The Insurance Verification Process

WHEN BENEFITS MUST BE VERIFIED

Nearly all private insurance companies have a telephone benefits line, whereby the Intake Coordinator can call to check/verify the insurance benefits on a pending referral. These telephone lines are usually available on standard non-holiday workdays, Monday through Friday, normal workday hours. Sometimes new referrals come in over the weekend. After hour (evenings, weekends, holidays) calls to the provider would constitute **on-call service**. It is next to impossible to verify benefits on a private insurance patient after normal business hours. In this case, the Assignment of Benefits would state that the patient would be responsible for all costs until insurance benefits can be verified. The patient may be accepted onto service if the Assignment of Benefits (AOB) is signed at the initial delivery. When benefits can be verified on the next business day, a new AOB is filled out with the insurance information, including co-pays and deductibles applicable, the total dollar amount of the cost of services, along with the expected amount of payment from the insurance company.

It is easier to verify benefits for Medicaid and Medicare *after hours.* The AOB can be filled out correctly during on-call hours, as long as the driver visually checks the Medicare or Medicaid card at the time of delivery. The patient or beneficiary carries a card issued from the state or federal government that identifies them as being eligible for benefits. In some state Medicaid programs, there may be different levels of card benefits. Some must be renewed monthly, and others may be valid for a year or more. Some state cards may have restrictions on the products and services that the beneficiary may receive.

Whether the particular provider has a separate form on which to verify benefits, or whether it is done in the financial section of the intake verification form, there are essential questions that must be answered to know whether the insurance company will reimburse for those products and services ordered for a pending patient. The following points identify **when insurance must be verified:**

1. All individual therapies/equipment must be financially qualified by verifying insurance benefits *before* the start of service.
2. For all established patients, the addition of another therapy/equipment after the initial start of service must be verified. This additional verification or re-verification, in the case of a patient who has changed insurance companies since the start of service, is also called re-qualification.
3. If the patient changes quantities or types of equipment and supplies, it may also be necessary to re-qualify benefits. Note: PBAs must also be obtained for any change in equipment or supplies.
4. Insurance benefits must be verified if a denial is received stating, "Coverage Terminated", or when a notification that the patient has changed employment or insurance companies has been received.
5. For those patients who were on service, were discharged, and have come back onto service within 30 days, provided they come back on with the *same* therapy, equipment, and supplies, benefits do not typically need to be re-verified. However, if the re-start of service is after the 30 days, or the re-start is not with the same equipment and supplies, then the patient must be re-qualified.

It is important to digest all of the information regarding the financial qualification of pending patients or referrals. The financial well being of companies depends upon being paid for the products and services provided. Although, companies may take on an indigent patient, one who has no means of payment for

the treatment, as a goodwill gesture of charity. Companies are therefore donating the products and service at no charge to the patient. The vast majority of patients are paying customers in conjunction with their insurance company.

INTAKE VERIFICATION FORM

When initially taking financial information from a referral source, the Intake Coordinator may only receive enough basic information in order to verify benefits. This basic information would probably include: the name of the insurance company, claims address, phone number, and policy number, which is usually the same as the social security number of the patient. When a call is placed to verify benefits, a representative of the insurance company must answer the following items in order to complete an accurate verification of insurance benefits. It is necessary to *write down the name of the representative at the insurance company* who provides the information regarding the patient's benefits. *Note:* it is advisable to write the representative's name down first, not at the end of verification, or after hanging up the phone. It is imperative to fill in this field on the form at the very beginning of the call.

Benefits that must be verified to complete an accurate verification of insurance benefits:

1. Correct policy number and group number if applicable
2. Policy effective dates
3. Type of policy
4. Which benefit covers the primary therapy
5. Policy limitations:
    a. Dollar amount capitation or maximum, and how much of the maximum the patient has already incurred.
    b. Time period limit and dollar amount, such as a yearly maximum or lifetime maximum, and how much the patient has already incurred in what time period.
6. Policy exclusions; specific products or services that are excluded from coverage payment
7. Deductible amounts, how much the patient has already satisfied in the deductible period, and the start date of the deductible period
8. Claims address and phone number
9. Whether prior authorization is required for any and/or all services; if and when case management is required
10. Out-Of-Network: If the company is Out-Of-Network (not a contracted provider), this will need to be specified when asking about deductible and co-pays. They may be different for In-Network benefits versus Out-Of-Network benefits. In some cases, there may not be *any* Out-Of-Network benefits under this patient's policy.
11. Billing requirements for type of claim form and coding
12. Timely filing limitations for claim filing
13. Documentation requirements

CASE MANAGEMENT

Nearly all large private insurance companies utilize case management for homecare products and services. Many of the smaller private insurance companies also utilize case management for serious or long-term care respiratory patients, such as oxygen and ventilator patients, and for those patients who

are considered catastrophic. **Catastrophic patients** are those patients who have diseases or illnesses that are long-term, permanent, or terminal. These are patients who are frequently or periodically hospitalized, and who may incur large benefit payouts throughout the course of their illness. These patients need a case manager, usually a Registered Nurse, to oversee their care. It is part of their job to make sure that the patient is cared for properly, and to ensure that all products and services ordered by the physician are medically necessary. In most cases, the case manager will issue a prior authorization for those products and services ordered by the physician.

It is at the core of the concept of the managed care industry as a whole that case managers monitor costs, and ensure that over-utilization of benefits does not occur. One of their primary functions is to secure adequate provision of services for the patient at the best possible price. For this reason, case managers are given the authority to authorize services and to negotiate pricing. Price negotiation from the Intake Coordinator's vantage point will be discussed at a later time. Check the company's policy on verification of benefits. Nearly all homecare companies require that benefits be verified through normal means, even if the case manager has already checked benefits prior to calling with the referral. The company will likely still require that a separate phone call be placed to the benefits line at the insurance company in order to properly verify benefits.

Discharge planners are case managers who work for the insurance company. Discharge planners are usually assigned to one or more hospitals, or a specific geographic territory. They are on-site at the hospital(s) daily to make arrangements for any patient that may be discharged from the hospital with homecare products or services. Although the discharge planner may give the initial prior billing authorization, thereafter, the patient may be assigned to a different case manager for on-going service and follow-up care.

REVIEW OF CONCEPTS

- **On-Call Service –** After hour (evenings, weekends, holidays) service.
- **When Insurance must be Verified:**
  - All individual therapies/equipment must be financially qualified by verifying insurance benefits *before* the start of service.
  - For all established patients, the addition of another therapy/equipment after the initial start of service must be verified. This additional verification or re-verification, in the case of a patient who has changed insurance companies since the start of service, is also called re-qualification.
  - If the patient changes quantities or types of equipment and supplies, it may also be necessary to re-qualify benefits. Note: PBAs must also be obtained for any change in equipment or supplies.
  - Insurance benefits must be verified if a denial is received stating, "Coverage Terminated", or when a notification that the patient has changed employment or insurance companies has been received.
  - For those patients who were on service, were discharged, and have come back onto service within 30 days, provided they come back on with the *same* therapy, equipment, and supplies, benefits do not typically need to be re-verified. However, if the re-start of service is after the 30 days, or the re-start is not with the same equipment and supplies, then the patient must be re-qualified.
- **Benefits that must be verified to complete an accurate verification of insurance benefits:**
  - Correct policy number and group number if applicable
  - Policy effective dates
  - Type of policy
  - Which benefit covers the primary therapy
  - Policy limitations:
  - Dollar amount capitation or maximum, and how much of the maximum the patient has already incurred.
  - Time period limit and dollar amount, such as a yearly maximum or lifetime maximum, and how much the patient has already incurred in what time period.
  - Policy exclusions; specific products or services that are excluded from coverage payment
  - Deductible amounts, how much the patient has already satisfied in the deductible period, and the start date of the deductible period
  - Claims address and phone number
  - Whether prior authorization is required for any and/or all services; if and when case management is required
  - Out-Of-Network: If the company is Out-Of-Network (not a contracted provider), this will need to be specified when asking about deductible and co-pays. They may be different for In-Network benefits versus Out-Of-Network benefits. In some cases, there may not be *any* Out-Of-Network benefits under this patient's policy.
  - Billing requirements for type of claim form and coding
  - Timely filing limitations for claim filing
  - Documentation requirements
- **Catastrophic Patient –** A patient who has a disease or illness that is long-term, permanent, or terminal. These types of patients are frequently or periodically hospitalized and may incur large benefit payouts throughout the course of their illness. A case manager or Registered Nurse (RN)

is usually needed to oversee the patient's care to make sure that the patient is cared for properly, and to ensure that all products and services ordered by the physician are medically necessary.

- **Discharge Planner –** A case managers that works for an insurance company and who is usually assigned to one or more hospitals, or a specific geographic territory. They are on-site at the hospital(s) daily to make arrangements for any patient that may be discharged from the hospital with homecare products or services.

QUESTIONS

1. What timeframes do the "On-Call" service hours encompass?
    a. Evenings
    b. Weekends
    c. Holidays or Branch Closings
    d. All of the Above
2. Insurance verification for after hours, on-call services should be performed the next business day.
    a. True
    b. False
3. What process should occur to ensure the provider has accurate Medicare and Medicaid information for verification?
    a. Call the physician's office
    b. Call the patient
    c. Request to see the card and obtain copy for the patient record
    d. Look at old medical records
4. Medicaid cards are divided into levels according to expiration date and renewals. Which time interval reflects the correct timeframes?
    I. Weekly
    II. Monthly
    III. Yearly
    IV. Every 2 Years
    a. I & III
    b. II & III
    c. III & IV
    d. II & IV
5. Which of the following is not required when verifying coverage for accurate insurance benefits?
    a. Obtain correct policy and group numbers
    b. Obtain policy effective dates
    c. Verify whether Infusion Therapy is covered under the plan
    d. Negotiate pricing
6. Which of the following are considered policy limitations?
    a. Time period limits
    b. Maximum out of pocket dollar limit
    c. Capitation PMPM maximum
    d. All of the Above
7. Specific products or services that are EXCLUDED from coverage payment are called:
    a. Policy Exclusion
    b. Policy Limitation
    c. Policy Exemption
    d. Policy Restriction
8. Which item is not included when obtaining deductible information?
    a. The deductible amount
    b. How much the patient has satisfied or met
    c. Start of deductible period
    d. Maximum amount of lifetime benefit