# Determining Patient Eligibility through Independent Verification Services

Making the most of available resources is the first thing that healthcare business managers tell their staff to get contented with. Independent medical practitioners and hospitals alike are today looking for innovative ways to bounce back from the slumbering healthcare business and want to manage claims at faster pace and with precision. Also, as fraudulent patient claims and false cases are on the rise, verifying patient eligibility and determining what service he/she gets and has received stands as a top priority.

The healthcare insurance business landscape has changed, and one of the greatest changes is the developing monetary obligation of patients with high deductibles that oblige them to pay physician practices for administrations. This is a one major region where independent practitioners are finding it difficult to increase the monthly collections and have an optimized billing system.

**Verification Process incorporated by Payers**

Insurance eligibility verification is one of the best methods for counteracting insurance claim refusals/denials. As a third-party vendor the administration or service starts with recovering the list of scheduled appointments and checking coverage plan for the patients. Once the confirmation is done the coverage details are placed specifically into the appointment scheduler for the in-house staff to get a notification regarding the same.

As basic as it can get, be it in-house or through ***outsourced verification service*****,** there are three strategies for checking patient qualification:

- Online - Using different Insurance organization sites and web payer portals, one can easily check patient qualification.
- Automated Voice Recognition (IVR) – This procedure utilizes an automated machine response that tells you the eligibility status of the patient by punching in the correct details.
- Insurance agency Representative Call - If necessary, calling an insurance agency agent can provide the payers a point by point benefit details for specific procedure when not accessible from either the website or automated telephone system.

Here are some of the best practices used today to independently verify patient insurance verification:

**Check patient qualification 48 to 72 hours ahead of scheduled visit utilizing one of these three strategies:**

- Business-to-business (B2B) confirmation, which empowers practices to electronically check patient eligibility utilizing electronic data exchange (EDI) by means of their electronic health record (EHR) and practice management arrangements.

- Looking for patient eligibility on the payer website.
- Call payers to decide qualification for more complex situations, such as, coverage of specific procedures and administrations, determining the maximum coverage in a full calendar year, or if administrations are covered if they occur in the doctor's office or diagnosis center. Clearinghouses don't provide the practitioner with these details. And in such a scenario giving this undertaking to an ***outsourced insurance verification agency*** can serve as the best option for your process.

Determining patient's monetary duties - High deductibles, out-of-pocket limits, and then making patients understand about their money related obligations before delivering services, instructing them on the amount they'll have to pay and when.

Regulating co-pays and collections before services are delivered.

However, even while doing this, there are still potential pitfalls, for example, changes in verification or eligibility because of employee termination of patient or primary insured, unpaid premiums, and subtleties in dependent coverage.

If all the above mentioned things seem to you as tedious undertaking, then outsourcing the work to certified outsourced independent insurance verification agency can help a lot in resolving many claims related issues. It would not only speed up the reimbursement process, but also lessen the AR days, and make your practice a profitable venture.

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