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Asking the Insurance Rep the Right Questions

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One of the first or last questions a potential patient often asks is: "Do you take insurance?" An ill-informed or optimistic, "yes" can result in delayed or non-payment. Instead, just say: "Let me check if you are eligible first."

Preparation

Before making a phone call to an insurance company, preparation is important for success. You will first need the necessary patient information. Begin by making a photo copy of the potential patient's insurance card (front and back) and ask for their birth date. If possible, ask for at least one or two conditions for which they seek treatment. From this, you now have or can obtain:

- From the insurance card: patient name, policy holder name, insurance id number, copays, telephone numbers for "provider services."
- From the patient: date of birth and, if possible, a symptom or two they seek treatment. (Social security number is not necessary for insurance validation or billing purposes.)
- From the provider: ICD10 codes for the symptoms the patient mentioned.

You also need to have handy the necessary practitioner information. The insurance representative will nearly unanimously ask for one or two identification numbers. The first is the tax id, also called the "employer identification number" or "EIN." The tax id can be obtained within a few minutes through the Internal Revenue Service website. The form requires very basic information such as name and a description of your business. This number identifies any business. The alternative is your social security number. They might also ask for the NPI number. This is the acronym for "The National Provider Identification Number" and is specifically used for health care providers. Obtaining an NPI number takes more time than the tax id.

The insurance representative may ask what services you plan to provide. For this, you need CPT (Current Procedural Terminology) codes for services you plan to render. CPT codes include 97810-Acupuncture, 97813-electroacupuncture, 99201-Initial Evaluation, 99211 -Re-evaluation. You might also need an ICD10 code (International Classification of Diseases) diagnosis code. Examples are, R51-headache, F43.0- acute stress reaction and M54.2-neck pain.

Making The Call

Calling for patient eligibility is made using the "provider services" telephone number on the patient's insurance card. After the standard automated greeting has ended, you will either enter or say your identification numbers or the patient's identification number into the telephone. When the insurance company representative answers, they will likely ask for the same information as well. Then they will likely read the patient's generic "in network" benefits from a computer screen that applies to medical doctors. The information the insurance representative will likely give immediately is:

- Patient's effective dates of the policy.

- Deductable, deductable paid thus far or remaining.
- Percentage payment is based on such as 90-10, or 80-20 if there is one.
- "Maximum out-of-pocket expense," if there is one.
- "Out-of-pocket" expense, "out-of-pocket" expense paid thus far or remaining.
- Hospital emergency room expenses.
- The above information in the context of the individual and family.

The deductable is the amount the patient pays the practitioner before the insurance company begins to pay for treatment. If the patient has a deductable remaining, then the patient is responsible to pay the practitioner until the deductable has been met. The practitioner prepares a bill/claim, which is sent to the insurance company so that payment is recorded. The deductable typically starts at the beginning of every calendar year.

The percentage payment means the insurance company will pay a percentage of the "allowable rate" for services rendered and the patient pays the remaining portion. The "allowable rate" is the fee the insurance company deems appropriate for a service rendered. Consider the following example for a "90-10" payment percentage. A provider bills an insurance company $40 for a single service, but the insurance company determines that the "allowable rate" is $25. The insurance company will pay 90% of the $25 and the patient is responsible to pay the remaining 10%. This is assuming the patient has already paid their deductable. The allowable rate and other payment details are explained on the Explanation of Benefits (EOB) page from the insurance company. This usually accompanies the payment or non-payment for services.

The "out of pocket" expenses are the deductables, percentages, copays, etc. Once the maximum "out of pocket" expense has been met, the patient is no longer responsible to pay until the time of policy renewal.

It will take a minute or two for the insurance rep to read through this information. Just remain patient, even if you already found the identical information on their website. They often seem to "need" to read the entire screen to you. Once they're finished, you may ask the relevant questions leading to, "will I get paid for what I do?"

Asking The Questions

Am I in or out of network? In and out network is the difference between getting paid or not. A practitioner may believe they are "in network," but are not due to variations in insurance company associations with each other or even inactivity of billing. For example, Empire Blue Cross Blue Shield is not the same as Empire United Health Care. Additionally, a patient may have "out of network" benefits. And those "out of network" benefits may have limitations which are important to know. Thus, a practitioner not in the insurance network can still get paid for services rendered.

Do you accept assignment of benefits? This is a polite way of asking "who gets the check." If the insurance representative's answer is "yes," then the practitioner gives the patient an Assignment of Benefits form to sign or "AOB." This form states that the patient is assigning their benefit of payment to the practitioner. Keep this document on file for future reference if needed. In other words, the insurance company sends payment to the practitioner. If the answer is "no," then the payment for service is given directly to the patient. If the insurance company does not accept the AOB, then the practitioner has two options. They may rely on the integrity of the patient to bring the payment to the practitioner when they receive the check. Or, the practitioner may accept payment from the patient at the time of service then give the patient a "superbill" (a simplified billing form). The patient sends the superbill to their insurance company for reimbursement.

Are the following treatment codes payable? This is good time to ask which treatment CPT codes are

payable. Even though a service is within a provider's scope of practice in their particular state, there is no guarantee that an insurance company will pay for it.

Are there limitations to treatment number? A patient's insurance policy may have limitation of number of treatments. If there is a limitation, then it is important to ask how many treatments are remaining. Afterall, the patient may have already received treatment elsewhere. Another question to ask: How to get approval for additional treatments once reaching the limit? If it is possible.

Are there restrictions or limitations regarding diagnosis? Occasionally, you will find an insurance company that limits treatment by diagnosis. The company may pay only a range of specific diagnosis such as arthritis or nausea due to chemotherapy. An insurance company may even limit the number of treatments per diagnosis. In this case, billing one diagnosis at a time is an effective strategy to maximize the number of patient visits. Therefore, it is a good idea to have several ICD10 codes available for the insurance representative to check.

How many days after treatment is the deadline for submission? A common deadline is 180 days, but not necessarily for all insurance companies. This seemingly long time period allows the provider to prepare the claim, the insurance company to receive and process the claim, the provider to receive a response, and if necessary, the provider may change the claim and then resubmit it for reconsideration.

How do I get credentialed to become "in network?" If you are "out of network" and would like to become "in network," the insurance rep can transfer you to "provider relations" or a similar department to begin the process. Before you do this, it is good to have your CAQH number available. This number is associated with the details of your practice such as professional training, spoken language, handicapped accessibility and hospital privileges (CAQH is medical doctor oriented). Make sure the representative tells you the information that applies to you.

Checking patient insurance eligibility via computer is a convenient alternative, but beware. After registering and logging in to check eligibility, you may only obtain the basic information pertaining to medical doctors who work in hospitals. Hence, the telephone call becomes a necessity. There are a few websites that will allow providers to check patient eligibility for multiple insurance companies regarding their specific training and network status. Checking for patient eligibility via telephone may last up to half an hour or more, but consider it an investment that can save you months of uncertainty regarding payment. After the relevant information has been obtained, you decide if it is financially advantageous to begin a provider-patient relationship with this potential patient. Next, you may contact the patient with the reply to their question "do you take my insurance?" with a meaningful answer. And depending on that answer, you just might have a new patient.

References:

1. Tax id: www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Apply-for-an-Employer-Identification-Number-%28EIN%29-Online
2. NPI https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions
3. ICD10 codes www.icd10data.com/
4. CAQH #: http://caqh.org/
5. Availity: www.availity.com/