Part B Insider (Multispecialty) Coding Alert

Reader Question: Set Up A Benefits Eligibility Verification Plan

The best time to confirm a patient's eligibility is before she walks into your practice.

Question: I've heard that verifying a patient's benefits before our doctors even see the patient can help cut down on our denials and reduce our need for aggressive collection efforts. When should we verify the benefits?

Answer: Verify as soon as possible. You really have four options for when your practice will perform the eligibility check:

- before the patient comes in
- at check-in
- while the patient is with the physician
- after the appointment.

Best bet: In an ideal world, verification should happen before the patient is treated. You wouldn't need to verify eligibility after you render the services and the patient leaves the office. By that point your options to collect payment are already diminished. Why waste time checking to find out whether or not you'll actually get paid at that point; it's too late.

That's why experts recommend that you verify benefits and eligibility before the patient even walks through the door.

Therefore, 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.

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.