Making Sure the Patient Is Covered

By Samuel A. Collins

Q: On many occasions, I have not been completely aware of what my patient’s insurance specifically covered, and to the patient’s and my own astonishment, a very large balance was left due. Do you have a format, checklist or something similar that my staff or I can use when we want to verify insurance coverage?

A: Insurance verification 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 is still done best over the phone, as it allows greater inquiry to the specifics of coverage. Under the guidance of HIPAA regulations, insurance verification can be done electronically, but this resource, though fast, only gives very basic and limited information of the policy, while over the phone, inquiries offer much more latitude as well as specificity of questions.

Insurance verifications that are documented and done properly protect the patient (consumer) and the doctor from carriers who 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, states that the service it reported as covered is, in fact, not, the company will be obligated to cover those services up to the point that the correct information is given. In other words, the insurer will be liable to pay for the services from the time it first acknowledged the coverage to the time it gave the correct information, which often can take weeks and cost hundreds of dollars.

These laws are in place for consumer protection. Patients make decisions about their health care based, at least 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 comprehensive, is a patient who has been induced by the insurance company to seek the care that they may 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. But the proof of inducement is predicated upon proper insurance verification and the proof that the carrier did, in fact
Therefore, it is very important to follow a consistent protocol and procedure of insurance verification, and to be sure all the pertinent questions are asked and answered completely. The specific order of questions should be as follows:

1. Is there chiropractic coverage?
2. Is a referral required?
3. Must the provider be in-network? If out-of-network benefits are allowed, are there any limitations for out-of-network providers?
4. Are there limitations of coverage?
   1. number of visits
   2. specific dollar amount maximums
   3. number of days per condition
5. Are there deductibles (individual and family)? How much has been met?
6. What are the specific limits of coverage for services by a chiropractor?
   1. exams
   2. X-rays
   3. spinal manipulation*
   4. physical therapy performed by a chiropractor**
   5. durable medical equipment (e.g., supports, braces, etc.)
7. And then a final, generic question: Any other limits to coverage not mentioned?

*Some plans actually pay for services in a chiropractic office, such as exams, physical therapy and X-ray, but do not cover spinal manipulation.

**If specific services are going to be performed, such as massage, myofascial release, etc., inquire about the coverage of those services specifically.

Be sure the date and time of the call is logged on the insurance verification sheet, along with the name of your office personnel who secured the information and the name, employee I.D. number, and I.D. of the phone call if available from the insurance person answering the questions. In this manner, 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 is important to be as detailed and specific as possible. I have seen cases in which a patient verified coverage indicating that chiropractic is covered, but failed to inquire about the need for being in-network. In that case, the insurer did not give misinformation; the company stated correctly that chiropractic was covered. However, the inquiring party did not go any further with questions about in- or out-of-network limitations.

This specific coverage information should not just go in the patient file, but also should be kept on an index card, filed under the specific carrier and policy. With this type of system, any patient who has the same policy will have the same coverage and further lengthy verification calls will not be needed. With the specifics of the policy verified, all that will be needed is a determination of whether the policy is inactive. This index card system also will allow further notations as to how the policy actually pays. For instance, if you find 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. This allows an office to maintain very specific and up-to-date information as to the intricacies of coverage, and thus can inform the patient as accurately as possible about the patient’s coverage and out-of-pocket expenses.

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