# Financial Clearance Center

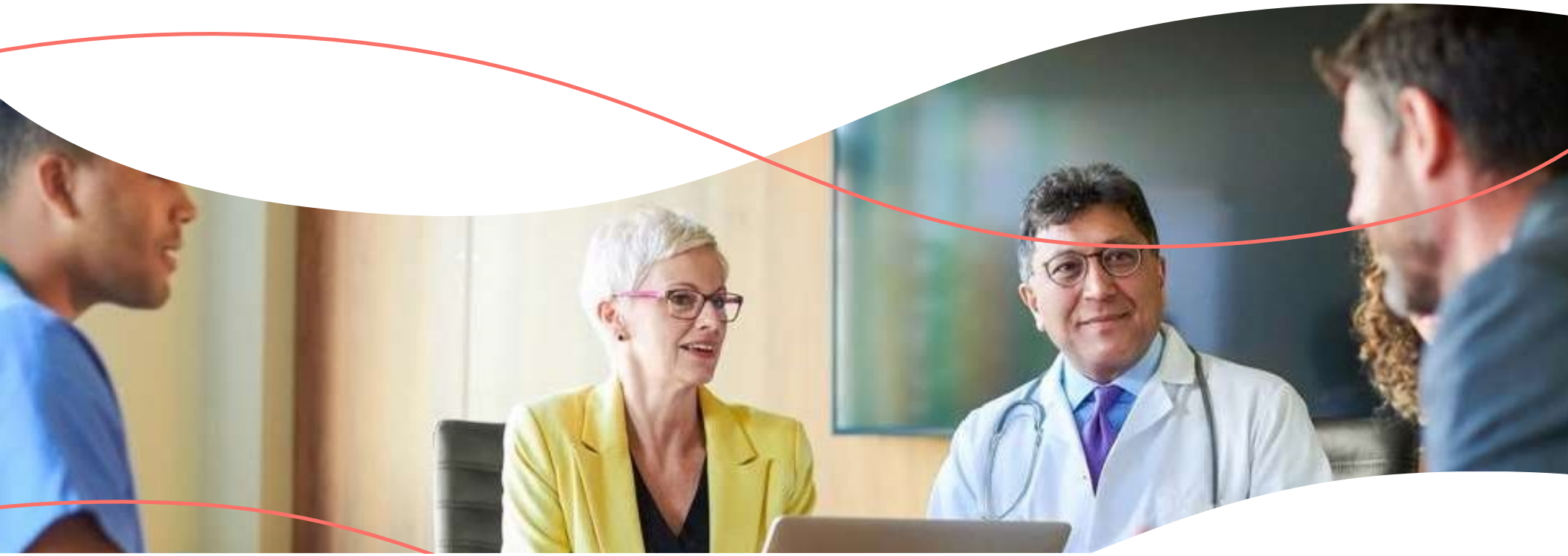
# Agenda

**Key Takeaways:**

1. **Mastering the Essentials**
2. **Overcoming Hurdles**
3. **Collaborative Insights**
4. **Leveraging Outsourcing**
5. **Actionable Tips**

SAVISTA

# Mastering the Essentials



## The Woes of the Financial Clearance Center

**5 phone calls**

**3 faxes**

*and a carrier pigeon deliver the message*

# The Woes of the Financial Clearance Center

**6 weeks** of conservative treatment

Documented **proof it failed**

***and Blood of your Ancestors to support the medical necessity***

# The Woes of the Financial Clearance Center

## When it’s for a knee injection

# The Financial Clearance Center Process Ensures that Patients are Properly Vetted

- Insurance Coverage
- Eligibility
- Financial Responsibility

***All Significantly Impact the Revenue Cycle***

# Core Elements of the FCC

**Insurance Verification & Eligibility Checks**

**Pre-Authorization/ Pre-Certification**

**Denial Prevention & Resolution**

**Patient Payment Collection & Financial Assistance**

**Performance Monitoring & Continuous Improvement**

*I’m sure everyone’s had this moment…*


THE
INSURANCE
HORROR SHOW

# Insurance Verification & Eligibility Checks

**Use real-time automated tools integrated with payer systems** to verify patient insurance coverage instantly at the point of scheduling or registration

**Ensure that eligibility checks are performed prior to patient visits —** ideally during scheduling or patient intake

**This reduces manual errors and speeds up the process**

**This allows enough time to resolve issues before services are provided**

# Pre-Authorization/Pre-Certification

## Submit pre-authorization requests as early as possible

- Ideally **at least 7-10 days** prior to scheduled services
- This **minimizes delays** or potential last-minute denials
- **Check with your payor** specific processing times

## Implement tracking tools for all pre-authorizations

- To **ensure deadlines are met**, follow-ups occur
- The **process is monitored** for any patterns of denials

## Train staff to understand payer-specific guidelines

- For pre-certification to **reduce errors**
- **Improve approval rates**

# Denial Prevention & Resolution

## Identify Common Denial Reasons

**Track and analyze denial trends** to identify common issues:

- ✓ Incorrect coding
- ✓ Missing pre-authorizations
- ✓ Eligibility issues

## Pre-Emptive Checklists

Ensure that all necessary documents and authorizations are in place **before** services are provided

**Proactively address these with preventive measures**

**Reducing errors that lead to denials**

# Patient Payment Collection & Financial Assistance

## Clear and Transparent Pricing

- **Provide patients with clear, upfront cost estimates** based on their verified insurance coverage, including co-pays, deductibles, and coinsurance
- **This improves trust and reduces confusion**

## Collect Payments at the Point of Service

- **Encourage and enable point-of-service payment** through digital payment options (online portals, mobile apps) or payment kiosks
- This can **significantly reduce outstanding balances**

## Financial Assistance Programs

- Establish financial assistance **programs for eligible patients**
- **Should be easy to apply** for and communicated clearly to patients during registration

# Performance Monitoring & Continuous Improvement

## Define Key Performance Indicators (KPIs)

### Establish clear KPIs

- ✓ Quality audit scores for registration error reduction
- ✓ Pre-authorization approval rates
- ✓ Point-of-service collections
- ✓ Denial rates
- ✓ Patient satisfaction to measure the effectiveness of the FCC

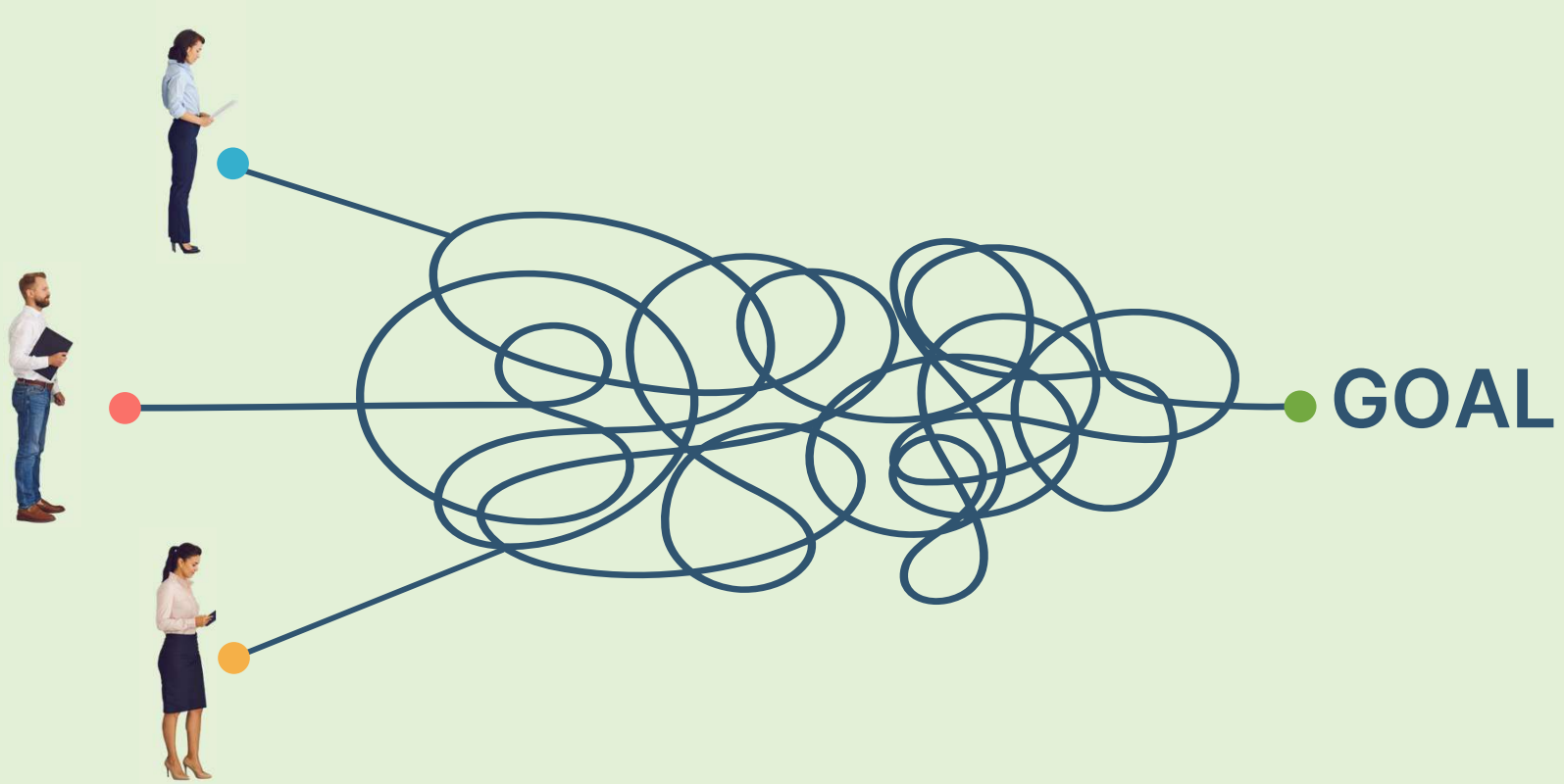
## Regular Staff Reviews and Feedback

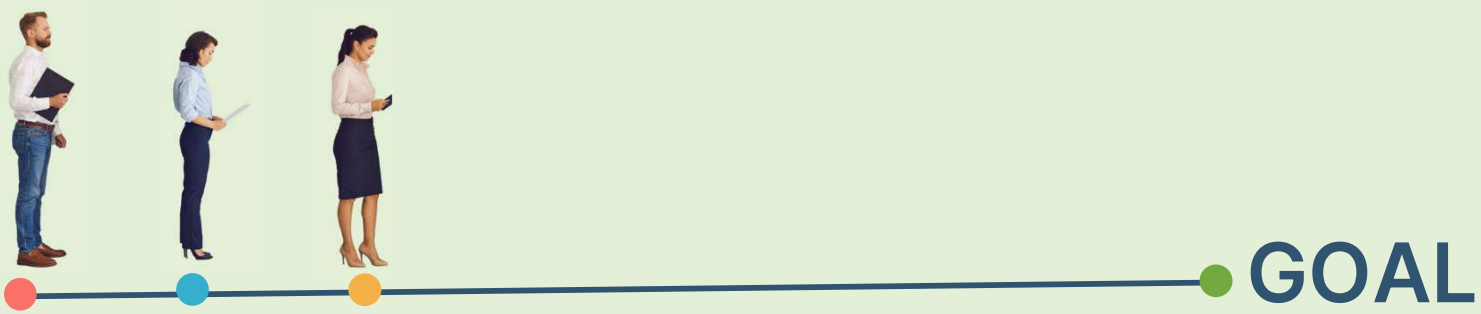
Conduct quarterly FCC performance reviews with staff, gathering feedback on what is working well and where improvements are needed

## Training Program

Establish ongoing training programs to ensure that all team members stay current with industry changes, payer requirements, and best practices in financial clearance

# Overcoming Hurdles


GOAL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# Establish FCC Best Practices

**Foster Cross-department Collaboration** between clinical staff, patient access, billing, coding, and finance departments

Sharing knowledge helps to better anticipate and react to changes in regulations and insurance plans

**Create Regular Feedback Loops** within the teams involved in the financial clearance process to continually refine workflows and adjust practices as regulations evolve

# Cross Department Collaboration

# Establish Strong Communication Channels

## Communication Channels

✓ **Internal**

- Implement regular team huddles to ensure that all are on the same page

✓ **External**

- Foster open communication with insurance providers

✓ **Patient**

- Transparent and clear communication with patients about their financial responsibilities is vital.
- Update patients on any changes in their insurance plans or coverage early in the process

## Utilize Technology for Alerts

- Track regulatory changes
- Receive Insurance updates in real-time
- Alerting your team when shifts occur

# Develop a Robust Insurance Verification & Eligibility Process

## Automated Eligibility Tools

Most health information management systems have an automated verification and eligibility software that allows for **real-time insurance coverage verification**

## Standardized Procedures

**Each FCC colleague** should know how to read a response history and generate estimates for patient to determine their financial obligation

## Pre-Certification/ Pre-Authorization Tracking

**Ensure that you have a system in place to track** which procedures require pre-certification and pre-authorization, especially if regulations evolve

# Collaborative Insights

# Harness the Collective Expertise & Perspectives

### Bring Together Department Leaders

from Patient Access, Finance, IT, Revenue Cycle, and Clinical Operations to collaborate on identifying pain points, opportunities for improvement, and innovative solutions

### Generate Actionable Insights, Prioritize

areas for improvement and develop a shared vision for process optimization

### Keep All Departments Aligned

Sharing quarterly or monthly reports that summarize the performance of the FCC and highlight key insights, bottlenecks, and wins

# Leverage Outsourcing

# Why Should You Leverage Outsourcing Your FCC?

- Cost Savings
- Access to Specialized Expertise
  ***(wink wink, nudge nudge: SAVISTA)***
- Improved Efficiency
- Capacity Management

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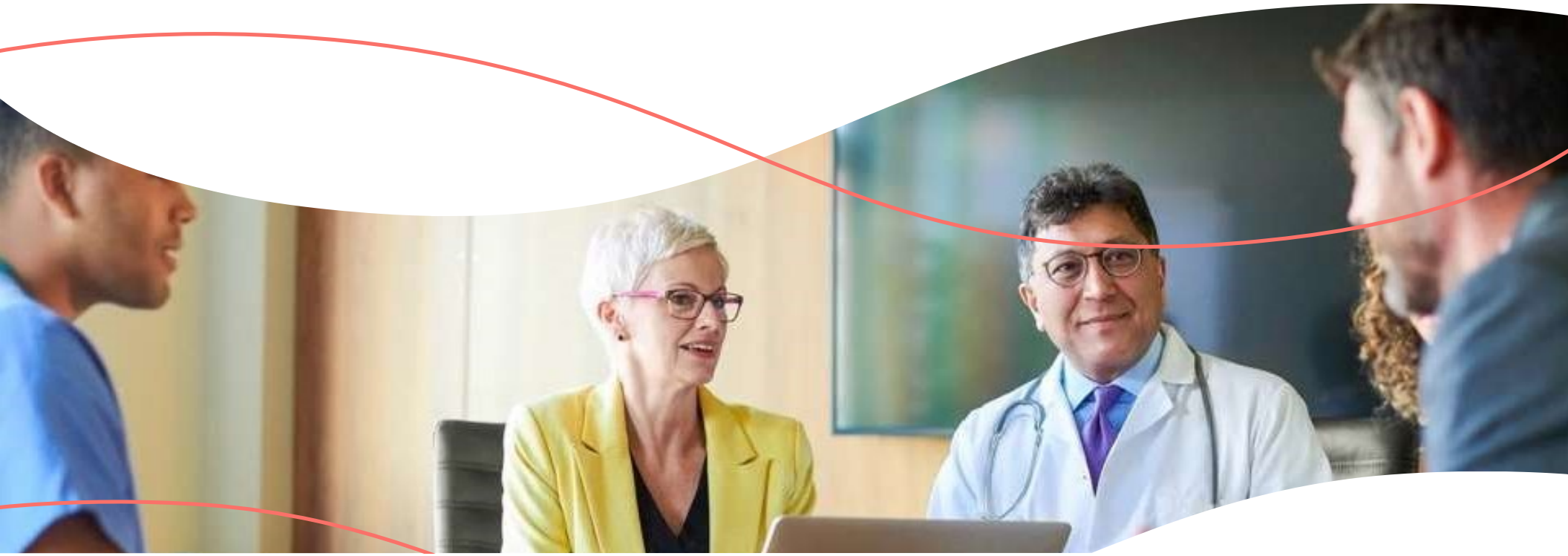
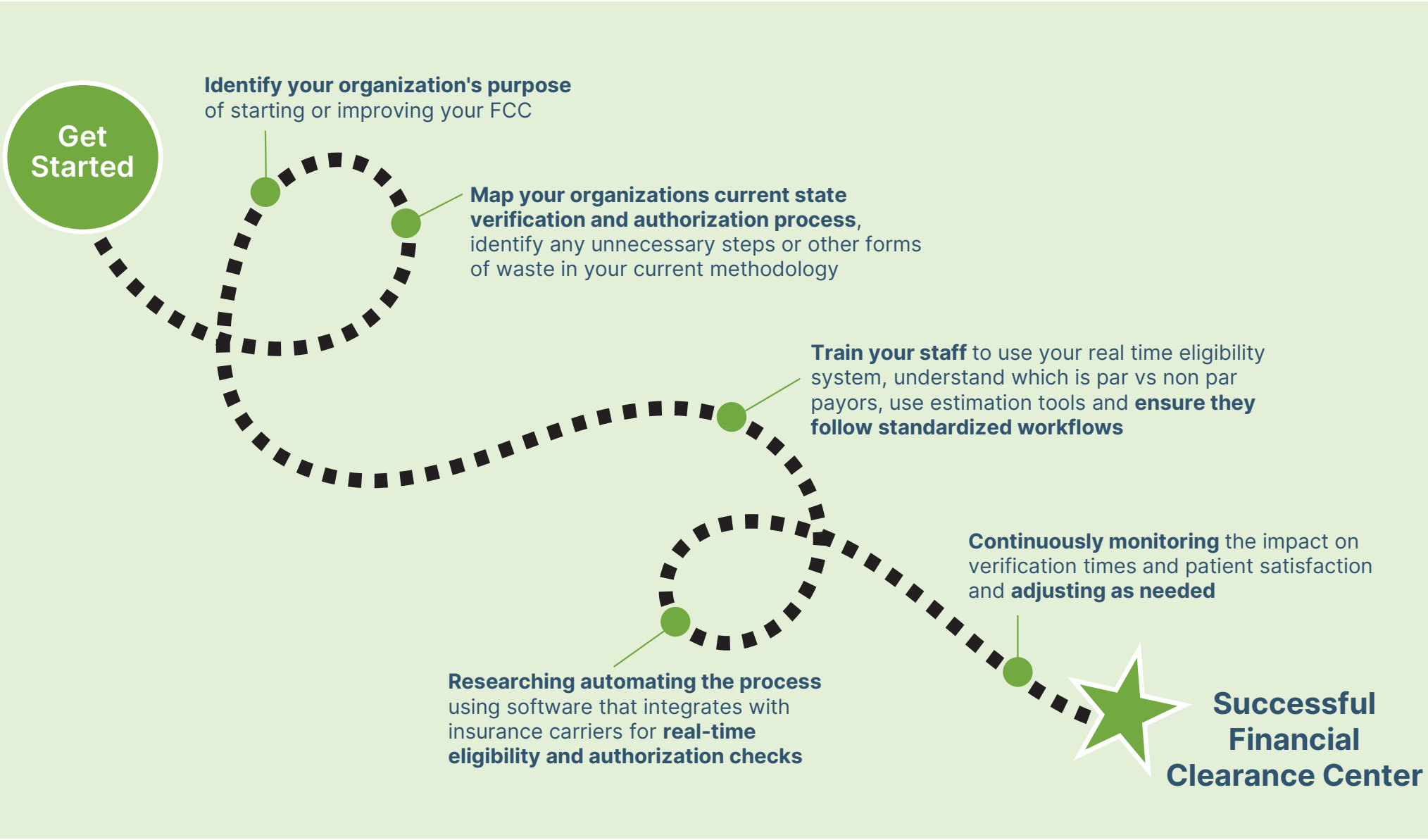
# Actionable Tips




Get Started
Identify your organization's purpose of starting or improving your FCC
Map your organizations current state verification and authorization process, identify any unnecessary steps or other forms of waste in your current methodology
Train your staff to use your real time eligibility system, understand which is par vs non par payors, use estimation tools and ensure they follow standardized workflows
Continuously monitoring the impact on verification times and patient satisfaction and adjusting as needed
Researching automating the process using software that integrates with insurance carriers for real-time eligibility and authorization checks
Successful Financial Clearance Center

# Closing

By incorporating these components, your Financial Clearance Center will help your organization and healthcare providers create a

- **Seamless experience for both patients and administrative**
- **While also improving patient satisfaction, financial outcomes, and operational efficiency**

# Questions

## For more information contact

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# Thank You