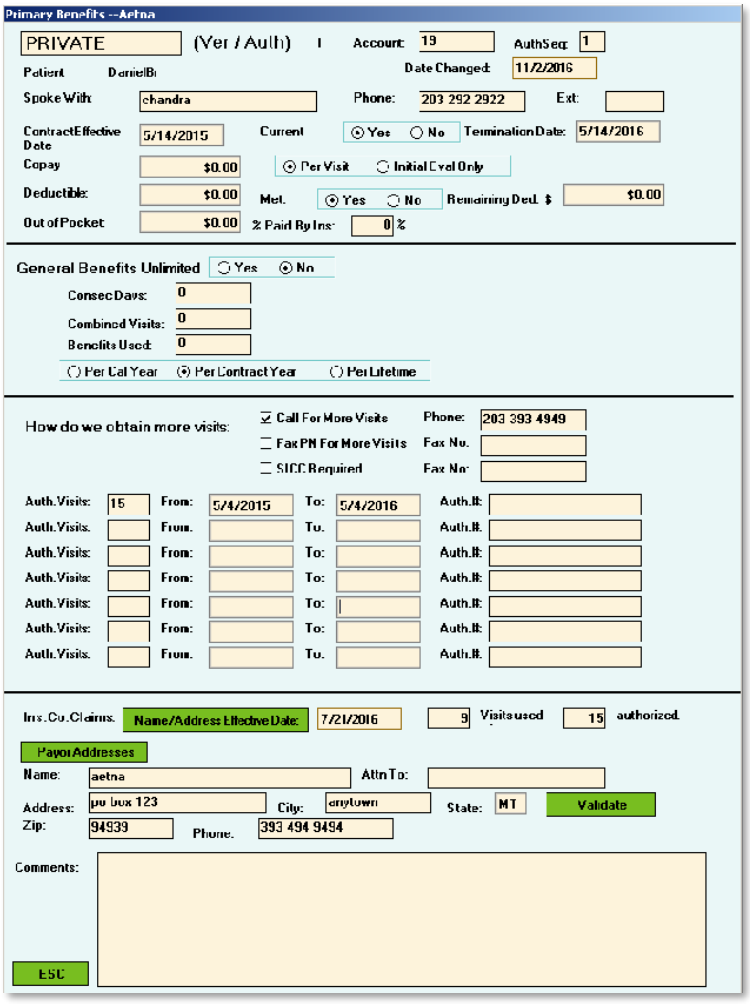
Verification & Authorization (V & A) Screen

NOTE! Payors such as Medicare, Self-Pay Regular, and Self-Pay Full charge do not require a V&A screen.



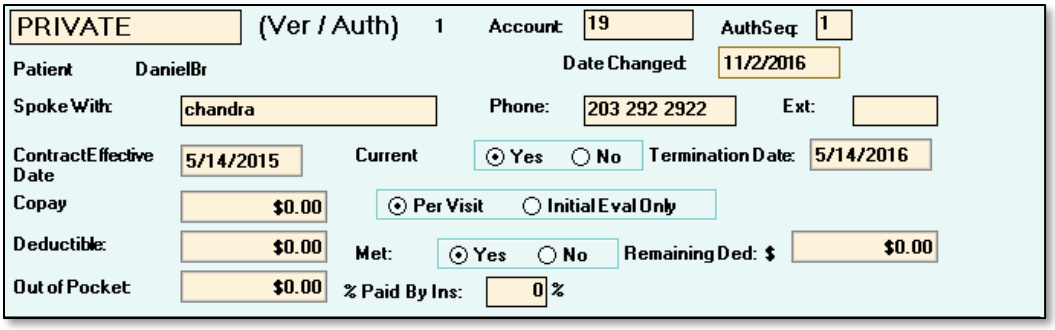
Block #1

Block #2

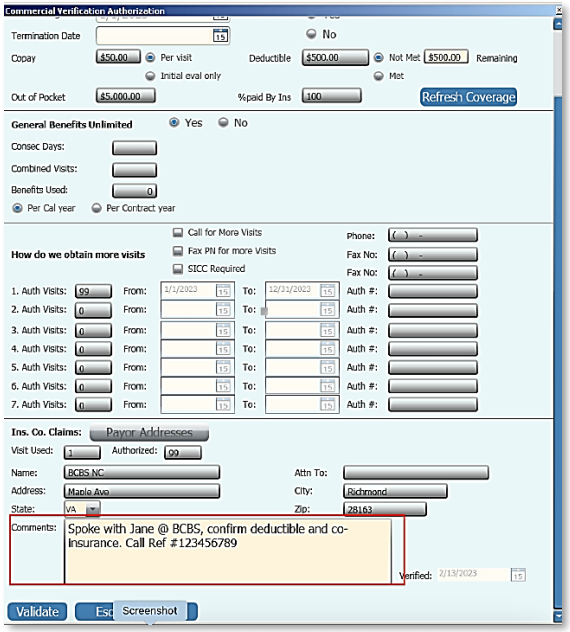
Block #3

Block #4

Block #1: This is the critical information for your Patient Billing & Collection Process



- If you call for benefits, **always** get the name of the person you spoke with. Also request a "Call Reference Number" at the end of the call and document that number in Block #4 "Comments".



- If you do not need to call the insurance, type which website you obtained the information from. Eg: PEI, ASHlink, Availity, OptumHealth

- If you called for benefits, enter the phone number that you called and applicable extension.

- If you do not call for benefits, record the phone number for "Provider Services" from the patient's insurance card.

- Obtain the start date of the patient's insurance policy. This is frequently the first of the year but not always, so be sure to verify. If you are advised that the patient's policy is terminated, mark "No" for current and enter the termination date.

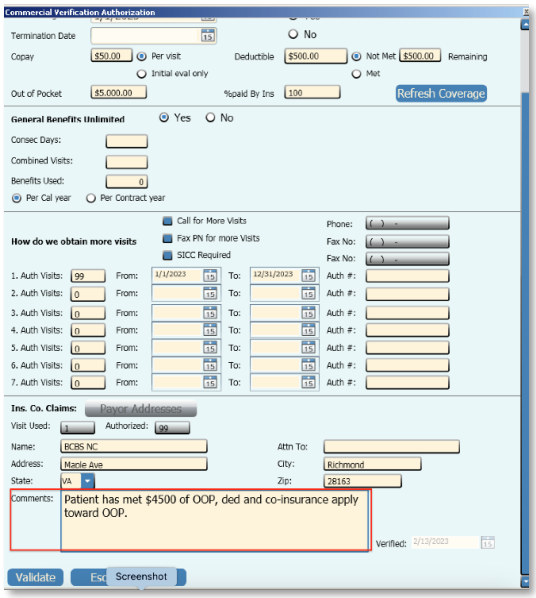
- Next check if patient has a co-pay, co-insurance, or both. Enter the co-pay amount in the box and check “Per Visit” or “Initial Evaluation Only” depending on what you were advised.

- If the patient has a co-insurance, you will enter the amount that the insurance company pays in the box “% paid by insurance”.

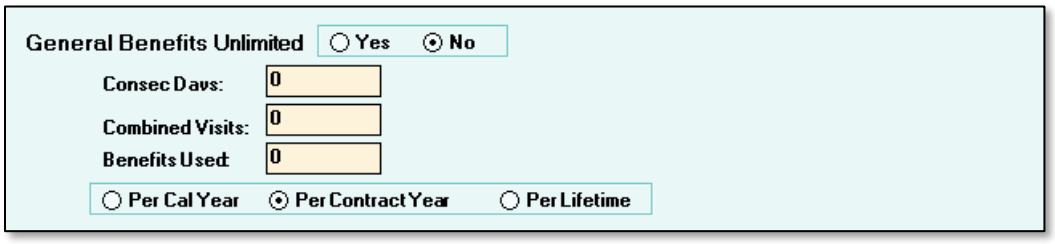
- Now look for whether the patient has a deductible and if so, how much has been met. Enter the deductible amount. If it has not been met, enter the amount remaining as of the date you verified the insurance benefits.

  It is very important to be aware that the deductible is met in the order that the claims are received by the payor, not by order of the service dates. It is very possible that your patient has had other medical treatments, and possibly other providers have already “collected” their deductible, but if your claims are received and processed before these other claims, the deductible will be taken from your payments and the patient will be responsible for paying that amount to you. It is always a good idea to explain that to the patient so there are no surprises.

- Finally, find the patient’s “Out of Pocket Maximum” for the year. This is the amount that the patient must pay before the payor will cover expenses at 100%. There is not a box to enter how much of that amount they have met at the time you verify benefits but it is recommended that you record that number in Box #4 “Comments”. You should attempt to determine if the patient’s co-pays count toward that out of pocket maximum.



Block #2: How much therapy is covered by the insurance policy.



Keep in mind that within a particular insurance company, there are different policies with different benefits. You can't assume all United Healthcare policies will have the same benefits. You must verify each patient's specific plan.

- You want to verify if this patient's therapy benefits are limited to a specific number of days or visits? Select "Yes" or "No"

- Benefits you may see are "30 consecutive days per condition", "30 visits per calendar year", "30 visits per contract year", "30 visits per lifetime", "unlimited", etc.

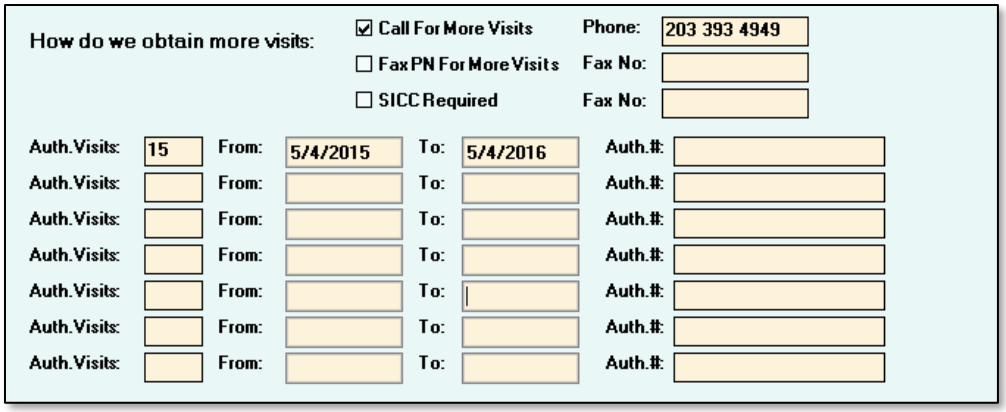
- Depending on how it is written, you will fill in the appropriate boxes. If the benefit is unlimited, enter 999 in the days and/or visits boxes. A number must be entered in each box to validate the V & A screen and sign the patient registration.

- It is very important you determine if the patient has used any of the allowable benefit. If it is not noted on the web page you **must** call the payor to obtain this information. Enter the amount of benefit used in the appropriate box.

- Select whether the benefits are Calendar Year, Contract or Policy Year, or Lifetime.

- *It's also important to know that some insurance companies have separate benefits on specific CPT codes. This information is usually not obvious on the benefit verification web sites and will require a phone call to the payor. An example is CPT 97140. Certain payors have a separate limitation on this code because of its use by multiple disciplines.*

Block #3: This information is used to track allowed visits. It provides the data that populates your work lists and the authorization number, if applicable, for billing.



- OMV stands for Obtain More Visits.

- To obtain authorization for additional visits, does the payor want you to call, fax a progress note or new script, or submit a SICC (Special Insurance Company Communique)?

- Select the appropriate choice and enter the necessary phone number or fax number.

- All patient accounts must have an entry the section “Auth. Visits”.

- If the patient’s benefits are truly unlimited, enter 999 for the number of visits and use the calendar or policy year start and end dates for the “From”/”To” dates. Leave the Auth. # blank.

- If the patient’s policy has a limited number of visits but does not require authorization to use those visits, enter the number of visits remaining in the benefit, and the current date to the policy end date for the “From”/”To” dates. This is essential for accurate tracking of visits to provide appropriate warnings when benefits are nearing exhaustion. Leave the Auth. # blank.

- If you are allowed to perform and bill the initial evaluation before getting authorization, enter “1” for the Auth. Visits, and the current date to the end of the policy year as the “From”/”To” dates. Leave the Auth. # blank.

- If the patient requires authorization for treatment, enter the number of visits authorized and the date range that the visits are authorized. If no date range is specified by the payor, enter the current date to the end of the policy year. Enter the authorization number if one exists.

- Systems4PT will track both the allowed number of visits and the termination date and notify you when either limit is nearing.

- When you obtain additional authorization it is very important that you update the V & A Screen appropriately for Systems4PT to continue to accurately track and warn you of expiring authorizations.

    - If you completed the number of authorized visits but not the date range, you will want to change the “To” date on the completed Auth. Visits line to the date of the last treatment covered by that authorization.

    - When you enter the new authorization, the “From” date will be the next consecutive date after the previous line’s “To” date. (Or the exact dates specified in the authorization if appropriate).

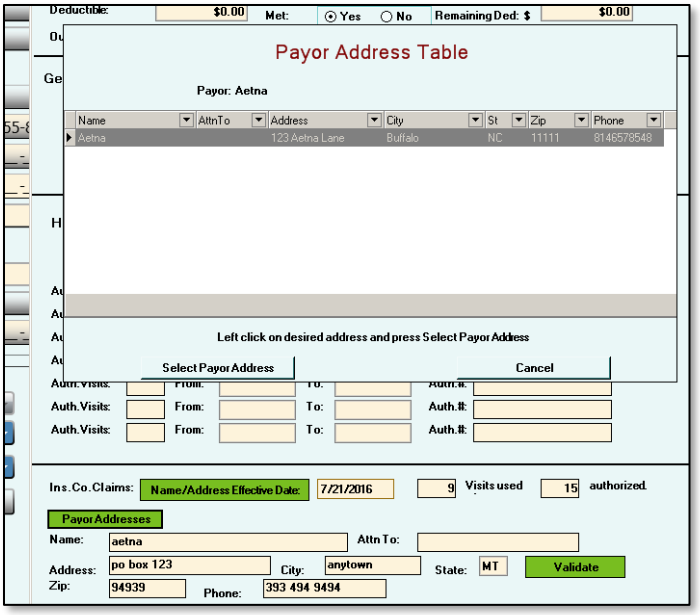
    - If you did not complete the number of visits authorized but the date range expired, you have 2 options depending on the payor. If the payor chooses to keep the number of authorized visits unchanged but extend the date range, you can just change the “To” date to the new date provided by the payor.

    - If the payor chooses to issue a new authorization with a new number of visits and a new date range, you will enter this new information in the next line. Enter the new Auth # if provided. You will go back and change the “Auth. Visits” on the expired authorization to the number of visits you actually used. You will change the “To” date on the expired authorization to the date of the last authorized visit.

    - If you do not change the “Auth. Visit” number on the expired authorization, Systems4PT will not accurately track the next series of authorized visits. The System keeps a running total of the numbers in “Auth. Visits” and compares it with the number of notes signed to provide warnings at the appropriate time. This is also why it is crucial that notes be signed in a timely manner, for accurate tracking.

    - If you run out of lines for entering Authorization data, contact Support for directions on consolidating lines.

Box #4: Verification of correct Payor and Address



- When verifying benefits, confirm what address the claims are to be sent to. Most payors have multiple addresses and the correct address is determined by the specific policy. This address will be on the web page and on the patient's Insurance ID Card.

- Even if that payor is billed electronically, the correct mailing address is necessary in case of problems that require submitting additional documentation or dropping claims to paper.

- **DO NOT** manually type in the Payor name and address.

- Click on the "Payor Addresses" button and a drop-down list of all addresses for the payor you entered on page 1 of the Patient Registration will appear.

- Click on the correct address and it will auto fill into the screen.

- If the Drop-down list does not appear or the correct address is missing, contact support and provide them with the Payor name, address, phone number, and the electronic id number. They will enter the data into Systems4PT for you.

- The "Comments" box is where you can enter any information specific to the payor such as the call reference number, comments made by the payor during the phone call that don't have an applicable box, and the amount of out-of-pocket maximum used as of a specific date. The information you enter in the comments box will not appear on the Patient Processing Screen (PPS) when checking in a patient. If there is information you want to appear on the PPS you will need to enter it in the "Comments" box at the top of the Registration Screen.

- Once all the appropriate information has been entered on the V & A screen, click on the "Validate" button on the bottom of the screen in Block #4. A "validated" message box will appear if all the necessary data is present. If anything is missing, a "Registration Validation Message" box will appear and will contain a list of all the required information that is missing from the V & A screen. You will not be able to sign the patient registration until this screen passes validation.

Tips on verifying benefits and completing the V & A Screen can be found in Patient Billing and Collections, Part 1.

At Systems4PT we provide an ALL USA BASED team that gets you PAID MORE, PAID FASTER, that COSTS LESS, and we only get paid AFTER you get paid!