Getting Patients Involved When a Claim is Denied

By P.J. Cloud-Moulds [2]

Here are some quick steps you can implement today to make sure coordination of benefits is not costing your practice money.

Oftentimes, patients will have a primary insurance they want you to bill, and sometimes a secondary insurance. But what happens when they don't tell you about an insurance they have, and the primary insurance company denies for coordination of benefits (COB)?

Something you need to realize that you are billing your patient's insurance as a courtesy to the patient. Yes, as a courtesy. A favor to them so they don't have to deal with HCFA forms. You are spending precious resources so that your patients do not have to hassle with the insurance companies that come back to you and your practice and deny claims. Once you have accepted that, this next statement will be a lot easier to read and apply. When you receive a denial for COB, it's time for the patient to get involved — immediately. When a patient is not upfront with your staff on their first or twelfth appointment, and do not provide all of the financial responsibility information to your staff, your claims are denied, then they become responsible for the entire balance.

In most cases, you are able to pass the entire balance to the patient. If your billing company is not currently following this procedure, it's time to meet with them and update your policies. You might be surprised how much of your A/R is aging out due to COB.

Here are some quick steps you can implement today to make sure this does not hold up any of your claims payments:

1. When your billing department receives an EOB stating COB, have them check to make sure they have all of the pertinent information from your front office staff.
2. If your staff has all of the information correct, your billing department can simply call the insurance company and re-bill through a representative with a date, name, and time.
3. If your staff does not have all of the information, then it's time to contact the patient. Be certain that your patient is also receiving the EOB, so this phone call to them should not come as a surprise. They will often pull the “I don't do the bills” or “I haven't opened my mail in weeks,” which would explain why there is a hang up in the first place.
4. Whether your billing department calls the patient or your front office staff, here is what you will need from the patient to move forward:
   • Subscriber name (often not the patients name; a spouse's or parent's, perhaps)
   • Subscriber date of birth
   • Policy number
   • Customer service number
5. Once this information has been obtained, be sure your staff verifies the insurance. You would be surprised how many insurance plans have termed. As long as the policy was in place during the specific dates of service, your billing office can still bill the plan.
6. Be sure that the information gets passed to the billing department and the billing department bills out the claims as soon as possible.
7. If you cannot obtain the information from the patient, or the insurance has sent the patient a form to fill out asking about how the patient was injured or that they (insurance company) show there is another source that should be billed, now is the time to pass the balance to the patient. Your billing department can send the patient a statement showing the entire balance is due since all of the insurance information was not provided. This will trigger a phone call from the patient. At this point your billing department will obtain the necessary information, receive payment for your services or place the patient on a payment plan if they are unable to pay the balance immediately.

Arm yourself with the appropriate information and rules so that you are not the one being left out to dry with these insurance companies. There is a line that you can draw between customer service and giving it all away, versus knowing your value and getting paid for it.
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