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Independent Insurance Eligibility Verification A Cost/Benefit Review for Immunization Billing

tapi The Arizona Partnership for Immunization

whyimmunize.org

Developed for
The Arizona Partnership for Immunization-TAPI
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During the original feasibility study conducted by The Arizona Partnership for Immunization (TAPI) as a part of the CDC demonstration grant, many of the most common reasons for denials of immunization claims were focused around insurance eligibility, enrollment, and determination of primary responsibility. Navigant has found that the most direct approach to address this type of denials is through insurance eligibility verification.

Verification of insurance eligibility has always been a key element in "best practice" revenue cycle management processes; but with increasingly accessible, electronic tools to process patient information and insurance coverage verification, it is now a cost-effective "must" for medical billing and claims processing.

Specific to TAPI, this report will define the role of independent verification in the revenue cycle process, identify best practice characteristics as they relate specifically to third-party insurance billing for immunization services, review how other similar agencies are dealing with verification, evaluate the costs and benefits of an effective eligibility verification process, and make recommendations to TAPI for implementation of on-going operations for independent insurance verification.

Eligibility Verification

Revenue cycle processes and workflows are becoming a focal point for efficiency and cost savings in an ever-evolving healthcare market place that demands lower cost, increased accuracy, and high patient satisfaction. Health care providers, including state and county run health departments, must devise new and innovative models in order to stay viable and competitive. Eligibility verification for insurance coverage and benefits is one of the front-line components of a well-run revenue cycle process and one that now truly benefits from advances in technology and data access.

Insurance eligibility verification is a part of the "pre-claim" process and in "best practice" operations is always an integrated part of the data collection process that ensures accurate claims submission and appropriate payment of billable services. The objective of completing independent verification of insurance coverage and benefits is to minimize the denial of claims and to maximize the number of clean claims processed by the system. A greater percentage of clean claims results in a higher flow of payments, less staffing costs per claim, and a healthier revenue cycle process.

The basic components of eligibility verification include the following:

- Collection of and retention of a copy of patient insurance information
- Contact with the insurance carrier to determine eligibility, policy status, and effective dates
- Determination of coverage limits
- Understanding of submission guidelines and verification of claims submission channel
- Calculation of patient responsibilities such as co-pays and deductibles
- Identification of plan exclusion
- Verification of eligibility by CPT code

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If done manually for each individual patient registration, eligibility verification can potentially be time consuming. Staff can be kept on hold for inordinate amounts of time, or may lack login information for a specific carrier, leading one to wonder if the process is worth the effort. But rest assured that without independent verification, significant costs and lost revenue will be incurred. Therefore, all public health department and practices should look to "best practices" within the industry for guidance in developing and improving the insurance eligibility verification process for their group or practice.

Industry "Best Practices"

In effective and efficient revenue cycle operations, eligibility verification occurs as part of the Patient Registration and Check-In function. There are several different best practices relative to the timing of patient registration, practice operations, and utilization of third-party billing services:

Pre-Registration: Ideally, insurance information would be collected from the patient in a pre-registration encounter either by phone or by patient portal. This should occur between 2 to 7 days prior to the scheduled patient encounter, allowing sufficient time to validate the information and independently verify current insurance coverage for the scheduled service.

Registration at Check-In: If a patient has not been pre-registered, then their data will be collected at the time of check-in for their appointment, with copies or scans of insurance cards retained for the medical record. Eligibility verification would then be done at time of check-in, prior to rendering services to ensure coverage and benefits.

Verification Prior to Claim Submission: In the case of third-party billing services, if eligibility verification was not completed during registration and check-in, then at a minimum; verification should be completed prior to all claim submissions.

There are many avenues for eligibility verification, including phone calls to carriers, insurance company websites, clearing house services, and batch verification services. Many of these resources are available at no-cost to providers, but do require a significant investment in staff time and effort to complete individual verifications. With many cost effective options for partnering with vendors, current best practice is to use electronic verification that allows for both individual and batch processing of eligibility inquires. This also allows for real-time, or near real-time verification that is returned to the practice in seconds or minutes. When performing batch verification through the practice management system eligibility results are returned directly into the patient's medical records in the practice management system. The provider can also set up parameters on how many days prior to the appointment the batch eligibility is run.

Also emerging as a "best practice" within the industry is the use of dedicated staff for verification activities. Even though this process is closely linked to the front-desk or check-in; assignment of responsibility for completing the process is accomplished much more effectively by staff with experience and training specific to insurance claims processing and eligibility requirements. In smaller settings, it

may not be possible to assign a full FTE of staff to this function, but even in those cases, the resource responsible for verification should receive adequate training to complete the task effectively. To assist with insurance eligibility verification training, one can contact the insurance provider representative to schedule a training session for staff.

The position of an Insurance Verification Specialist is an important one within any healthcare setting. The scope of work for this position continues to grow in complexity as health insurance itself becomes more complex. This position is likely to also be involved with patient registration. It can vary depending on the volume of patients at the county health department. Below is a brief job description for this critical position:

Responsibilities:

- Timely verification of insurance benefits with all payors (both government and commercial);
- Documentation of information from the health insurance carriers;
- Obtain pre-certification or authorization if needed prior to services being rendered;
- Ensure that the appropriate payer and benefit information is captured in the practice management software;
- Effectively communicate with the patient the benefits that they have or do not have for the services being requested; and
- Assist with front office registration.

Skills, Abilities and Qualities:

- Comprehension of and ability to translate benefit details into a written document;
- Understanding of healthcare terminology;
- Ability to multi-task and attention to detail;
- Excellent customer service skills; and
- Capable of interacting with patients, families, staff, management, clinic providers, insurance companies, third-party payers as well as the general public in a professional manner.

The focus on independent insurance verification continues to grow within the health care marketplace, so the expectations for performance will vary significantly dependent on the maturity or evolution of a county health department's verification process. However, with designated verification staff and a clearly defined process for the verification function health departments can use some industry benchmarks to set expectations for the performance for their group's process:

Performance Category	Benchmark Metric
# Insurance Verification/ FTE- Manual	64 Cases/ Day
# Insurance Verification/ FTE- Online	120-160 cases/ Day
Insurance Verification Rate- Within 24 Hours of Patient Arrival	100%
# Pre-Certification/Authorization/ FTE	48-64 Cases/ Day

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TAPI's Peer Group Utilization

TAPI is not alone in its need for addressing and optimizing the billing process for immunization services. All community health entities must recognize the need for additional public and private revenue in light of decreasing government funding available to meet immunization goals. Given the squeeze on public health resources, TAPI saw a need to assist Arizona's county health departments develop billing mechanisms for the immunization services, specifically for patients covered by public and private insurance.

As part of this study, several state and county agencies were identified as the "peer" group and were asked to participate in an on-line survey regarding billing and eligibility verification practices. Invitations to participate were sent to agency contacts in six states (a list of these contacts is included in the appendix). Individual responses were kept anonymous, but participation was verified from the following agencies: Arkansas Department of Health; Colorado Immunization Program; Georgia Department of Public Health; Oklahoma State Department of Health; New York Office of Public Health Practice and four New York municipal public health departments.

In addition to the survey participation, several agencies provided TAPI with copies of their billing manuals/plans for review of their practices, policies, and procedures for immunization billing. These entities included: Kern County, California Public Health Services; the Washington State Local Health Jurisdiction; and the Georgia Department of Public Health Practice.

Results from the respondents to the survey, although not statistically significant, do provide a reasonable portrayal of the full spectrum of processes being utilized to bill for immunization services. While almost all of the agencies register their immunization patients, the level of billing processes for these patient runs from many years of experience, to just began or are considering billing, to do not bill for immunization services.

Both Georgia and Binghamton, NY have been billing for services for over 15 years. These two agencies have established procedures for registration, eligibility verification, claims processing and follow up. They participate and bill with both public and private insurance and use some third-party services to augment their revenue cycle management. They are good examples of near "best practice" operations. (Note: Georgia was one of the entities that provided a copy of their billing manual, which was a significant supporting reference for the "best practices" section of this report.)

The majority of responding agencies do: register their immunization patients, verify Medicaid eligibility by website or by phone, and are considering alternatives for billing for these services either in-house or through a third-party biller. All respondents indicated that they are already billing for or are considering billing for immunization services in the future. This is further evidence that the squeeze on public health resources is pushing agencies to find alternative sources for revenue to support their public health goals.

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In comparison to the peer group, TAPI's billing program falls in the middle of the spectrum of activities. With several years of billing efforts for immunizations with multiple county agencies, TAPI is establishing itself well to realize returns from both public and private insurers and the current efforts to improve eligibility verification is a step in the right direction to ensure accurate and effective revenue cycle management processes.

Cost and Benefit of Eligibility Verification

The unprecedented attention that revenue cycle processes and workflows are receiving as the healthcare industry faces new demands on financial management has spurred the development of tools and services needed by healthcare providers to create more innovative management models and to remain competitive and viable. Insurance eligibility verification is one of the areas that is benefiting from these changes.

Traditional channels from verifying insurance coverage are still available to agencies and practices alike, such as toll-free carrier phone service, insurance website, Medicaid websites, and magnetic card reader services. There are also clearing house services, vendors who contract with multiple insurance carriers to aggregate verification databases into a single access point. These provide an electronic data interface (EDI), which works through web portals or even through direct connection with practice management and EHR systems to complete insurance verification rapidly and at very low cost.

Some of the companies in the marketplace include Passport, Relay Health, Emdeon, and Navicure. Also, as demand for this type of service increases, new companies that are primarily web based and target smaller practices and agencies are coming to market as well, some of these are CareVault, Claim Remedi, and Health Fusion.

Insurance verification, whether completed by staff through traditional no-cost channels, or through a partnership with third-party vendors has a cost associated with the process. That cost is a combination of staff time (in wages and benefits) and in subscription or utilization fees for third-party services. The fees for clearinghouse services come usually in two forms, either an annual subscription fee, or a "per-click" fee for each verification processed. Actual fees for these services vary based on volume, number of providers, and the terms of the agreement; but in general subscription rates range from $40to $145 per month, and/or per-click charges from $0.08 to $0.20 per verification.

A recent study, conducted by the National Healthcare Exchange Service, estimates the cost of manual eligibility verification at $3.70 per claim and the cost for automated, or electronic, verification at only $0.74 per claim. This study confirms, that automated eligibility verification has significant cost savings and so long as the clearinghouse has data for the majority of insurance carriers that an agency or practice uses, is a desirable option from a verification cost stand point. In fact, even at the high end of the fees, savings may be realized with as few as 50 verifications per month.

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The true benefit of insurance eligibility verification is clean claims processing, or claims paid on the first pass. A major expense to health departments and practices alike is the effort required to manage claim denials and to re-work claims through multiple submissions. The same study referenced above, estimates the cost of claim submission to be $6.63 when processed manually (on paper) or at $2.90 when submitted electronically. In addition to the cost savings of clean claims processing, the Center for Health Transformation estimates a benefit of more than $3.00 per claim through improved Accounts Receivables and reduced claims follow-up that is attributable to first pass claims adjudication.

Given the benefits numbers represented by these studies, a benefit of approximately $6.00 per clean claim is a reasonable expectation as a benefit from insurance verification. At a per click cost of $0.20 per claim (this is likely much less on a subscription basis) the eligibility verification process would need to provide a 3.3% improvement in claims processing, or in other words produce 1 more first pass claim for each 30 claims processed.

TAPI has entered into an agreement with Navicure to provide insurance verification clearing house services for commercial payors. The terms of the agreement require a single use subscription for each CHD that is billing immunization through TAPI. At the current contracted rates, a conservative estimate of the break-even point for each CHD would be between 13 to 15 first pass claims per month.

Conclusion

In our evolving healthcare marketplace with ever increasing pressure to control costs and meet patient needs, independent insurance eligibility verification plays a critical role in ensuring that services, coverage, and the claims process functions accurately and efficiently. Benefits from a robust and consistent eligibility process come from "first-time" accuracy of claims submission and the alleviation of expensive denials management and claims re-processing. It also provides a greater degree of patient and provider satisfaction, because issues are dealt with once and only once.

Current costs associated with eligibility verification are commensurate with the associated benefits, and as technology and electronic health records systems continue to evolve, will likely continue to decrease over time, giving sustained and improving cost/benefits in the future.

Independent insurance eligibility verification is an essential step to ensure accurate pre-registration and registration information. Identification of eligibility issues as early in the process as possible, facilitates a streamlined workflow process, maximizing productivity and allowing corrections to be made prior to service, or, at the very latest, prior to claim generation (claim drop). Systems and services are available to facilitate and track eligibility for immunization benefits and are a vital component of the revenue cycle management process.

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Recommendations for TAPI's Executive Committee

The findings of this report support the following five recommendations to the TAPI Executive Committee:

1. TAPI needs to educate participating CHDs about and encourage compliance with "front-end" insurance eligibility verification. Best practice is to complete this verification prior to delivery of service. At a minimum, CHDs should verify all AHCCS patients and if possible, through the Navicure contract, also verify coverage for all private insurance patients.

2. TAPI must complete insurance verification for 100% of all immunization claims prior to submission. This will entail validation of verifications done at the CHDs with follow up as necessary. Also, verification through Navicure and other channels for all patients not verified at the CHD at time of registration.

3. Designate and train staff to perform "Insurance Verification Functions". Industry best practice is to have staff assigned to insurance verification that have the background, training, and current industry knowledge to quickly and accurately facilitate the eligibility verification process. Staff should be designated at the Front-End in the CHDs to initiate and complete as much of the verification process as possible. With TAPI providing Back-End resources to ensure final validation of all claims prior to submission. TAPI is in the unique position to maintain staff that provides this function for the benefit of all participants in the immunization billing program to both educate and support each CHD; where doing so at the county level would be cost prohibitive and difficult keep staffed.

4. TAPI needs to establish operations and performance standards for the insurance verification process based on benchmarks and best practices. At a minimum the standards should include: 100% of claims verified prior to submission, and 50 to 75 verifications processed per day. Additionally, TAPI should establish a reporting methodology to track compliance with the performance standards on a regular basis.

5. Finally, TAPI should continue to pursue an "Outreach" program to the non-participating counties in Arizona. The TAPI immunization billing program, with its associated systems and procedures is a resource that can be leveraged to provide greater returns through increased participation from the Arizona CHDs.

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APPENDIX

Prevention and Public Health Fund Projects to Improve Reimbursement in Public Health Department Clinics - Implementation Phase: Program Contact List	
Arkansas	Lee Clark Reimbursable Services Manager Arkansas Department of Health Little Rock, AR
California	Juliet Rafol Assistant Branch Chief California Department of Public Health Richmond, CA
Colorado	Cathleen Beaver Special Projects Coordinator Colorado Immunization Program Denver, CO
Georgia	Kimberly Russell, CPC Billing Specialist Department of Public Health Atlanta, GA
New York	Scott Coley Immunization Billing Coordinator Office of Public Health Practice New York State Department of Health Albany, NY,
Oklahoma	Yvonne Myers Chief, Health Planning and Grants Oklahoma State Department of Health Oklahoma City, OK