RelayHealth | Financial

Provider

Revenue Cycle Management

RelayClearance™ Authorization Helps Optimize Patient Pre-authorization and Medical Necessity Processes

In the face of declining profit margins, providers often struggle with improving revenues and cutting costs while maintaining patient satisfaction. The pre-authorization/medical necessity checking process is one area that has traditionally been inefficient and costly, often consuming significant amounts of staff time, delaying patient care, and complicating medical decisions. RelayHealth has recognized the need to streamline these processes to assist in making them less labor-intensive and costly. The RelayClearance Authorization solution helps manage pre-authorizations for commercial payers and medical necessity for Medicare.

Streamline the Pre-authorization Process

RelayClearance Authorization, helps automate manual processes by determining if a pre-authorization is required and on file with the payer. It electronically monitors payers for pending pre-authorization decisions and updates the HIS/Practice Management system with pre-authorization results. It also provides a consistent workflow for manual intervention of pre-authorization follow-up, helping to ensure these mission critical activities are not missed.

From the beginning, RelayClearance Authorization helps accelerate the authorization process by integrating with your scheduling system. Electronic messages received from the scheduling system kick off the authorization process, allowing your team to know if work is needed even before the account gets to Pre-registration. This saves you time and helps you obtain the pre-authorization before the patient arrives for service.

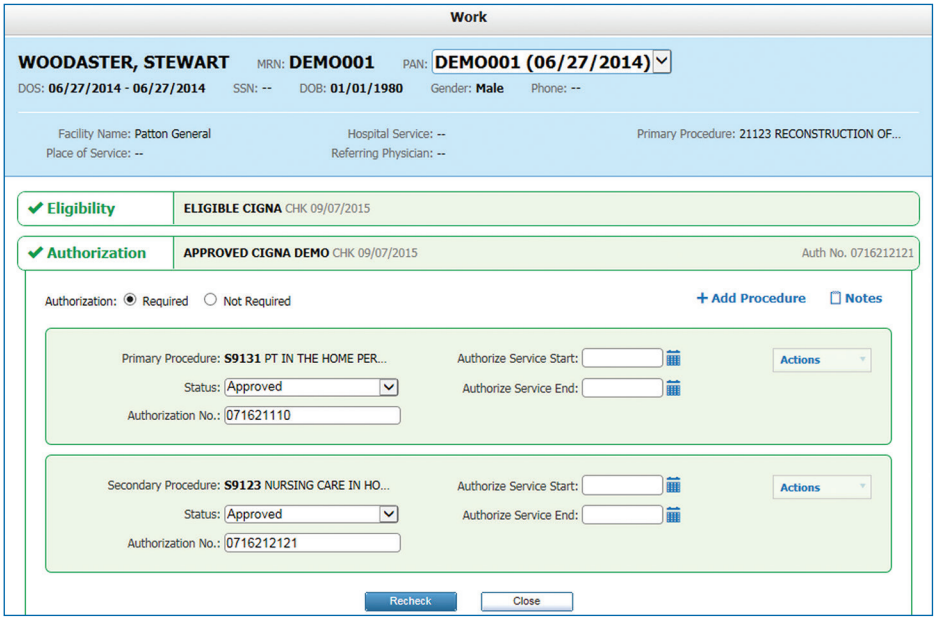
RelayClearance Authorization utilizes multiple payer access strategies to help ensure that all services can be reliably screened and verified for payer pre-authorization requirements. The solution provides automated, proactive account monitoring for pending pre-authorizations and obtains payer pre-authorization decisions, including approval and

Key Functionality:

- Integrates with scheduling systems to kick off authorization processes
- Determines if pre-auth is required
- Monitors payers for pending pre-auth decisions
- Obtains pre-auth results and can post to the HIS
- Identifies accounts needing intervention
- Provides an audit trail to help appeal authorization-related claim denials
- Automates medical necessity checking
- Creates Advance Beneficiary Notice

RelayClearance Authorization Helps:

- Increase administrative efficiency
- Provide consistent workflow
- Reduce risk of denials and bad debt
- Improve patient decision making



authorization number, as soon as they are available. The pre-authorization results can be posted to the HIS where the authorization number is stored.

RelayClearance Authorization also provides easy-to-configure Work Queues to identify accounts that require immediate follow up. Users can then work this exception list, focusing on accounts that need the most attention. Users are also alerted to discrepancies related to procedure codes or service dates so they can proactively work with payers and physicians to resolve issues prior to service.

RelayClearance Authorization also assists with authorization-related claim denials by providing an audit trail so you have documentation for instances when authorization verification was obtained, but the claim is later denied because the payer indicated that a pre-authorization was not obtained. RelayClearance Authorization stores the authorization verification result and date, and provides authorized users with a link to the payer website response at the time of the check to support your authorization decision.

Confirm Medical Necessity and Perform Clinical Code Auditing

RelayClearance Authorization also helps automate Medical Necessity checking as a part of the registration process and performs clinical code auditing for Medicare outpatient services, helping to reduce losses due to Medical Necessity write-offs. The solution allows users to check to see if an Advance Beneficiary Notice (ABN) is required from directly within the financial clearance workflow integrated with the HIS. It also provides the ability to electronically check against Medicare rules in real time when clinical codes are available. In addition, the solution assists you in triggering medical necessity checks for Medicare Advantage plans using plan code-based rules if desired. Easy reporting helps you in finding previously completed medical necessity checks, and you can easily modify a check after it has been completed.

The solution assists you by helping to confirm ongoing compliance with the latest audit rules, and monitors regulatory and policy changes from multiple sources. Regularly updated Local and National Coverage Determination (NCDs and LCDs) content services are also included to help confirm comprehensive Medicare compliance. Lastly, if the projected services are deemed not medically necessary, you can generate an ABN with expected charges for the patient, enabling them to accept liability for procedures that are not covered and documents their decision prior to service delivery.

To learn more, contact a RelayHealth Solutions Advisor at 800.752.4143.

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