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Optometry Coding & Billing Alert

Is Lack of Verification Costing Your Practice? Stop the Bleeding

Implement an eligibility check before the patient comes into your office

Verifying insurance coverage and benefits eligibility consumes precious time and resources in a practice. When a third-party payer keeps your staff on hold for inordinate amounts of time, you may start wondering whether you should take time to verify at all. But if you don't check and confirm each patient's insurance coverage, you could be costing the practice much more time and money on the back end from denied claims and lost copayments.

By checking a patient's insurance eligibility, you prevent not only claim denials but also payment delays that arise when patient insurance information doesn't match up with the carrier-s.

Don't worry: If you set up a solid, streamlined process, insurance verification will become second nature.

Step 1: Verify As Soon As Possible

The first question about insurance verification that many practices wrestle with is when they should perform the eligibility check -- before the patient comes in, at check-in, while the patient is with the physician, or after the appointment.

Best bet: "In an ideal world, it should happen before the patient is treated," says **Laura Colbert Carbonaro**, director of central billing operations for a practice in Tarrytown, N.Y. "There is no need to -verify- eligibility after the services are rendered and the patient has left the office. Your options to collect payment are already diminished. At that point, why waste time calling to find out whether or not your gamble paid off?"

Bonus: "If you verify it before the patient walks through the door, you can be sure you have the correct information and the copayment," says **Brenda L. Smock**, billing/coding specialist for Allendale Family Practice in Allendale, Mich. You can also confirm any other special 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.

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 does and that the services your physician is rendering are not covered for your office. And the patient may not bring the money to pay for the service and you have not prewarned the patient that she will have to pay for noncovered services, making collection at time of service difficult.

Step 2: Figure Out How You-ll Verify

A patient's insurance company name and ID number may be all you need to verify coverage. First, call the patient to get that information before her visit or ask for it when she makes the appointment. Then, verify the information by calling carriers directly.

"See if your software can run eligibility checks against the appointment schedule," Colbert Carbonaro says. This eliminates the painfully long phone calls made to the third-party insurance carriers.

Take advantage of carrier Web sites to make insurance verification less time-consuming. Find out which carriers you deal with have verification Web sites and sign up for them. There are also some clearinghouses that offer eligibility information as well.

Step 3: Copy the Card Every Time

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Even if the patient's insurance hasn't changed, sometimes the copayments, 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 verify that nothing has changed.

"Some people hand you cards that are not active and then you have a heck of a time getting new information or money from them," Smock says. "I can sometimes find their new coverage depending on the insurance, but it is a lot of work sometimes."

Don't miss: Date the copy of the card and shred any previous copies so that there is only one card the claims specialist has to refer to.

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