

Insurance Verification - The Important First Step

The majority of problems associated with insurance reimbursement can be avoided with correct and accurate verification of coverage. While it is possible to verify some medical benefits via fax or internet, for particular types of benefits, such as acupuncture, chiropractic, podiatry etc, a phone call, (or two) Should be made to insurance correct coverage information is given. The following are tips when making that call.

1) If possible, try and have your providers give you both the patient's insurance ID AND the social security number of the insured as well (this may be the husband, wife, mother, father etc.). While it is commonly thought that the benefit information can only be accessed through the insurance ID, most carriers also have the insured's social security number in place. For various reasons, carriers often issue new IDs for patients with or without the patient's knowledge. Often times, this change in ID can take place weeks or months before a new card is issued. Conversely, some patients continue to carry around outdated cards, despite receiving a new one, with the rationale that there is "no change" in coverage. While it would be nice if carriers accessed old as well as current IDs, typically, this isn't the case. However, if you have the insured's social security number, you can receive benefits despite having an incorrect ID.

2) Confirm that you are quoted correct network benefits. Most errors occur when out-of-network providers are quoted in-network rates. Out-of-network benefits are always quoted in percentages. If you are out-of-network and the rep quotes a co-pay, stop and confirm that indeed you are getting the out-of-network benefits. This holds true with the deductible. While in-network benefits sometimes have no deductible, almost all out-of-network benefits are subject to a deductible.

3) Find out if the plan is true insurance, or if the carrier is acting as an administrator for a "self-insured" plan. Close to 70% of health benefits are not true insurance plans, but rather self-insured plans handled by an insurance company, (or TPA). It is most common for mistakes to occur when quoting benefits for self-insured plans. The companies that fund these plans have the ability to write their own benefit package - they can add certain coverage that the policy sold by the carrier may not cover. Reps are familiar with the carrier's policies and may have the official insurance carrier bulletin to read from. When quoting a self-insured plan the rep must find the employer's policy from the many they administer. Some don't take the time; they assume benefits are the same across the board. Fortunately, there are procedures in place should you receive incorrect information.

But, you need to know just what kind of plan you are dealing with. True Insurance plans are monitored by the State Department of Insurance, and while they will handle insurance complaints, they will not get involved with problems associated with self-insured plans. These problems must be handled with a different course of action. Problems concerning self-insured plans are handled using an internal appeal process that all self-insured plans must have in place. (In another article we will address the exact course of action for a success appeal.)

4) Always get the name of the person with whom you spoke--some can also give you their company personal identification number. Most important: get a reference number associated with the phone call. Never count on the disclaimer that the call is being recorded. Experience has shown that the carrier will find documentation of a call, only when it supports *their* position. The information is there, they just won't acknowledge it. Appeals are won when you have the name of the person you spoke to, the information given, and the reference number for the call.

5) Find out the filing time for a claim. All carriers are cutting down on the time allowed to file claims. Many in-network claims must be filed within 90 days, or they will not be accepted.

6) Finally, ask about diagnosis restrictions. Certain carriers, Aetna and Cigna among them, have very specific diagnosis' they will cover for certain treatment or procedures. Be ready to quote the diagnosis, as well as the actual ICD-9 code that will be used on the claim. Typically, carriers will not volunteer

information about diagnosis restrictions. This is where many billers fall short. They confirm that the patient has the coverage, yet never take the time to ask if there are limitations or exclusions involving diagnosis. The reps don't offer this information, so the office assumes broad coverage. When in actuality, there IS coverage, but it is limited to very specific diagnoses. Sometimes carriers will not release this information to a practitioner, or a billing service, but they must provide it to the patient. If there is an indication that the patient's diagnosis may not be covered, have the doctor's office get the patient involved. This is where a proactive patient can get results that we can't.

Unfortunately, there are no short cuts when verifying insurance benefits. Most offices don't like to hear this, but if you feel that you are quoted incorrect benefits, if the rep seems unfamiliar with the benefits Requested or changes his mind while giving you information, you must call back and speak to someone else. If you are then quoted the same information, you can be fairly certain you have the right information. Taking the necessary time in the beginning can get a claim paid sooner rather than later or not at all.