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Optometry Coding & Billing Alert

Billing: Step Up Your Benefits Verification for the New Year

Don't leave eligibility checks to the last minute or you'll face non-payment.

With the new year right around the corner, now is the time to shore up your benefits verification process to ensure patient coverage changes don't wreak havoc on your practice's bottom line. If you aren't checking insurance plans and ID cards, your practice may submit claims for uncovered services that will leave you chasing patients for payment.

While verification of patient benefits is good practice all year long, January is the time when you'll see more insurance changes, including payer, benefit, and deductible/copay changes, than at any other time during the year because most employers hold open enrollment in December.

Review the experts' tips on benefits verification so you can get ahead of the game and avoid costly billing errors in early 2015.

Start Verifying Early

Verify a patient's benefits as soon as possible. You really have four options for when your practice will perform the eligibility check:

1. Before the patient comes in
2. At check-in
3. While the patient is with the physician
4. After the appointment.

Many practices agree that option 1 is the best approach. Finding out about insurance changes before the patient's appointment gives you time to check if you are a participating provider with the payer and verify coverage. That way, you can be sure the services will be covered and you can check for any other coverage issues, such as whether any special procedures can be done in your office or if you need to send the patient to other practices (for example, ultrasound in an obstetrics practice). You can figure out the patient's copay and/or deductible that you should be collecting when the patient comes in as well.

"It's absolutely a must to verify insurance coverage, deductibles, if deductibles have been met, and copays before patient is seen, or comes to the office," says **Catherine Brink, BS, CMM, CPC, CMSCS**, president of Healthcare Resource Management Inc. in Spring Lake, N.J.

The problem with waiting until the patient is in your office to check her benefits or waiting until after the physician performs the service is that you may find the patient really doesn't have the coverage she thinks she has and that the services your physician is rendering are not covered for your office. That's when your denials rate will start to rise.

Warning: Make sure you ask the eligibility date. This is an important question to ask the payer because many employers don't make health insurance coverage immediately available to new workers. A patient with a new job and new insurance coverage may be in your office for a visit today, but his insurance isn't effective for two months.

Develop a Verification Process

If you set up a solid, streamlined process, insurance verification will become second nature. Depending on the payer, you may need to call the insurance company or go online to the company's website to verify patient benefits. If available, using an online benefits verification service that provides the copayment, up-to-date deductible totals, and other benefits information is often easiest and least time consuming for practices.

Work faster: Take advantage of payer websites to make insurance verification less time-consuming. Find out whether payers you deal with have verification websites, and sign up for them. Some clearinghouses also offer verification services.

"Practices that accept insurance for most of the major payers usually have one or two staff personnel who verify insurance coverage and may also get authorization from payers for procedures," Brink explains. "If that is the case, then these personnel should have developed a spread sheet or form to fill out about patient insurance coverage before they are seen by the provider."

Tip: If another physician referred the patient to you, try calling the referring doctor to see if he has the insurance information on file. If he does not, contact the insurance company directly, and as a last resort go to the patient.

Good advice: If your software won't allow easy checks and your practice can't spare the resources to check every patient's insurance, verify eligibility of new patients and surgical cases at a minimum, experts advise.

Confirm Your Findings

Although verifying coverage in advance is preferable, many practices have patients confirm their insurance coverage and note any changes when they check in for their appointments.

If you are unable to verify the insurance coverage, or you find that the patient is not eligible for coverage on the day of the visit, inform the patient of the problem and ask if he wants to reschedule the appointment (unless it's an emergency visit). Otherwise, explain to the patient that the visit and services may not be covered, and that he must pay the bill himself.

"If a patient is not covered by insurance or ineligible on the day of the visit, then absolutely tell the patient he is not covered by insurance and advise patient to reschedule," Brink says. The patient can then check with his insurance to see if there is a problem, rectify the problem, and then reschedule, or the patient can keep the appointment and self pay "which most patients will not do," she adds.

Important: Have the patient sign a waiver stating that the services rendered that day may not be covered by the new insurance, and that he is financially responsible. Keep the signed waiver in the patient record.

Watch Out for Card Expirations

Most payers will send a subscriber a new insurance card at the start of a new year. Beware of patients showing you an old card that may have older, and incorrect, benefits details such as the wrong copay amount.

Even if the patient's insurance hasn't changed, sometimes the copays, the terms, and the precertification phone number can change. Therefore, it's important to get a copy of that insurance card at every visit or at least compare the card to your copy of the card and ensure that nothing has changed.

Tip: If the patient doesn't yet have an identification number with her new insurance company, ask for the name of the insurer and the policy number from the patient, or from the patient's employer. Then, call the insurer and verify the coverage and the date of eligibility, and get the appropriate information to identify the patient on your claim.

Example: A patient comes into your office. The physician performs an exam, and then the patient checks out at the front desk. Because the patient states that she has the same insurance as she had at her last visit, you collect a copay of $15, which was the copay of record.

Problem: You process the claim and find out the patient still has insurance with the same payer, but her employer has changed the terms of the insurance and the patient now has a $40 copay. To collect full payment, you now need to send the patient a bill for $25 and hope she pays it. The cost of billing the $25 copayment is quite high, and, if this happens with multiple patients, you're racking up costs that could have been avoided if your office had verified insurance before their visits and if you had gotten copies of their current insurance cards.

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