



ORTHO2

Handling Patient Insurance Benefits – What’s to Like?

by **Tina Byrne**

In the July 2014 issue, the first part of this article explained the first three P’s for an effective insurance system. A brief recap of the earlier commentary would advise:

1. We maintain a comprehensive understanding of Plans and Participation – particularly if you are accepting assignment of benefits and/or contracted as in-network providers. Far too frequently, the primary deficiencies I encounter in offices participating with benefit plans is a lack of the most general insurance knowledge and a failure to retain current fee schedules for in-network plans.
2. To establish Practice Policy for pre-crediting, accepting, and following up with benefit receivables. Consider pre-crediting only primary carrier’s benefits at the start of treatment when benefits exist with more than one insurance carrier. It may serve your practice well to collect your fee at the time of service and allow benefit payments to go to the subscriber/patient for miscellaneous charge procedures, as these types of charges are likely to be dictated by limitations and exclusions.
3. Your Preparation is complete if you are making use of the many functions for insurance within your practice management software, aligning CDT codes to your specific treatment plans or procedures, and utilizing well-formatted forms for verification, treatment fee presentations, and financial contracts. Furthermore, insurance circumstances which may result in negative exchanges with patients/responsible parties are totally predictable – educational materials for third party benefits are as important as treatment educational materials.

Process

The process of insurance, the fourth P of our system, involves three specific tasks or areas: verification of benefits, claim submission, and benefit payments. With

proper execution of each task, the job of the insurance coordinator is made much more efficient and manageable.

A) Verification of benefits or eligibility is a necessity if you are pre-crediting and accepting assignment of the insurance benefit. For new patients, benefit verification should take place prior to the initial evaluation appointment so that the treatment coordinator has accurate information for the fee presentation. For recall or growth and observation patients, it is helpful to establish a protocol where a reminder is sent the month prior to the appointment to request your office be updated on any new or changed benefit information. This eliminates the need to establish eligibility and benefits while the patient is in the chair when treatment is indicated.

Be certain to identify the following details, exclusions, and limitations at the time of verification:

- Benefit amount and percentage of fee paid
- Effective date of plans
- Waiting period
- Adult treatment
- Code exclusions – no benefit for limited or interceptive care
- Code limitations – the allowance of only one comprehensive treatment code
- Treatment or work in progress
- Coordination of benefit method
- No out-of-network assignment or no out-of-network benefit

Reprinted from

The Newsletter for Members and Friends of Ortho2
October 2014 - Volume 32 Issue 4

B) Claim submission is one of the most straightforward tasks within your process, however standard guidelines for the set up of claims should be established.

- Complete all necessary information for your claims to be accepted on the first submission.
- Submit your full fee to the insurance carrier, unless the carrier mandates submission of an allowed fee schedule amount.
- Use a formulary to break down the fee into the initial amount due and the period fees. It should be the manner in which you determine your fee is earned – 25% of the fee amount as the initial, and the remainder of the 75% divided into the number of months of treatment.
- Enter the information to accurately and automatically generate ongoing or continuation claim forms. Approximately 85-90% of insurance carriers will not require ongoing claim submission for payment once the initial claim is opened or activated. Missing the setup for the other 10-15% will in due course result in delinquent insurance benefits.
- Submit start of treatment forms and miscellaneous charge forms the day appliances are placed.
- Submit ongoing or continuation of treatment forms no later than the 5th of each month.
- For claims with secondary benefits, submit the day the primary insurance payment or information is received along with a copy of the Explanation of Benefits form from the primary carrier.

Both Ortho2 Edge and ViewPoint programs allow for the preparation of insurance claims and financial contracts as proposed treatment. With this function, claim submission should never be delayed past the time frames mentioned above.

C) The posting of benefit payments must not be considered a mindless task. I mention this as I see many offices delegating this duty to team members other than the insurance coordinator. I firmly recommend your insurance coordinator be the one posting benefit payments to ledgers. Tried-and-true advice for posting benefit payments includes:

- Post insurance payments along with details for the date of service – e.g. DOS Apr-Jun 2014. Reviewing previous payment notations made in the same manner will allow for the identification of consistencies or inconsistencies of payment as expected.

(Useful Tip: Label your insurance carrier names with a code at the end which denotes the frequency of your benefit payments. Example: " Metlife_Q" for quarterly payment)

- Carefully review all Explanation of Benefit (EOB) statements for the following information and make adjustments to your pre-credited insurance or claim setup accordingly:
 - With receipt of the initial payment:
 - Look for the frequency of ongoing payment, and the necessity for submission.
 - Confirm for contracted/managed care, the allowed fee is in agreement with our final fee to the patient. There should be no discrepancy.
 - With receipt of scheduled or ongoing payment
 - Look for chronological consistency with your dates of service.
 - Make certain the amount of the payment and the frequency with which you are receiving payment will result in full disbursement of your pre-credited benefit.
 - With receipt of any payment or EOB with no payment:
 - Review the remark codes and corresponding comments.

Punctuality

The sense of urgency with which you address delinquent patient receivables must also be applied to your delinquent insurance benefits. This requires both reviewing the Explanation of Benefit statements as they are received and auditing the insurance reports each month. ViewPoint's Insurance Detail by Company report or Edge's Open Insurance report are excellent sources for your monthly audit.

There are some overdue benefit situations which indicate it is best to contact an insurance carrier – e.g. overdue initial payment. The oversight made by most offices with regard to delinquent benefits is the failure to communicate with the patient/responsible party!

Our system should include:

1. A delinquent insurance mailing to the patient/responsible party when an insurance benefit is 45 days delinquent. The mailing should ask for their assistance by contacting their carrier and remind them that the benefit is ultimately their responsibility.
2. A second past due insurance mailing/transferring the balance if the insurance benefit is more than 75 days delinquent and the patient/responsible party has not been in contact with you.
3. A transfer of benefit mailing indicating you have received notification from the insurance company (remark from EOB) that the benefit has either been paid in full or terminated and the insurance balance that exists has now been

transferred to the patient/responsible party for payment. If there is a disagreement by the responsible party, allow them to do follow up with their carrier.

As I stated in part one of this article, insurance coordinators are finding it difficult to identify anything they like about handling patient benefits. I believe the problems exist within the insurance system whereas team members feel responsible to solve the many circumstances taking place while managing benefits and the overwhelming time required in deal with the situations.

Review the Five P's of your current insurance system to identify the need for change and implement! For additional questions or assistance feel free to contact me at tinabyrne@byrne-consulting.com. ☺

About the Author



Tina Byrne's leadership qualities and upbeat presentation style provide a fresh perspective on the many challenges faced daily by the entire orthodontic team. She offers practical solutions to maximize practice productivity and profitability. Tina is the keynote speaker at the 2015 UGM.