Dynamic Chiropractic

INSURANCE & BILLING

The Insurance Verification: Common Errors and Fixes

Brandy Brimhall, CPC, CMCO, CCCPC, CPCO, CPMA | DIGITAL EXCLUSIVE

A properly collected insurance verification is a critical resource to the practice. After all, the details of the verification provide necessary information in terms of the patient's individual policy benefits and limitations – the parameters by which the claims will be processed. The verification also serves as a twofold communications tool that is necessary to the practice for claims preparation and billing, as well as for practice-to-patient communications such as patient responsibility and expectations for time-of-service collections (deductibles / co-pays / co-insurances / non-covered items and procedures).

A Common Verification Challenge

One common insurance verification challenge is when the CA / biller discovers upon receipt of processed remittances (EOBs / ERAs) that charges were not processed as expected according to verification data collected. Could it be a payer error? Of course, a payer could have processed erroneously; in this event, your practice will have to contact the payer or resubmit the claim to identify the error and request correct reprocessing.

However, in many cases, the processing surprise isn't a matter of payer error, but rather a matter of insufficient verification information collected, resulting in a misunderstanding in billing and a miscommunication to the patient. *(I hope you're reading EOBs properly!)*

Other Common Challenges (and How to Avoid Them)

Let's look at just a few common examples of issues that could occur – issues you can avoid by simply gathering additional information upon verifying benefits or communicating differently with your patients for those procedures for which there are no benefits.

- Chiropractic benefits are not always under the same set of benefits as therapies, X-rays and E/M (exams). In other words, patients may have a complete separate set of benefits as it relates to any of these categories. This also means there could be additional co-pays / co-insurances under these benefits.
- Annual maxes or other limitations may differ in these categories as well. Once a maximum benefit has been exhausted for a particular procedure, this becomes patient responsibility, while other types of procedures may still be covered, so long as all other policy guidelines are met.
- Payers may have additional requirements before coverage will be considered. This may include preauthorization requirements or other documents the practice must complete and return to the payer, such as Patient Summary Forms or Medical Necessity Review Forms. Your practice should confirm this information as well, because in the event something of this nature is required for coverage, but not adhered to by the practice, your claim will be denied and oftentimes, patients may not be billed instead. This can become a very costly oversight! *(Again, make sure you're reading EOBs!)*

Avoiding Denials: Are You Meeting All Three Criteria?

Yet, even with having collected a detailed insurance verification, it is a common occurrence for

entire claims or individual claim line items to be denied with various explanations, and patient records or payer recoupments are often being requested. *What could be the cause of this?*

To shed some additional light on the question above, logging in or calling to verify benefits, you will see or hear the standard statement, "*This information is not a guarantee of coverage. Coverage will be determined once a claim is received and processed.*" This important statement is standard for a reason, and it should be communicated to your patients when you review financial details with them. (Maybe even consider including it in your financial policy documents or on your verification form if a copy is provided to patients.)

There are a few reasons why that statement is so important! First, this is telling you that the claim is going to be reviewed to ensure it meets coding and billing guidelines, which includes procedure / supply codes (CPT / HCPCS), modifiers and sufficient diagnosis (ICD-10) to support necessity for treatment. Second, the claim is going to be processed according to the benefits and limitations as defined within the patient policy. And third, the claim is also going to be processed according to the provider's network status *along with* the specific payer policy guidelines for your provider type. Most importantly, coverage is only available for claims *when all three of these criteria are properly met*.

Also consider that, for every procedure rendered, you must have sufficient diagnosis to support the procedure. Remember, your procedure codes (CPT / HCPCS) say *what* you're doing with the patient and the diagnosis codes explain *why*. For example, if you are billing multiple therapies or multiple units of timed therapies, you must have adequate diagnosis for each procedure / unit rendered to support necessity and explain why those procedures are necessary for patient improvement.

In other words, just because a particular procedure may be "covered" under a patient's benefits, it doesn't mean the procedure is eligible for coverage if your claim isn't meeting payer policy requirements, such as properly representing / supporting medical necessity. To put it simply, claim forms communicate much more to payers than you might realize!

Two Parts to the Whole

An easy way to look at coverage and eligibility is that there are two parts to the whole. One, of course, is the patient policy itself, which includes benefits and limitations as it pertains to that specific patient. Part two is the payer policy guidelines, which are in place and applicable to every specialty or type(s) of treatment, regardless of provider network status; however, for an in-network provider, additional components will often apply.

A payable claim must adhere to each of these two parts in order to be eligible for coverage. This is also what makes the provider's documentation so important. In the event claims or charges come under question or scrutiny by a payer *(when, not if)*, it is rarely because there is question as to coverage under the patient policy. Rather, it is typically that there is question of coverage due to claim detail perhaps indicating the treatment rendered is outside of the specific payer policy guidelines for that provider type.

Take-Home Points

The insurance verification has tremendous value and purpose, but it can easily be done improperly, causing big problems. In addition to reviewing your insurance verification and patient communications protocols, practices should also annually review payer policy guidelines. Understanding how each of these two major parts of coverage and eligibility work together will

help your practice communicate internally, communicate with patients and know which procedures are expected to be covered by insurance and which should be patient responsibility. Remember, your collections and patient relationships may depend on it!

Resources

- Aetna Chiropractic Policy
- UHC Chiropractic Policy
- Cigna Chiropractic Policy

MARCH 2021