

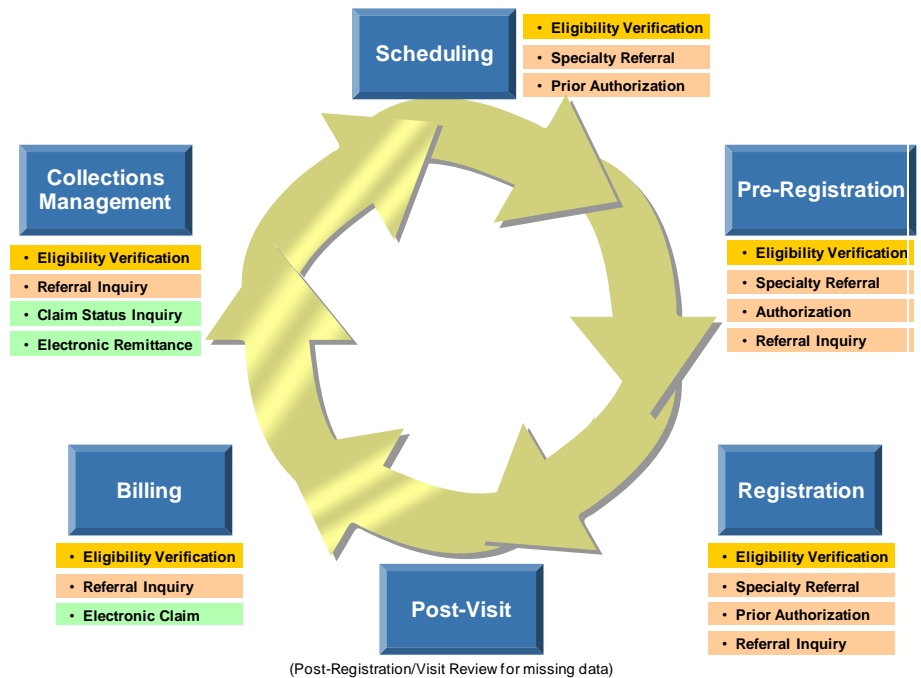
## Eligibility in the Revenue Cycle – When and how often to inquire?

Across the United States, approximately 25% of all health care claims are rejected. Of those rejected claims it is believed that 80% are rejected for reasons associated with eligibility verification. These could be prevented by performing electronic eligibility verification and updating the billing system with the correct information.

Despite the wide adoption and use of electronic eligibility, providers continue to see claim rejections for reason such as “Invalid Member Id”. This document will discuss ways to improve the effectiveness of electronic eligibility as well as options for getting additional value from your processes.

Eligibility verification is useful at many points in the revenue cycle from the point when a patient schedules an appointment to researching claim denials. We encourage providers to utilize all available transactions as often as necessary to verify information and ensure that claims are correct the first time and paid in a timely manner.

Since each organization has different business practices and system capabilities, we do not recommend a single process for verifying eligibility but identify the points in the revenue cycle where there are definite benefits to checking eligibility. We also encourage providers to assess the various options available for checking eligibility, from integrated eligibility inquiry from within their Registration or Scheduling System to accessing individual payer websites, and the use the best option for their business process.



### Scheduling

When scheduling appointments, providers have their first opportunity to obtain correct insurance information. Information provided at previous visits cannot be relied upon since insurance information can change at any time. At a minimum, schedulers should ask for and record current health insurance information.

Ideally, provider staff has the ability to record insurance information and other required data for eligibility verification and perform a real time eligibility check while on the phone with the patient. This ensures that the insurance information and other data required for billing is entered correctly in advance. Scheduling staff may also remind patients of co-pay collection policies or refer them to the financial office if they require assistance.

Checking eligibility at scheduling also allows the provider to review PCP information and inform the patient that they must call their Health Plan if they need to change the PCP information on record. The provider may also remind the patient to obtain a referral if required by the plan verified during the eligibility check.

Most payers provide the option for a name search so a patient or person making the appointment need not have an insurance card in front of them to make the appointment as long as they have name, date of birth, and gender information.

**Best option at scheduling: integrated real time.**

### Pre-Registration

Even if eligibility is checked at scheduling, there are benefits to checking again 3-7 days prior to the appointment date. Many times appointments are scheduled months in advance and insurance information may have changed. Information recorded at scheduling may be incorrectly entered in registration systems or not updated.

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Sending a batch of eligibility transactions 3-7 days prior to a visit provides enough time to contact a patient if there is an issue. At a minimum, the eligibility checks that are invalid should be worked prior to the appointment date. You may also want to look at the data for patients in managed care plans to ensure PCP information is correct and referrals are received.

Another use of a pre-visit eligibility check is to ensure critical data stored in the registration/billing system matches the payer's response. An invalid date of birth or incorrect spelling of a name may result in a claim rejection and rework at the back end.

If the payer's data is incorrect the patient or employer must contact the payer to correct the information. Beginning that process earlier will ensure a clean claim is submitted earlier.

***Best option 3-7 days prior to visit: batch***

**Registration**

Eligibility should be checked at every visit. Again, insurance information can change at any time and some Health Plans such as Medicaid and Managed Medicaid plans require that you check eligibility on the day of the appointment. Checking eligibility during registration also ensures that same day appointments are verified.

The person registering the patient should compare the results of the eligibility check with the data stored in the system and ensure that discrepancies are corrected. To keep things moving, refer problems such as ineligible, no insurance, mismatched data, and incorrect PCP to a "specialist" to resolve. A specialist should know all the options for verifying eligibility and be willing to assist the patient in calling the health plan if information such as PCP needs to be changed.

***Best option for registrations: integrated real time***

**Post -Visit**

There are times when you may also want to verify eligibility after a visit. This is done to compensate for scheduled or unscheduled time when on-line eligibility is unavailable, to verify issues identified during registration have been resolved or to provide feedback to individual registrars or an entire department/location on performance.

***Best options for post-visit: integrated real time/batch***

**Pre-Billing**

Sometimes information is not available until after a visit has occurred. Providers can check eligibility prior to generating a bill if there are situations where the patient never registered such as emergency room visits or lab specimens submitted by a physician's office. Also, if a patient has applied for assistance such as Medicaid but a decision was not available during the visit, the provider may check prior to submitting a bill. You may also want to flag other self-pay patients for further investigations such as minors/young adults unaware of a parent's health insurance coverage. For larger claims, providers may want to again check that the information on the bill matches the payer information to ensure the claim is not rejected and payment delayed.

***Best options for post-visit: integrated real time/batch***

**Collections Management**

When providers fail to obtain correct information prior to or during registration, the collections staff must follow up upon claim rejection or denial. The goal of every provider organization should be to minimize the amount of follow-up work after a claim has been generated.

If a claim is rejected or denied due to incorrect date of birth, name, or member id, providers use a real-time eligibility option to resolve the discrepancy and resubmit the claim. Payer web sites may provide additional search options if an eligibility issue is discovered. Be sure to advise staff to update the permanent registration information if discovered after a bill is submitted to prevent the same problem from occurring again.

Providers should track the frequency and reasons for eligibility related rejections and denials. Look for patterns where eligibility is either not verified or information not updated correctly prior to billing. Communicate with registration staff and propose solutions to improve eligibility verification processes.

***Best option upon claim rejection or denial: Integrated Real Time, Payer Web Sites***