The Impact of Patient Eligibility Verification Mistakes on Claims

Errors in patient eligibility verification carry significant implications for both healthcare providers and patients. Inaccuracies, such as incorrect insurance information or outdated coverage changes, can result in adverse outcomes such as denied claims, delayed reimbursements, and heightened administrative burdens for healthcare facilities. For medical practitioners, these errors pose a threat to their financial stability, disrupting timely care delivery.

In this post, we explore the importance of precision in navigating the intricacies of healthcare billing and reimbursement, emphasizing the significance of real-time patient eligibility verification.

- The Top 7 Common Patient Eligibility Verification Mistakes and Their Impact on Claims
- A Checklist For Medical Practices to Effectively Verify Patient Eligibility
- Self Service Eligibility Verification Applications: Reinforcement For Medical Practices?

The Top 7 Common Patient Eligibility Verification Mistakes and Their Impact on Claims

According to a report by The National Library of Medicine, nearly 10% of patients encounter misidentification during EMPI(Enterprise Master Patient Index) searches and EHR (Electronic Health Record) data review. When compounded with prevalent mistakes in patient eligibility verification, practice owners can suddenly find themselves facing imminent revenue bleed. Here

are the common errors in patient eligibility verification, causing medical practices to lose revenue.

Incorrect Patient Information

Error: Incorrect patient names, addresses, and contact information adversely affect the eligibility verification process. Errors in patient data entry also include failure to promptly update changes in the patient's personal or insurance information.

Impact: Inaccurate patient information significantly increases the likelihood of claim denials, causing considerable financial setbacks for practice owners. If it isn't outright claim denials, incorrect patient information during eligibility verification significantly expands reimbursement timelines, leading to disputes with insurance providers.

Coverage Discrepancies

Error: Insurance coverage verification errors occur when medical practices fail to thoroughly verify the specific services covered, limitations, and changes in the patient's details. Coverage verification errors usually happen due to an oversight of the policy details by the front-end staff.

Impact: Coverage discrepancies result in partial reimbursement or underpayment for the services rendered. They can also lead to prolonged dispute-resolution sessions with the payer. In short, efficient patient eligibility verification enables practice owners to secure full reimbursement for services and maintain a financially sustainable practice.

Inadequate Benefit Verification

Error: There are many nuances to the benefits patients get from payers. Hence, It requires deft hands and a watchful eye to identify them accurately. Oversights in verifying details such as coverage for prescription drugs, preventive services, or specific medical procedures directly affect reimbursements.

Impact: Inadequate benefit verification leads medical practitioners to underestimate the services covered by the patient's insurance plan. It results in billing loss for certain covered services and a long chase for practitioners to resolve reimbursement issues.

Inaccurate Provider Information

Error: Incorrect details about the healthcare provider or care facility during the patient eligibility verification process can affect claims just as much as incorrect patient information. Errors related to provider information usually encompasses inaccuracies in provider name, contact information, National Provider Identifier (NPI), or facility particulars.

Impact: Inaccurate provider information heightens the risk of rejected claims for medical practices.Insurance providers may necessitate additional verification or clarification, prolonging processing times and, subsequently, delaying reimbursement for rendered healthcare services. Additionally, inaccurate provider information may give rise to potential contractual issues with insurance companies, impacting the terms and conditions of reimbursement agreements.

Lack of Pre-Authorization

Error: Pre-authorization is followed to ensure 'expensive' medical procedures are necessary for patients in specific cases. When practices initiate treatment requiring specific medical devices, and prescription medications, pre-authorization reduces the risks associated with claims management. Unfortunately, pre-authorization errors significantly affect reimbursement rates.

Impact: : Failing to secure pre-authorization approvals can lead to outright claim denials, creating financial strain for the healthcare provider.It also adds additional administrative burden on medical practices to rectify the situation. Healthcare providers may need to navigate appeals processes, engage in retrospective authorization requests, or undertake other time-consuming measures to secure reimbursement for services already rendered.

Failure to Verify Referral Requirements

Errors: Advanced medical conditions and chronic pain cases usually require visits from specialists. Payers establish many referral requirements that must be verified before scheduling appointments with specialists. An oversight from the medical practice in verifying the referral requirements lead to complications that may result in denied claims.

Impact: Many insurance plans mandate referrals for specialist visits, and without the necessary documentation, claims submitted for these services may be rejected. This leads to potential financial setbacks for the healthcare provider. In cases where referrals are mandatory, the absence of proper verification can result in patients facing denied specialist services. This not only causes dissatisfaction among patients but also disrupts the continuity of their care, potentially impacting their overall health outcomes.

Overlooking Patient Financial Responsibility

Error: The complexities surrounding copays, deductibles and out-of-pocket expenses makes it essential to keep patients aware of their financial responsibility. Hence, issues such as failure to inform patients about their financial responsibilities at the point of service, or incorrect assessments of patient financial responsibility and coverage adversely affects medical practices and its patients.

Impact: Without clear communication, patients may be unaware of their financial obligations, leading to discrepancies in billed amounts and potential disputes, creating administrative challenges for practice owners. Additionally,patients may experience dissatisfaction and trust issues if their financial responsibilities are not clearly communicated. This lack of transparency can erode patient-provider trust and negatively impact the overall patient experience, potentially leading to reduced patient retention.

A Checklist For Medical Practices to Effectively Verify Patient Eligibility

Item	Description
Co-Pays and Co-insurances	**Verify and communicate patient copayment amounts for services.**
Payable Benefits	**Assess and communicate the specific benefits covered by the patient's insurance plan.**
Deductible	**Verify the amount the patient must pay before insurance coverage begins.**
Policy Effective Date	**Confirm the start date of the patient's insurance policy for accurate eligibility assessment.**
Type of Plan and Coverage	**Identify the type of insurance plan and the extent of coverage for different services.**
Exclusions if Any	**Check for any exclusions or limitations in the insurance coverage that may affect eligibility.**
Mailing Address	**Ensure the accuracy of the patient's mailing address for effective communication.**
Referrals and Pre-Authorizations	**Confirm whether specialist visits require referrals and obtain necessary pre-authorizations**

Self Service Eligibility Verification Applications: Reinforcement For Medical Practices?

Currently, most medical practices delegate revenue cycle operations to service providers. But with the digital age leaving its mark on the healthcare industry, healthcare applications are leading the charge for efficiency in practice administration. They can enable medical practices to cut costs by employing service providers for relatively simple RCM processes.

The age of 'self-service' applications may be the way forward for medical practices to harness better efficiency in patient eligibility verification and claims check process. Promising features such as real-time eligibility verification, EHR integration, automated eligibility verification, etc, carry immense potential to speed up the process and ramp up accuracy in the two essential aspects of the practice RCM cycle.