Verifying Benefits/ Eligibility Prior to Services

- Always have patient provide insurance card(s). Be sure to either scan or copy both sides and notate date of the copy.
- Best to verify eligibility prior to patient presenting to practice
    - This can determine prior to being seen if coverage is active or if patient will be responsible.
- When scheduling surgery, prior authorization may need to take place the same month.
    - This is to confirm coverage is still active
- While prior authorization does not guarantee payment, you are guaranteed not to get paid without one.
- When prior authorizing or pre-certifying coverage, always provide the payer representative with:
    - Date of service that is to be performed
    - CPT code or codes
    - ICD-10 codes for each service rendered
    - Physician, practice NPI and Tax ID
- Always have on record:
    - Name of payer representative you spoke with
    - Date and Time of call
    - Effective date of patients coverage
    - Is physician in or out-of- network
    - Is a pre-determination required to see if patient has active coverage
    - Any pre-existing conditions that delay service
    - Patient deductible and maximum out-of-pocket
    - What percentage of coverage the patient will be responsible for including any copays that are applicable
    - If approved, the prior authorization number.
- Educate patient on findings from payer if they are to be responsible.
    - Remember out-of-pocket expenses for surgery may include facility fees and anesthesia. Patients should be aware of all costs before surgery.
- If there is a family of CPT codes, it is proactive to pre-authorize multiple codes as the surgeon may have to change intraoperatively. Many payers will not allow for a CPT code they did not authorize.
    - Often if CPT code 66984 Cataract surgery is authorized, however the surgeon performs a complex case (66982) intra-operatively, payers deny as they were not provided the new CPT code, even upon appeal.
- Pre-authorization does not look at bundling edits. Always check with the payer prior about whether codes can be submitted same session. Many payers have a look-up option on their website.

- When determining coverage for Category III codes, ask for the allowable. If there is no allowable, there is no coverage.
- Assure coverage if an office based surgery where typically only covered in a facility. Always provide the place of service.