The University of Toledo Medical Center (UTMC) will verify insurance eligibility and benefits for patients per scheduled service encounter. Necessary pre-certification will be obtained prior to performing selected elective outpatient services as required by carrier contracts, including but not limited to imaging services. Emergency and STAT medical care will not be delayed due to this process at any time.

To ensure accurate and timely verification of patient benefits in order to obtain proper reimbursement for services rendered; to identify and qualify individuals for financial assistance when appropriate; and to be sure the patient understands their financial responsibility before services are performed.

Retroactive: Used to describe a point in time. For the purposes of this policy this term is used to establish that account notes may not be placed on the account after the date of the work has occurred. In most cases this would be prior to the patient’s date of service.

1. Timely work
   a. Staff must work their assigned schedule daily.
   b. Cases that are added on “today for tomorrow”.
Insurance Verification & Pre-certification

1. Admitting will call ext. 5095 with the information & that case will be worked as a priority.
2. Same day add-ons are within are not in scope for the department.

2. Pre-certification work detail
   a. Staff member must review each account and note Insurance on file
      i. Must cross-reference each patient’s insurance to the Authorization Matrix located on: Z:\PatientAccess\StandUpTracker.
      ii. If requirement is still in question, staff must call the insurance company directly.
   b. Staff member must work to obtain the required pre-cert/auth-referral as needed
      i. Use medical records from Athena and/or clinical portal as needed.
      ii. Work daily until authorized or denied and retain notes: source/dates/time of work.

3. Documentation
   a. Daily work is to be retained in STAR and/or Athena as appropriate on the day is actively worked.
      i. NO retroactive (retro) notes are permitted.
   b. The authorization number needs added in STAR and/or ATHENA as necessary for billing the claim with the necessary information.
      i. STAR → account revision → Approval #
      ii. ATHENA → quickview → Add/view authorizations

4. Cancelling services
   a. If a service is denied the clinic needs notified, the schedulers need notified and the patients need notified.
   b. This needs to be done at least 24 hours prior to scheduled service.
      i. Call & notify the ordering clinic
      ii. Call & notify the scheduling department
      iii. Call & notify the patient
   c. Place the patient on the Issues tracker located: Z:\PatientAccess\StandUpTracker
   d. Email @ end of day notifying of all cancellations:
      i. Pre-cert Manager and Patient Access Director

5. Peer-to-Peer
   a. The clinic needs notified at least 2 days prior to the scheduled date of service.
      i. Reference Athena notes to verify that a peer to peer has not yet occurred.
   b. Notify the schedulers of this information.
   c. Note the account with this information.

6. End of Day
   a. Record your days out on the days out tracker located on:
      Z:\PatientAccess\StandUpTracker.
b. Place paper copies of approvals and denials with their MRN and account number in the authorization bin to get scanned into HPF.

(F) Service Specific Differences
1. Guidelines for prior-authorization and pre-certifications are established by individual insurance companies and generalized within contracts with UTMC. The guidelines are laid out by service types and change/add/delete throughout the calendar year. For this reason, there are exceptions to the above policy and procedure that are established within the department in Standard Operating Procedures and Check Lists. The major service types are listed below. This list is not all inclusive.

   a. Surgery (Inpatient and Outpatient)
   b. Outpatient Medical
   c. Radiology
   d. Other Outpatient Diagnostics
   e. Other Outpatient Procedures

(G) Financial Counseling
1. The Financial Counselors will be notified of patients without insurance coverage and patients with liabilities greater than $5,000.
2. The Financial Counselor will make every effort to secure financial assistance for patients unable to pay following UTMC’s Patient Financial Assistance Policy.¹
3. Except for medical emergencies, services will be delayed or denied unless the patient arranges a payment plan, including a payment at time of service, with the Financial Counselor, or qualifies for Medicaid, the Hospital Care Assurance Program or another assistance plan.
4. A patient’s Physician may override the decision to delay or deny care.

(H) Out of Network
1. Patients who are insured by insurance carriers not contracted with UTMC will
   a. Have their in and out of network benefits verified
   b. Will be counselled on the two benefit levels and their estimated out of network costs
   c. Will be required to pay their out of network amount prior to service
   d. Will be delayed/denied until payment made and will be encouraged to schedule services at their network provider

¹ Patient Financial Assistance Policy 3364-142-13
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<th>Approved by:</th>
<th>Initial effective date:</th>
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<tr>
<td>Robin Horani</td>
<td>6/3/2009</td>
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<tr>
<td>Administrative Director, Revenue Cycle</td>
<td>Review/Revision Date:</td>
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<td>10/1/2012</td>
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<tr>
<td>Nickolas Vitale</td>
<td>Next review date:</td>
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<tr>
<td>Interim Chief Financial Officer - UTMC</td>
<td>5/1/2019</td>
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Review/Revision Completed by:

Policies Superseded by This Policy: None