10 MISTAKES TO AVOID WITH PATIENT BENEFIT VERIFICATION & PREAUTHORIZATIONS / PRECERTIFICATIONS

ELIGIBILITY VERIFICATION & PREAUTHORIZATION CENTER

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OCTOBER 2024

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CONTENTS

CONTEXT 3

MISTAKE #1 – Lack of Due Diligence Prior to Initiating Benefit Verification Calls 4

MISTAKE #2 – Incomplete Data Points Provided to the Payer.....4

MISTAKE #3 – Incomplete Data Obtained from the Payer.....5

MISTAKE #4 – Relying On Online Portals / EMR Systems For Benefits Verification 6

MISTAKE #5 – Staff Overload > Low Morale > Lost Revenue 6

MISTAKE #6 – Absence Of A Documented Process.....6

MISTAKE #7 – Inability To Differentiate Between Junior and Senior Reps.....7

MISTAKE #8 – Ambiguity About ICD-10 And The CPT Codes That Need To Be Authorized.....7

MISTAKE #9 – Lack of HIPAA Compliance.....7

MISTAKE #10 – Hiring 'Just About Anyone' for Patient Benefits And Pre-Authorizations 8

CONCLUSION 9

CONTEXT

Online eligibility verification is a tempting shortcut, but ultimately counterproductive. Online portals and EMRs can only retrieve a limited amount of data from insurance companies. As a result, they provide inaccurate and incomplete information from time to time. This whitepaper will outline the right way to **call** the insurance company**, ask all the right questions** so you can get **accurate, detailed patient benefits, pre-certification and pre-authorization information for all your procedures** before you start treatment. The result - Happy patients, happy staff and less claim denials.

THE #1 CAUSE OF CLAIM DENIALS

Not having accurate (and comprehensive) benefits information and pre-authorizations is THE number one reason for claim denials. Let's face it - no one enjoys calling payers to verify benefits. It's far more tempting to click a few buttons in web portals to get patient benefit verification data. However, this data is often incomplete, and a single mistake can cost you tens of thousands of dollars in claim denials. There are no shortcuts, and the only way to get the most accurate and reliable information is to get the information the old-fashioned way by calling the payer, asking a specific set of questions, and getting a call reference number at the end of the call. There is no margin for error, because a single error can lead to a claim denial.

Denial reasons include benefit caps, policy/coverage is no longer active, authorization denied, and denial for non-covered services. This results in payment rejections, and even permanent loss of income due to delayed or improper submission.

Some clinics deal with this by having staff on the phone, for 30-45 minutes or more for each phone call, as they try to get answers from an insurance company.

Others rely on technology for eligibility information online, but the information from online portals is not accurate, and in most cases, incomplete. Here are the 10 common mistakes that lead to claim denials.

MISTAKE #1 – LACK OF DUE DILIGENCE PRIOR TO INITIATING BENEFIT VERIFICATION CALLS

It's important to internally document the NPIs of all rendering providers, the tax ID of the clinic and the list of payers you work with before calling the payer. In addition, it's important to call each payer to make sure they have all of this information (NPI, tax ID) accurately in their own internal systems. All this must be done before starting benefit verification calls with payers.

MISTAKE #2 – INCOMPLETE DATA PROVIDED TO PAYER

All the following patient data points must be provided to the payer.

- First Name
- Last Name
- Date of Birth
- Address
- Phone Number
- Payer Name
- Patient's Insurance ID
- Insurance Group Number
- ICD-10, CPT codes and dates of service (for pre-authorizations)

MISTAKE #3 – INCOMPLETE DATA OBTAINED FROM THE PAYER

The following data points must be gathered from the payer with every benefit call:

- Verification that the policy number and group number provided by the patient is 100% accurate
- Policy effective dates & current status
- Type of policy and services covered
- Co-pay & Co-insurance
- Deductible limit and utilization in current period
- Policy limitations
- Therapy cap met / not met by the patient
- Services that are excluded from coverage payment
- Verification of paper claim mailing address and phone number
- Claims adjusters name and phone number
- **Requirement for pre-authorization or referrals**
- **Pre-authorization number, authorization effective date, authorization end date, number of visits approved, number of visits already used and approved CPT codes**
- In network benefits (if the patient is in network)
- Out of network benefits (if the patient is out of network)
- Timely filing limitations for claim filing

- Documentation requirements
- Date of call, name of insurance company rep and call reference number from the payer

MISTAKE #4 – RELYING ON ONLINE PORTALS / EMR SYSTEMS FOR BENEFITS VERIFICATION

Benefit verification with online portals & EMRs is inaccurate & incomplete; a single mistake could cost you thousands of dollars in claim denials. Insurance company representatives on the phone have access to as much as 3 times more data than online portals, data that is absolutely necessary to get your claims paid.

MISTAKE #5 – STAFF OVERLOAD > LOW MORALE > LOST REVENUE

Benefit verification delays and mistakes with precertifications can cost a practice thousands of dollars in lost revenue. If you pay a staff member $15/hour, and they spend 45 minutes getting eligibility information, 15 minutes entering this information into an EMR and filling out authorization forms, the clinic has invested $15-$20 into the eligibility verification process for that patient. Despite this, the clinic may still end up with incomplete / inaccurate information, which ends up becoming very expensive for the clinic. In a competitive business like healthcare, this can drastically reduce profitability, and lower staff morale.

MISTAKE #6 – ABSENCE OF A DOCUMENTED PROCESS

A step-by-step process must be in place that documents every stage of the benefits verification and pre-authorization process. Are all payer phone numbers easily accessible? Can the patient benefits be verified as soon as the patient data points are received? Are all the online credentials for payer portals easily available? What happens once a pre-certification is received – how is it documented, and how does the practice know when it's time to get another pre-certification? These are just some of the questions that must be documented.

MISTAKE #7 – INABILITY TO DIFFERENTIATE BETWEEN JUNIOR AND SENIOR PAYER REPS

Remember, payer representatives are meant to serve you, not control you. Often times, they are inexperienced and provide the wrong information over the phone. It's important to identify the validity of the information provided by the payer representative with a series of probing questions during every call. Our experience team members can instantly identify the experience of the rep (and the accuracy of the information they provide) as soon as the rep answers the phone. Often, it's necessary to ask for a supervisor, or hang up and call back to get a different rep on the phone.

MISTAKE #8 – AMBIGUITY ABOUT ICD-10 AND THE CPT CODES THAT NEED TO BE AUTHORIZED

Every clinic should have a clearly-defined list of ICD-10 and CPT codes that must be authorized by the payer, so that the clinic doesn't overlook a single code.

MISTAKE #9 – LACK OF HIPAA COMPLIANCE

If you call a payer to verify patient benefits, and a single person is able to overhear the call, it is considered a HIPAA violation. If you have information on post-it notes or on word documents on your computer, it is considered a HIPAA violation. In fact, emailing patient information or submitting patient information via payer portals using computers that are accessible by other staff members can also constitute a HIPAA violation. A single innocent mistake can expose your clinic to liability, and potentially put you out of business.

MISTAKE #10 – HIRING 'JUST ABOUT ANYONE' TO VERIFY BENEFITS AND PRE-AUTHORIZATIONS

It takes a specialist, a dedicated, patient person (preferably an AAPC certified coder / biller), who knows that questions to ask and how best to get the required information from the payer. It's a mistake to hire someone with no experience or background in healthcare and HIPAA compliance. You wouldn't hire someone off the street to fix your front door, because a single mistake could allow intruders in. Similarly, hiring a non-expert to verify benefits and get pre-authorizations opens you up to the possibility of claim denials, in addition to criminal liabilities related to HIPAA violations.

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CONCLUSION

The First Thought: At Eligibility Verification, we eliminate the need for you to call the payers. We get on the phone and get you all the information, even if it takes us upwards on 45 minutes for each call (that's our problem, not yours). You focus on patient treatment and patient satisfaction. Get paid. **Make us an extension of your clinic.**

The Second Thought: Imagine a day in your clinic where every new patient had eligibility verification and pre-authorizations done, without a single member of your staff spending a minute on hold with an insurance company - all for a fraction of the cost of doing this in-house.

Eligibility Verification is a powerful and effective service to combat claim denials for reasons such as 'non-covered service' and denials due to lack of eligibility and pre-authorizations.

The Cost: The cost is $8 per patient with a monthly minimum of 50 verifications / pre-authorizations.

If this number is not reached, we will charge the minimum charge for 50 verifications, which is $400 for that month. No carry forward**.** **If you see 5-8 new patients a week, you'll easily reach the monthly minimum because you'll do 5-8 verifications a week**, plus additional verifications during re-evaluations / progress notes (highly recommended). You will also need pre-authorizations for many of your patients.

YOU GET:

A detailed summary of communication with the payer and all relevant information - in many cases, before a patient walks into your clinic.

We have a large team of specially trained callers who pick up the phone and call the payer for every single patient. We provide you with detailed information before you start treatment.

YOU ENJOY

- Higher revenue
- Lower costs
- Greater patient satisfaction
- Reduced stress
- Higher staff morale

THANK YOU!

FOR MORE INFORMATION,

EMAIL: SUPPORT@ELIGIBILITYVERIFICATION.COM

CALL: 201-430-5358

VISIT: WWW.ELIGIBILITYVERIFICATION.COM

HOW THIS WORKS

WATCH 3-MINUTE DEMO

QUESTIONS? LET'S TALK

SCHEDULE A CALL