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Insurance Verification: Good for the Doctor, Good for the Patient

By Samuel A. Collins

Q: I have, on many occasions, not been completely aware of what my patient's insurance specifically covered, and to the patient's and my astonishment, a very large balance was left due. Do you have a checklist or format my staff and I could use that would allow us to verify insurance coverage?

A: Verification of coverage is a very important step in processing an insurance patient. As you have noted, if not done thoroughly, it can be detrimental to the patient and, ultimately, to the doctor's office. Insurance verification still is best done over the phone, as it allows greater inquiry as to the specifics of coverage. Under the guidance of HIPAA regulations, insurance verification can be done electronically (online); however, although this resource is fast, it only gives very basic and limited information of the policy, while phone inquiries offer much more latitude and specificity of questions.

Documented and properly done insurance verifications protect the patient (consumer) and the doctor from carriers that disseminate incorrect information. All states have laws that prohibit insurance carriers from giving false, misleading or inaccurate information. For instance, if an insurance company gives incorrect information about specific plan coverage and then some time later, indicates that service it reported as covered is not, the carrier will be obligated to cover those services up to the point that the correct information is given. In other words, the insurance company will be liable to pay for the services from the time it first acknowledged the coverage to the time it provided the correct information, which often can be weeks and amount to hundreds of dollars.

These laws are in place for consumer protection, as patients make decisions about their health care based, in part, on their out-of-pocket liability and specific insurance coverage. A patient who decides to seek care with the assumption that the bulk of the cost is covered under insurance and then later is told the coverage is

far less, has been induced by the insurance company to seek care they might not have otherwise sought. This style of inducement is strictly prohibited by state laws and will be enforced by the insurance commissioner to the carrier for liability of the claim. However, the proof of inducement is predicated upon proper insurance verification and proof the carrier actually did misinform.

Therefore, it's very important to follow a consistent protocol and procedure of insurance verification and be sure all the pertinent questions are asked and answered completely. The specific order of questions should be as follows:

1. Is there acupuncture coverage when performed by a licensed acupuncturist?
2. Is a referral required?
3. Must the provider be in the network? If out-of-network benefits are allowed, are there any limitations for out-of-network providers?
4. Are there any limitations of coverage?
   a. number of visits;
   b. specific dollar amount maximums; or
   c. number of days per condition.
5. What are the deductibles (individual and family, and how much has been met)?
6. Are there specific limits of coverage for services by an acupuncturist?
   a. exams (evaluation and management);
   b. physical therapy performed by an acupuncturist (if you know the specific services that are going to be done, such as massage, myofascial release, heat, etc., inquire on those specifically); or
   c. any other limits to coverage not mentioned.

Be sure the date and time of the call are documented, along with the name of the person who gathered the information, and the name, employee I.D. number and I.D. of the phone call, if available, from the insurance employee who is answering the questions. With this protocol, the call can be verified, as insurance carriers routinely record and log all phone calls received. Should there be a discrepancy of actual coverage from what was verified, the actual phone call can be checked.

It's important to be detailed and specific, as I have seen cases in which someone verifies coverage, indicating that acupuncture is covered, but fails to inquire about the need for services to be provided in network or performed by a medical doctor. In that case, the insurance did not give misinformation, as it did

state correctly that acupuncture was covered. The inquiring party did not go any further with questions about in- or out-of-network limitations; as such, the insurance carrier would not be liable.

This specific coverage information should not just go in the patient file, but also should be kept on an index card file under the specific carrier and policy. With this type of system, any patient who has the same policy will have the same coverage. Further lengthy verification calls will not be needed, as the specifics of the policy have been verified and all that would be needed is determination as to whether the policy is inactive. This card system also will allow further notations as to how the policy actually pays; for instance, if the policy will not pay for certain services, limits certain types of care or requests records after a certain number of visits. All that information can be logged on the index card to ensure the most accurate information is available to the doctor and patient as to how the plan actually is implemented and pays toward their care.

Following a consistent procedure allows an office to maintain very specific and up-to-date information as to the intricacies of coverage. This allows the doctor to inform the patient, as accurately as possible, about the patient's coverage and out-of-pocket expenses.

Click here for more information about Samuel A. Collins.