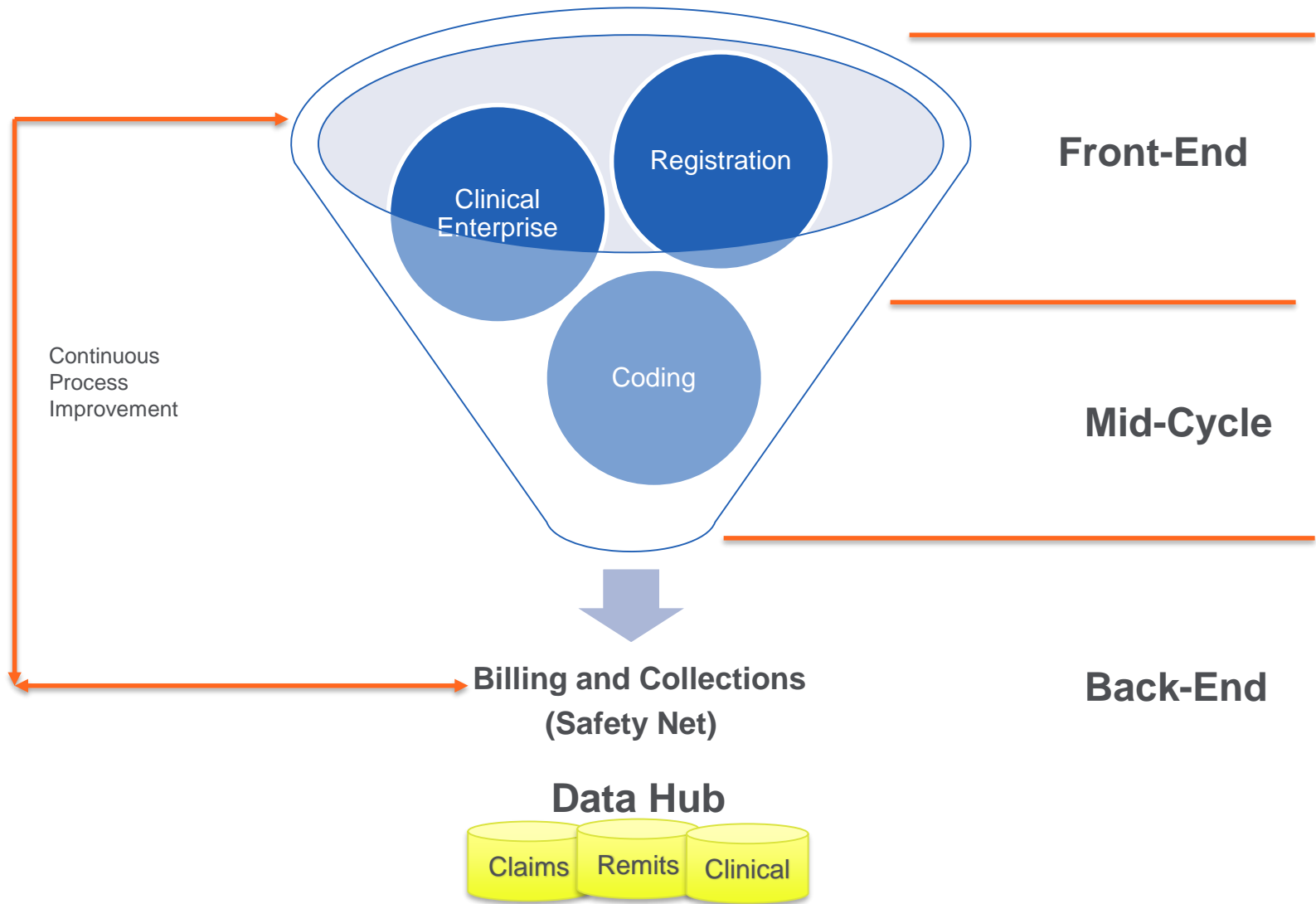
 In 2015 25% of employers are only offering high deductible plans**

Source: *Price Waterhouse Copper HRI Consumer Survey 2014
Source: **Money Matters Billing and Payment For A New Health Economy

REVENUE CYCLE OF THE FUTURE

- **Three Greatest Sources of Revenue Leakage or Lost Yield**
 - **Patient Access**
 - **Guarantor Obligations / Collections**
 - **Denials Management**

REVENUE CYCLE MANAGEMENT



Reallocating processing to the front-end will result in cost reductions and increased yield

OVERARCHING THEMES

- We must simplify the health care consumption experience
- Consumers will pay more for healthcare
- Providers will have to collect payments directly from the patients
- Employer sponsored health insurance will evolve to only high deductible plans with the end game being “defined contribution”
- We must significantly take down the cost structure – not bend the cost curve.



ACA IMPACT

TARGET AREA	2013	2014	2015
Uninsured Rate	41%	17%	13%
Under Insured (Deductible / Co-Pay over \$2,500)	22%	29%	43%
Medicaid Recipient	10%	13%	16%
Healthcare Exchange	NA	6%	9%
Platinum	NA	2%	3%
Gold	NA	17%	13%
Silver	NA	60%	65%
Bronze	NA	21%	19%

Source: [Kaiser Family Foundation](#)



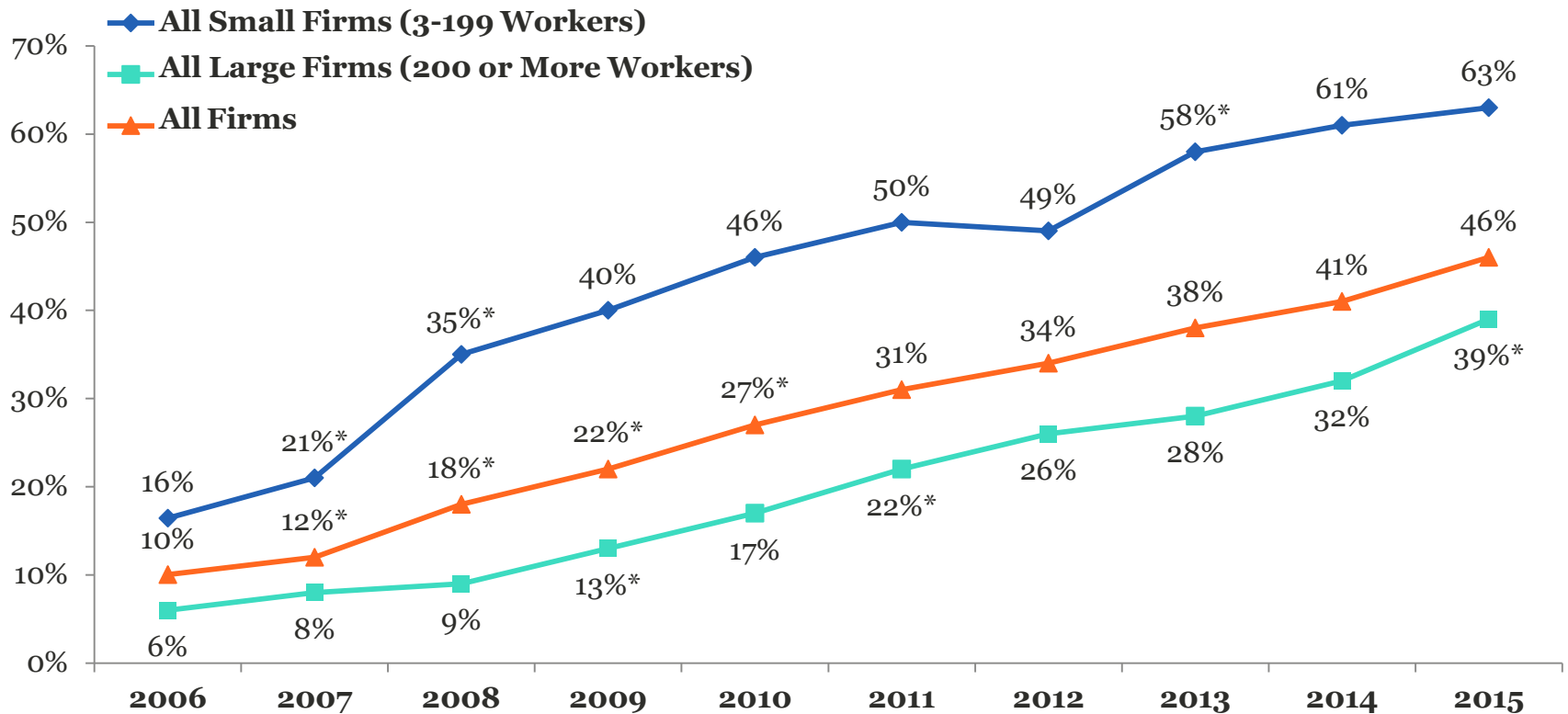
FUTURE STATE OF ACA

Target Area	2016	2017	2018
Uninsured Rate	10%	9%	4%
Under Insured (Deductible / Co-Pay over \$2,500)	43%	49%	52%
Medicaid Recipient	16%	18%	20%
Healthcare Exchange	11%	13%	15%
Platinum	4%	4%	5%
Gold	13%	15%	17%
Silver	67%	69%	70%
Bronze	16%	12%	8%

Source: Kaiser Family Foundation



PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF \$1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

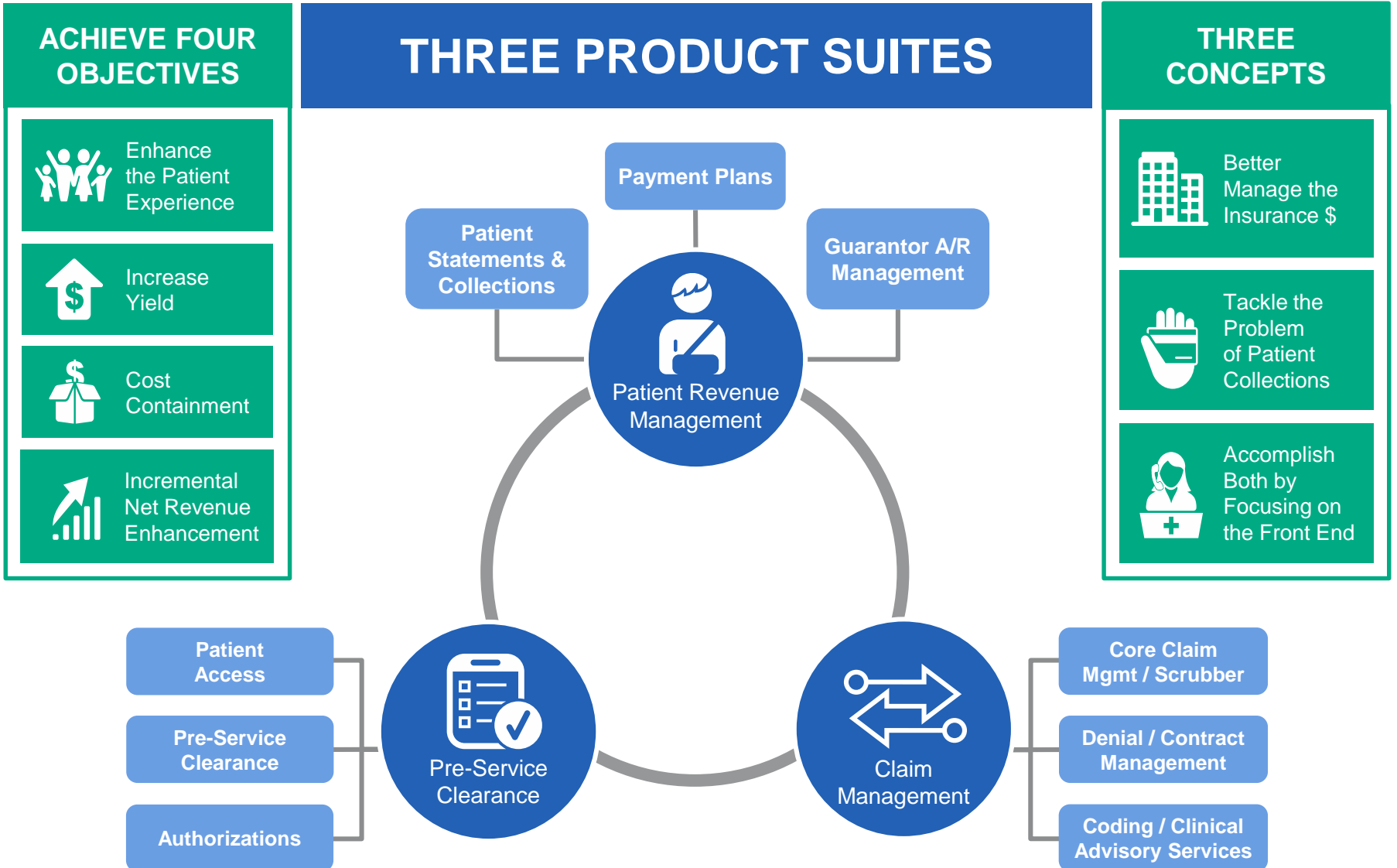
NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs,



HOW MUCH IS TOO MUCH?

- Patients are **unlikely to pay** medical bills that are **greater than 5.0% of household income**, per The Advisory Board
- Median household income in the United States is approximately \$53,000 suggesting that **when out-of-pocket expenses exceed \$2,600** guarantor collections become extremely difficult

PROVIDER STRATEGY: REVENUE OPTIMIZATION



SHIFTING FOCUS TO PRE-SERVICE CLEARANCE

Why it's important...

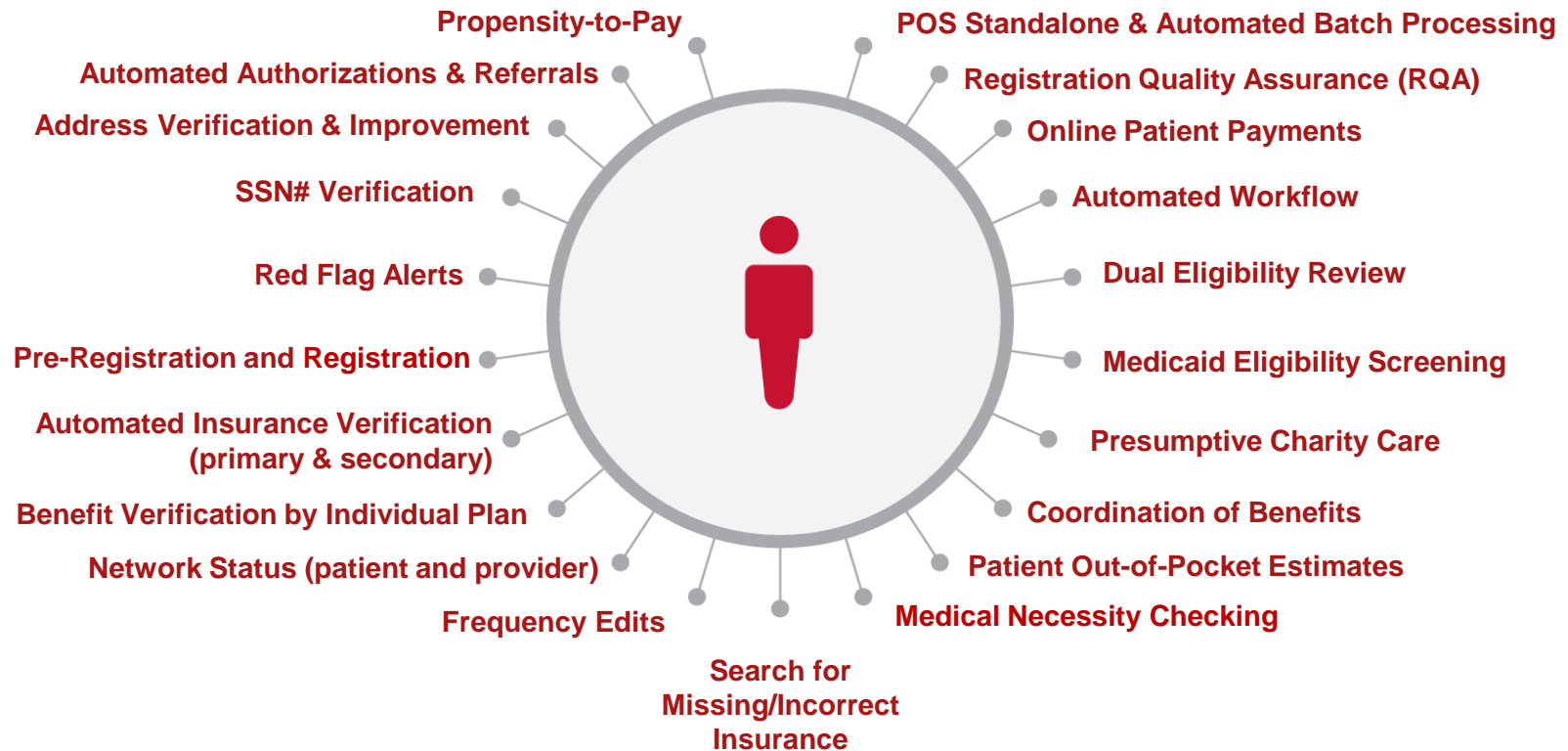
- Roughly 45% of denials are due to patient access issues
- Only 40-60% of post-service patient responsibility is ever collected
- Only 25-30% of self-pay is ever collected after 90 days from service
- Expectation that Pre-Service Clearance programs would increase yield (cash) by approximately 3% to 4% of Net Patient Revenue (NPR)
- Tackles consumerism and patient experience head-on. Separates the patient clinical encounter from the financial clearance process in order for the visit to the provider to be purely clinically related
- Allows for the conversion of the revenue cycle to a “clinically driven, retail model”
- Provides for the horizontal integration of functionality across the revenue cycle, which will improve efficiencies, reduce the number of errors, and streamline the back-end process while enhancing the patient experience
- Provides a mechanism to manage increased volume, due to the evolution of the market to a decentralized ambulatory or outpatient care model



PATIENT SERVICES + CLINICAL REVENUE INTEGRITY + A/R MANAGEMENT

PRE-SERVICE CLEARANCE

PERFORM ALL ADMINISTRATIVE FUNCTIONS PRIOR TO THE PATIENT ENCOUNTER

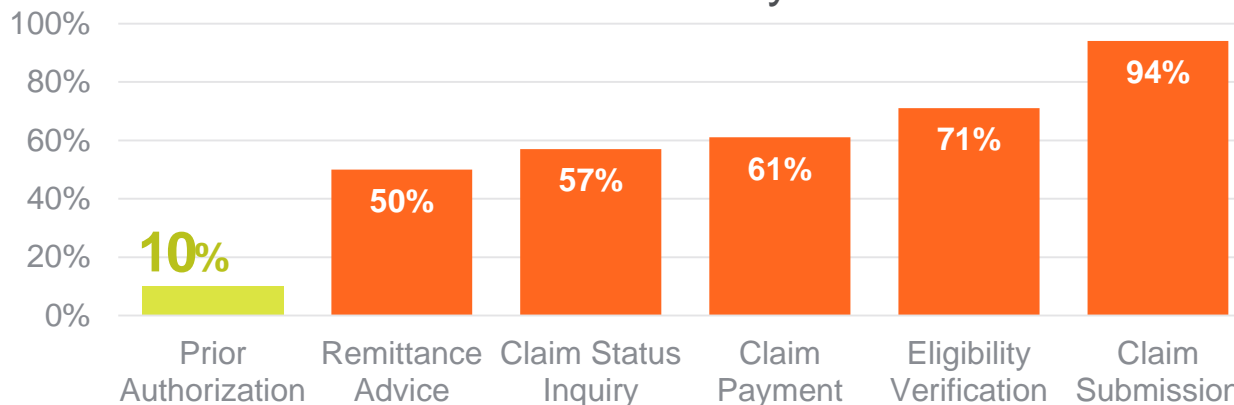




PRE-AUTHORIZATIONS HAVE THE LOWEST RATE OF AUTOMATION

2015 U.S. Healthcare Efficiency Index Report

Percent of transactions conducted electronically



\$8

Billion

Potential industry-wide savings for electronic adoption of these six transactions

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OBTAINING PRE-SERVICE AUTHORIZATIONS IS A HUGE CHALLENGE FOR ALL HEALTH SYSTEMS

- Current state of the Authorizations
 - Utilizes manual processes between payer
 - Staff can only process 15-25 Authorizations per day per representative
 - Team spends 20 to 40 minutes on the phone per Authorization
 - Denials impact lost revenue - higher than appropriate/expected denial rates due to manual processes
 - Missed opportunities for reimbursement on procedures on a regular basis
 - No good mechanism for adjustments to authorizations from changes in services rendered
- Patient and provider dissatisfaction
 - Long wait for required procedure
 - Unexpected Denials from missing or none obtained Authorizations
 - No Authorization needed initially Then Payer “changes their mind”
- Employee dissatisfaction
 - Tedious, time-consuming tasks
 - Unnecessary Denials after all the hard work up front on the phone



THE PROCESS NOW TAKES MINUTES, NOT DAYS

Step 1:

Determine if the authorization is required

Automatically checks for **CPT-specific** eligibility and benefits and determines whether a prior authorization is required. If a prior authorization is not required, it immediately notifies the pre-cert team members.

Delivers CPT specific co-pay information, ensuring accurate point-of-service collections

Medical Necessity Checking

Step 2:

Obtain the Authorization

- Submits the authorization request in real-time.
- If a prior authorization cannot be obtained automatically, Automated Solution helps the pre-cert team members answer clinical questions by automating the remaining steps required to obtain a prior authorization.

Step 3:

Return authorization number

- Continually checks the payer or RBM websites to find out the latest status of the prior authorization.
- As soon as the prior authorization is obtained, returns the prior authorization approval number, valid dates and an archived screen capture of the authorization details that can be integrated into your core HIS solution (Epic, Cerner, McKesson, Meditech, MedHost) via HL7.
- Documentation can be saved and attached to the medical record for audit purposes.



Automated validation of key data fields to ensure accurate Prior Auths

eviCore healthcare

Announcements Home Search/Start Case Case Summary - 38540812

CASE SUMMARY

Thank you for submitting your preauthorization request. The Case has been Approved.

Case/Authorization

Authorization Number: A45872369
Initiated Date: 07/08/2016
Auth Effective Date: 07/08/2016
Auth End Date: 08/20/2016
Authorization Type: Initial
Case Status: Approved

Patient

First Name: PITER
Last Name: PARKER
Address: 56 W MAURYA DR, FISHER RD, MD 21087
Member ID: 105524851
Insurer: CIGNA HEALTHCARE
Program: CWH/CIGNA FI-DC OAP/PPO

Referring Physician

First Name: JAMES
Last Name: QUICK
Address: 4587 OLIWOOD CT ST 112, KITES, MD, 20857429
Phone: 401/885-1458
Fax: 401/885-7896
Specialty: PHYSICAL MEDICINE & REHABILITATION
Tax ID: *****7004

Requested Facility

Name: Demo Location8
Address: 4400 KITES SANDY RD STE 100 KITES, MD, 20857
Phone: 401/260-7894
Fax: 401/260-3214
Equipment: MRI Scan, MRI Open Only
Tax ID: *****5412
NPI: 1954255116

CPT Codes

CPT Code	Units	Description	CPT Status	Cpt Modifier
72146	1	MRI Thoracic Spine, (spinal canal and contents); without contrast material	Approved	

Diagnosis Codes

ICD Code	ICD Version	Description
M96.1	10	Postlaminectomy syndrome, not elsewhere classified

Web Support 800-575-4594
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Screenshot of “Auth not required” stored within AuthPal & sent to client

eviCore healthcare
Innovative solutions

Online Chat Logout

Announcements Home **Search/Start Case**

PATIENT & CASE LOOKUP

Patient Lookup

Insurer:*

Member ID:

or

First Name:

Last Name:

Date of Birth:

*Select the Insurer (and) enter either the Member ID (or) Patient First Name, Last Name and Date of Birth

Case/Auth Lookup

Case ID Auth Number

Patient Search Result(s)

Member ID	Patient Name	Date Of Birth	Gender	Address	Program	Program Effective Date	Pr
U46987451235	SMITH,JUSTIN	07/19/1986	MALE	# 73 86TH STREET NW, Virginia ,20014	CIGNA-NO PA		

PLEASE MAKE SURE YOU ARE SELECTING THE CORRECT PATIENT BY VERIFYING THE PATIENT'S NAME AND DATE OF BIRTH BEFORE STARTING A NEW REQUEST

Patient Detail Information

Member ID:	U46987451235	Gender:	MALE	Program:	CIGNA-NO PA
Name:	SMITH,JUSTIN	Address:	# 73 86TH STREET NW, VIRGINIA ,20014	Program Effective Date:	
Date of Birth:	07/19/1986	Insurer:	CIGNA HEALTHCARE	Program Term Date:	

Patient History - 0 Records found



SOLUTION BENEFITS WITH TOUCHLESS / AUTOMATED PRE-SERVICE AUTHORIZATIONS

- Benefits of Automated Authorizations
 - Automated processes in place for Authorization submission and obtaining approvals – highly efficient
 - Staff productivity increases to the ability to process 90-120 Authorizations per day per representative
 - With the staff able to process 4x authorizations volume, the number of authorization staff can be reduced significantly (if 43 FTEs, should be able to reduce to 13 FTEs) 24-30 FTEs to reallocate
 - Significant reduction in denials
 - Increase in payer payments
 - Eliminate missed opportunities for procedures due to slow authorizations
 - Provides mechanism to produce new Authorizations when there are “changes in service rendered”
 - Controls authorization approvals and proper payment not relying on Physician offices efforts
 - Availity can go-live with manual face sheet entry mode initially, no IT interface required
 - PDF is provided with Authorization approval for long term storage of the approval obtained
 - Availity will pay for side interfaces on behalf of the client when hospital is ready to activate the electronic interfaces to the Authorizations solution for inbound and post-back requirements



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