Internal Medicine Coding Alert

Compliance: Insurance Verification Is Key To Capture Hundreds of Lost Dollars

Double check to ensure patient's insurance info is valid before first visit.

When you are getting new patients to your practice, you need to verify their insurance quickly. Failure to do so could lead you to many risks to your practice that could range from effects to your patient relations to losses to your practice.

When it comes to avoidable cash flow problems, poor insurance verification is "the single most deadly income killer to practices," says **Cyndee Weston, CPC, CMC, CMRS**, executive director of the American Medical Billing Association (AMBA) in Davis, Ok. "Failing to verify benefits causes practices to lose otherwise collectable insurance dollars."

Help's here: We asked the experts for some advice on insurance verification best practices. Take this knowledge to heart, and you'll be on your way to minimizing the risk that there's an insurance snafu with a patient.

Verify Info Well Before the Initial Visit

According to **Alice Scott**, co-founder of Solutions Medical Billing in Rome, N.Y., your practice should make every effort to verify insurance information before the patient reports to the practice for her first visit.

Consequences: If the practice doesn't verify the patient's insurance ahead of time, the practice could suffer:

- Lost revenue
- Lost work time
- Damage to patient relations
- Trouble with the payer
- Payment delay
- Potential nonpayment for services.

And all those problems can add up to big losses for the practice, experts caution.

"It is a task that can be time-consuming, but not doing it often results in practices writing off charges," warns Weston.

If you cannot verify the full insurance picture pre-visit because you lack certain data, get any missing information from the patient when she arrives for the first time, Scott continues.

Tip: Place a single staffer in charge of verifying patient insurance. This individual must understand the process of verifying insurance, and have enough extra time to take on the task.

Who performs this task is not necessarily important, Scott says. It could be anyone "from the receptionist to the office manager," as long as she can perform the job, Scott explains.

Focus on These Areas When Collecting Patient Info

When the practice is getting information from the patient, be sure to get the patient's:

- Name
- Birth date
- Insurance carrier
- Patient ID number
- Group plan number

- Contact information for the insurance company
- Date patient's plan is effective
- Name of policy holder (if it is different from the patient's).

Try this: Getting a copy of the patient's insurance card "is ideal then you know where to call, and you have all the pertinent data in front of you," Weston recommends.

Follow Up With Payer to Make Final Verification

Once you get all of the patient's pertinent insurance information, you need to vet the data with the payer.

According to Scott, when the practice rep contacts the payer, she should first check all the information that the patient provided. Then, she should ask the payer these follow-up questions to drill down into the patient's pertinent data:

- Is your practice in-network or out-of-network with the patient's plan?
- If the practice is out-of-network, are there out-of-network benefits?
- Does the patient have a copayment? If so, what is it?
- Does the patient have co-insurance?
- If so, what are the details of the co-insurance?
- What is the effective date for the patient's plan?

"Also, don't forget to ask about the patient's deductible status," suggests industry experts. "Many patients are now enrolled in high-deductible health plans with annual deductibles reaching into the thousands of dollars. As long as the deductible is unmet, the patient is usually responsible for the full allowed amount, unless the service is deemed preventive. Knowing what the patient's annual deductible is and how much of it he or she has met at the time of service is useful information," he adds.

Remember that issues like copayments, co-insurance and deductible must be vetted thoroughly to avoid any confusion with the patient. For example, there might be different copays for different types of services and providers. Weston says that her personal insurance copay is $20 for many services. "But if I go to, say, a podiatrist, the copay is $50. Or, if I go to the ER, I have a $400 deductible," she explains. "However, if I am admitted, the copay is waived down to $200."

Much like copayments, checking about secondary coverage is vital to spot-on verification even if the patient reports that she doesn't have secondary coverage. Some patients might have secondary insurance that even they don't know about, relays Weston. A quick check with the payer on any other insurance the patient might have can save you future trouble, Weston says.