INSURANCE VERIFICATION

Terms:

- **COPAY**: also known as Copayment. Copays are flat fees for certain visits. A patient might have a $20 copay for each general doctor's visit and a $50 copay for each visit to a specialist. **They have to pay a fixed amount until their out-of-pocket max is met.**

- **DEDUCTIBLE**: also known as DED. A deductible is the amount the patient's pay out-of-pocket for covered services before his/her health plan kicks in.

The exact deductible amount will be based on the FEE SCHEDULE of the practice. These amounts are also known as the **maximum allowed amount.**

Scenario 1: DED 3000/0 met COINS 80/20 OOP 3500/0 met

The patient will need to accumulate the $3000 before insurance pays 80% of the maximum allowed amount. IF DED is met (3000/3000 met) - Patient pays 20% until the OOP is met.

Fee Schedule Amount for Blue Cross Blue Shield for the CPT Code: 99204 and 99214

Consultation/Exam Code for a new patient: 99204 is $161.03

Consultation/Exam Code for a follow up patient: 99214 is $106.43

The patient will have to pay $161.03 for the first visit. Then $106.43 for the following visits

Scenario 2: DED 3000/3000 met COINS 80/20 OOP 3500/3000 met

1. The deductible (DED) is $3,000 and it has been met. This means that the patient no longer needs to pay the maximum deductible amount for their covered healthcare services.

2. The coinsurance is 20%, which is the patient's share of the costs of a covered healthcare service, calculated as a percent (20% in this case) of the allowed amount for the service.

3. The maximum allowed amount for a particular service (99204), as per the fee schedule, is $161.03. And $106.43 is for follow-up patients.

Given this, to calculate the patient's cost:

- You take 20% of $161.03, which is $161.03 x 0.20 = **$32.20. - New Patient**

- You take 20% of $161.03, which is $106.43 x 0.20 = **$21.28. - Follow Up Patient**

So, the patient would be responsible for paying $32.20 for this service, considering the deductible has already been met and the insurance covers the rest.

Scenario 3: DED 3000/3000 met COINS 80/20 OOP 3500/3500 met

Given that both the deductible and the out-of-pocket maximum have been **met**, the **patient should not have to pay anything more for covered services**, as the **insurance would cover 100%** of the costs up to the plan's coverage limits. Therefore, for any covered healthcare service, **the insurance should pay the full allowed amount, and the patient would not owe anything.**

****This computation applies to all covered services.****

- **COINS**: also known as COINSURANCE. Coinsurance is the percentage of the bill you pay after the patient meets the deductible amount. This applies to Scenario 2. However, if the COINS is 100%, the out-of-pocket maximum limit would still be in effect. This means that once the patient's total expenses (including deductibles, copayments, and coinsurance) reach the out-of-pocket maximum, the insurance would typically start to pay 100% of covered expenses for the remainder of the policy period.

- **OUT OF POCKET**: This is the total cost that represents the patient share of the hospital or doctor's bill throughout the entire calendar year.

On Scenario 3: Given that both the deductible and the out-of-pocket maximum have been **met**, the **patient should not have to pay anything more for covered services**, as the **insurance would cover 100%** of the costs up to the plan's coverage limits.

- **(MAXIMUM) ALLOWED AMOUNT** - These are amounts based on the **FEE SCHEDULE** that is mostly provided by the practice.

INSURANCE VERIFICATION - Call

Details to prepare prior calling insurance providers:

- Patient's Name
- Patient's DOB
- Patient's Insurance Member ID #
- Provider's NPI Number and Tax ID
- Provider's Clinic Address and Call Back # or YOUR call back #
- CPT Codes

Some practices require certain CPT codes OR procedure codes to be verified, for ex. X Rays, MRI/CT, DME (Durable Medical Equipment), etc. Please refer to your client's requirement*

- *For each type of service. If the patient is subject to a DEDUCTIBLE PLAN, make sure to get the COINSURANCE and ACCUMULATIONS. Also, get the OUT-OF-POCKET MAX and its accumulations.*
- *If a patient has a copay: Subject to DED? NO.*
- *If a patient has a deductible: Subject to DED? YES.*
  a. *If the DED is MET, then COINS applies until OUT OF POCKET is met.*
  b. *If OUT OF POCKET is met, then the patient is COVERED 100% by the insurance.*

Insurance Calling Script:

"Hello, my name is (Your Name) This is from (Practice Name)

I am calling to verify the Chiropractic Benefits for a patient please? / I'm calling to verify chiropractic benefits for the policyholder [Policyholder's Name]."

Rep will confirm the **Patient's Insurance ID #, Full Name and Date of Birth, Provider's NPI/TAX ID

General Questions:

- *Could you confirm if chiropractic care is covered under this patient's policy?*

Provider Network Participation

- *Can you confirm if our clinic is in-network for chiropractic services? If not, what percentage of the charges would be covered for an out-of-network provider?*

Visit

- *What is the coverage amount for chiropractic visits?*
- *It is important to confirm if the patient is covered under COPAY or DEDUCTIBLE for each type of service. If the patient is subject to a DEDUCTIBLE PLAN, make sure to get the COINSURANCE and*

ACCUMULATIONS. Also, get the OUT-OF-POCKET max and its accumulations.

Visit Limits

- *How many chiropractic visits are allowed per year under this policy?*

CPT Codes (Some practices require certain CPT codes OR procedure codes to be verified)**

- *May I also verify if the patient has coverage for the following CPT Codes? If yes, What is the coverage amount for each? (Provide the CPT Codes needed.)*

Authorization Requirements

- *Are there any pre-authorization or referral requirements for chiropractic services?*

Additional Information

- *Are there any other details or considerations related to chiropractic coverage that I should be aware of?*

Conclusion

Thank you for providing this information. May I just confirm the details provided to me:

(Repeat all the details provided: for ex. For each Chiropractic visit, patient has a copay of $20, for XRays: Patient has a deductible amount of $3000, for which $ has been met.. etc.)

If the Rep confirms all details are correct, *May I have a reference or confirmation number for this call and your name, please?*

Rep provides the number or his/her name as a reference.

Thank you and have a good day!

Remember to take notes during the call for **reference number and the name of the representative you're speaking with** and make sure to follow up in writing to confirm the details obtained. This script is a guide, and you may need to adapt it based on the specific questions and policies of the insurance company you are contacting.