

Instruction Sheet for Verifying Benefits

Implementation of federal and state regulations, electronic health record systems, HIPAA, and other requirements, have all combined to make clinics busier than ever. Verification of a patient's benefits, while time consuming, is one task that cannot be set aside in the new landscape of healthcare reform. The traditional questions asked of a payer regarding insurance coverage have changed. This is why performing a thorough verification of benefits by asking the right questions can make the difference between a struggling clinic and a highly successful one by decreasing costly denials and enabling more informed communication with patients.

To assist doctors, ACA has updated the sample Verification of Benefits Form (found online in the [ACA Practice Resource Center](#)) to help your clinic in determining the most important information about your patient's coverage. The form addresses topics such as: covered services, copay amounts, deductibles, pre-authorization requirements, etc. It also addresses questions such as: Does the plan reimburse for manual therapy when performed by a massage therapist? and Do physical therapy services have a separate deductible?

HealthCare Reform

The healthcare exchanges bring a new set of rules that affect coverage and benefits; for example, there is a three month grace period for patients when coverage is terminated due to nonpayment of premium. The law states, *A QHP [qualified health plan] issuer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium... During the grace period, the QHP issuer must **notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.*** This means you could provide a patient thirty to sixty days of care before you would receive notice regarding termination of their insurance coverage. Without an updated, thorough verification process, it is difficult to keep up with these details on each patient.

In addition to new regulations, the new marketplace exchange plans are available, while at the same time, plans that are excluded from the Affordable Care Act are still being allowed. This complicates the verification process. Some plans will include chiropractic in the payer's essential benefits while other payers may not. Some plans may have pre-existing clauses or lifetime limits while others will not.

What are the basics you need to know? What do HMO, PPO and POS stand for? What are the metal plans? Note: We have included a glossary at the end of this document for definitions of

these terms. Knowing the basic structure of your patients' plans, will help you ask the right questions when verifying benefits. Remember, the majority of your patients will **not** know what these new terms mean, and in order to collect payment, you may need to explain these coverage changes.

Marketplace Plans Overview

According to www.Healthcare.gov , plans in the Marketplace are primarily separated into four health plan categories: **Bronze, Silver, Gold, or Platinum**; based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category chosen affects the total amount the patient is responsible for to cover what are referred to as the essential health benefits throughout the term of the plan. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This differs from coinsurance, where the patient pays a specific percentage of the cost of a specific service.

Let's look at Bronze plans which splits covered expenses 60%-40%. This plan is less expensive because the insurer pays 60% of the patients covered health expenses, and the patient is responsible for the remaining 40%. Bronze plans also have the most basic benefits and most limited networks of doctors and hospitals.

Catastrophic coverage is available to some people under 30 and those with hardship exemptions. According to www.Healthcare.gov , a catastrophic health insurance plan covers essential health benefits, but has a very high deductible. This means it provides a kind of "safety net" coverage in case you have an accident or serious illness. Catastrophic plans usually do not provide coverage for services like prescription drugs or injections. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means the patient will have to pay several hundred dollars before full coverage begins.

With a high deductible plan, often the patient is informed by the employer or insurance agent that the plan does not have a copay. As a result, the patient may be confused when a clinic attempts to collect payment for services rendered. A patient may think that if they do not have a copay, they do not owe anything. When this happens, it is up to the clinic staff to educate the patient on their coverage and patient responsibility.

TIP: Confusion and frustration can be avoided by having information available for patients who do not understand insurance terms and payment options. Including this information online with your new patient paperwork is a great way save both you and the patient time by educating them on the different types of plans and payment requirements ahead of time.

What Should Your Verification Form Contain?

PATIENT INFORMATION

Name: _____ DOB: ____/____/____ Last 4 SS# _____
Female Male Married Divorced Single Widow Retired Student Disabled

PRIMARY INSURANCE INFORMATION

Insurance _____ Plan _____
Member ID _____ Group # _____
Subscriber _____ DOB: ____/____/____
Patient is listed on policy as: Self Spouse Child Effective Date: ____/____/____

Consider ACA's Verification form. One of the first pieces of information requested is the effective date. This date helps determine when coverage started, deductible amounts, and benefit limitations. The effective date will assist your clinic in knowing which payer to bill services to when a patient experiences a job change or policy change. This way, you can avoid the denial reason, policy not active on this date of service.

Clean Claims Contribute to Timely Payments.

It is important to make sure that benefits are re-verified at the start of the year and also at the start of new plan years for patients whose plan years are different than the calendar year. Ask all insurance patients upon check-in about changes to their insurance coverage. A simple question and a thorough verification process can help prevent costly denials.

The benefits verification form should also contain an area to gather important demographics so that you can obtain the correct benefits. Some plans offer coverage ONLY for the employee and not the spouse or child. When you call the payer, make sure you have the name and date of birth of the patient being seen. Don't verify benefits assuming that the subscriber's coverage covers everyone in the household.

The verification form should have a place to clearly define both Primary and Secondary plans. The National Association of Insurance Commissioners (NAIC) has drafted a document that outlines the rules entitled, [Coordination of Benefits Model Regulation](#). Information on how to determine which plan is primary can come in handy when the patient provides two insurance cards and does not know which is primary.

the payer if you may provide some procedure codes to see if they are a covered and payable service when rendered at a chiropractic office.

Most payers are willing to give you that information and appreciate your thoroughness. If not, simply ask them who you should contact in order to obtain specific coverage details. This section is vital to the verification process because it can directly affect reimbursement.

Notice the ACA's form allows you to write down the copay or deductible amount next to the specific procedure. This is helpful when you are obtaining benefits on a plan that breaks down coverage based on office visits, chiropractic services, physical therapy services and/or diagnostics. The last column is where you can note if a certain procedure is non-covered or if it has a visit or dollar amount limit.

It can be advantageous to have a portion of your Verification Form dedicated to a Patient Responsibility Agreement. This is your opportunity to review the benefits with your patient, explain their financial responsibility, and you can even choose to have the patient sign the agreement. It is important to update the patient's file with the information regarding their financial responsibility so that during the check in process, payment can be easily collected.

Patient Responsibility

Patient Attestation	
I _____ am aware that according to my insurance benefits, I am responsible to pay: \$ _____ copay per visit and/or _____ % coinsurance after first reaching my out of pocket deductible in the amount of \$ _____. My plan allows _____ chiropractic visits per year or a \$ _____,00 maximum per year.	
I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from my healthcare provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.	
Patient Signature: _____	Date _____

TIP: Avoid the awkward moment when front desk staff attempt to collect payment from a patient and are told, "I do not have a copay". Front desk staff should be proactive by saying something like, "Good Afternoon Mrs. Smith. I'd be happy to collect your insurance patient portion and get you checked in today", rather than asking, "What is your copay?"

GLOSSARY*

COBRA-A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Dependent Child Covered Under More Than One Plan-Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows: (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. For more information, go to:

http://www.naic.org/documents/committees_b_revised_coord_benefits_model_reg.pdf

Effective Date- The effective date is the earliest date coverage can begin. For example, if a patient enrolls in a plan in February by the 15th the coverage would normally become effective March 1st. If the patient changes plans between February 16th and the end of the month, the coverage does not usually take effect until April 1st. The effective date of a policy will not necessarily run concurrently with the calendar year.

Grandfathered Health Plan- As used in connection with the Affordable Care Act, a group health plan that was created or an individual health insurance policy that was purchased on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S.

Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

<https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)-

HMOs and EPOs may limit coverage to providers inside their networks. If you use a doctor or facility that is not in the HMO's network, you may have to pay the full cost of the services provided. HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs.

High Deductible Health Plan (HDHP)- High Deductible Health Plans typically feature lower premiums and higher deductibles than traditional insurance plans. As of 2013, HDHPs are plans with a minimum deductible of \$1250 per year for individual coverage and \$2500 for family coverage. If you have an HDHP, you can use a health savings account or a health reimbursement arrangement to pay for qualified out-of-pocket medical costs. Additional Information is available at: <https://www.healthcare.gov/choose-a-plan/plan-types/>

Metal Plan Descriptions

- Bronze: Health plan pays 60% on average. Patient pays about 40%.
- Silver: Health plan pays 70% on average. Patient pays about 30%.
- Gold: Health plan pays 80% on average. Patient pays about 20%.
- Platinum: Health plan pays 90% on average. Patient pays about 10%.
- Catastrophic: Catastrophic coverage plans pay less than 60% of the total average cost of care on average. These plans are available only to people who are under 30 years old or have a hardship exemption.

Preauthorization/Precertification- A decision by the insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary, (also known as prior authorization, prior approval or precertification.) A payer may require preauthorization for certain services before a patient can receive them, except in an emergency. Preauthorization is not a guarantee that one's health insurance or plan will cover the cost.

Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS) - These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you'll have to pay more than if you use those that are in-network. If you have a PPO plan, usually you can visit any doctor without a referral. If you have a POS plan, you can visit any in-network provider without a referral, but you'll need a referral to visit a provider who is out- of-network.

*Source: www.healthcare.gov