Eligibility

Let's say staff calls a payor to verify eligibility for Mr. George Smith and is told that he is eligible. What does that really mean? Well "eligible" only means that as of the payor's current data base the monthly premiums for Mr. Smith have been paid. In a "macro" sense he is eligible for your care. But in a "micro" sense he may not be. Confusing? Sound like double-talk?

Well think back just a couple of pages to the discussion on Covered Services. With that in mind here are two examples when "eligible" does not mean eligible.

Let's say Mr. Smith's benefit plan includes an annual "routine" eye exam. So with a macro view he is "eligible" for an eye exam as that is a Covered Service. But if Mr. Smith last had an exam eleven months ago then with a micro view he is not "eligible" today for that particular Covered Service. So he is eligible, but he is not "eligible."

Or consider this disparity I've occasionally come across between a payor's commercial and Medicare Advantage product lines. If Mr. Smith is covered under a Medicare Advantage product then he's going to be eligible for Medicare benefits including iStent (0191T) when placed along with cataract surgery. But if instead Mr. Smith is eligible under the same payor's commercial HMO or PPO products he may not be eligible for that iStent if the payor deems iStent to be experimental or investigational. So considering that payor's commercial product lines in a macro view he is eligible for surgical eye care services, but in a micro view he's not eligible for iStent.

Bottom line: Confirming "eligibility" is not enough. Staff must confirm both current active enrolled status and also eligibility for specific services -- the availability of which may be product line specific.

Please recognize that if staff does not ask the right questions it's kind of hard to expect that the payor's representatives or, perhaps, on-line accessible services, will provide the complete picture. But let's assume as a matter of practice staff does dig and extract the best available information, yet still claims are denied. What might one do contractually in an attempt to limit or preclude collateral financial damage when the fault or source of flawed information lies with the payor, or its affiliates, or its employer group clients, or with any other entity outside your control?

All payors will make available a means to verify eligibility, typically on-line or by phone. Of course it is each practice or facility's responsibility to confirm eligibility between the time an appointment is made and the day the "eligible" presents. And as a means to minimize patient upset and practice disruption I recommend reconfirming the day before to get the latest information on any unmet deductibles.

The Issue: Many Provider Agreements state that an ID card is not proof of eligibility. And many will also state that confirmation of eligibility is not a guarantee of payment. **Even if eligibility is confirmed on the date of service**, when that person for whom you received authorization later turns out not to have been eligible most payors disingenuously reserve the right to tell you *"Too bad,"* and retroactively take back monies already paid, or offset against future payments.

The payor position is that if the patient (no longer classified by the payor as a "Member") were not eligible on the date of service that person knew it and presented under false pretenses. A **very few** payors may work with practices and facilities to interface with employers and assist in the collection of denied claims or retroactive takebacks, but generally they are not obligated to do so.

Rather, payors will tell you to seek compensation from the patient or, alternatively, seek another financially responsible party, for example a different insurance. However, in most cases by the time staff learns of the takeback and exhausts a futile appeal that patient is long gone, and it may be impossible to determine if another insurance company is in the mix.

In my opinion this "dodge" of financial responsibility after providing inaccurate information is unconscionable. But this is Managed Care, and it's their agreement. If a payor contractually refuses to stand by the accuracy of its data and in doing so sticks **you** with the collateral financial damage of **its mistakes**, well in my opinion that's a "WART," not a "wart."

I'll discuss retroactivity and takebacks in more detail later. But for now here are two possible ways to push back on a payor that would try to deny payment for the properly authorized services you've provided. The first puts financial responsibility squarely back on the payor while the second, certainly less aggressive, gives the payor a little "wiggle room." **I recommend getting your attorney's input.**

Possible Solutions: In this first example the payor represents or warrants (legalese for "guarantees") the accuracy of its data and, further, **acknowledges that you will rely upon this data in your performance under the agreement**. Further, it would guarantee payment for services rendered in good faith after proper eligibility verification, including for services provided to those retroactively deemed to have been ineligible if the information supplied by the payor later turns out to have been wrong.

If a payor digs in its heels and won't represent that its data is accurate or stand behind the information its staff provides (certainly a likely possibility) then the second suggested compromise language would allow the payor to deny payment after previously authorizing services, **but only if the practice or facility is promptly informed**. If the Notice period is kept short enough (see the option **{in brackets}** within the suggested text) you'd hopefully have at least a reasonable opportunity to submit a claim to another insurance company or seek payment from the patient.

After discussions with your attorney present your edited text to the payor and seek its insertion into an appropriate section of the Provider Agreement or into a section of its own.

Eligibility verification: As set forth in the Provider Manual, <name of payor> shall provide Physician with a verification system for identifying all Members. Except for emergency care Physician shall confirm Member status before rendering services using <name of payor's> eligibility verification system. Physician shall be entitled to reasonably rely on verification of Member eligibility as provided by <name of payor> or an Affiliate, and <name of payor> or Affiliates shall hold Physician harmless if Physician reasonably relies on that verification.

Notwithstanding anything contained in this Agreement to the contrary, if Physician renders a Covered Service to a Member after having obtained eligibility confirmation from <name of payor>, <name of payor> may not retroactively deny or adjust payment for the Covered Service after it was rendered.

In the event that Physician fails to verify Member eligibility in accordance with procedures set forth in the Provider Manual, <name of payor> shall have no obligation to compensate Physician for any services provided to patients who are not Members of <name of payor> at the time such services are rendered.

Alternatively:

Plan is obligated to pay Physician hereunder. However, in the event the Plan learns that a Member is no longer an eligible Member, Plan is not obligated to pay Physician for any services provided to such Member so long as Plan notifies Physician of the Member's ineligibility within thirty (30) days of the date of service {optional suggestion: or within 30 days of the claim submission date}. In such event Physician may bill the Member.