



DISCLAIMER

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Agenda

INTRODUCTION

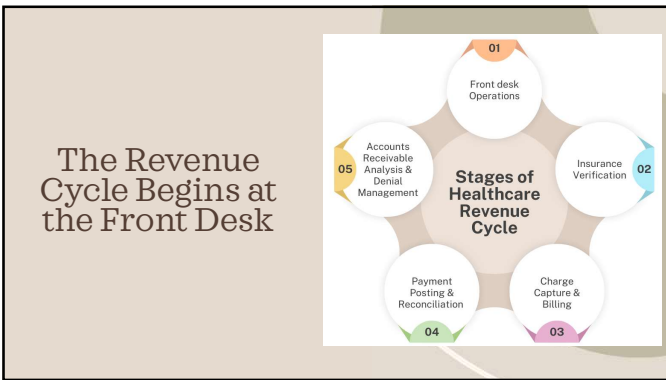
PATIENT INTAKE

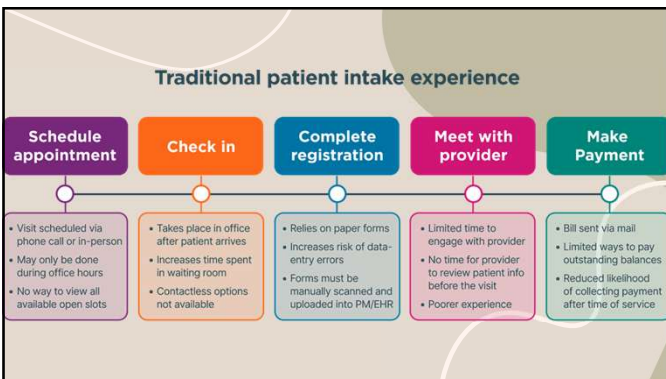
INSURANCE VERIFICATION

MEDICARE BASICS

FINAL TIPS & TAKEAWAYS







WHAT INFORMATION ARE WE COLLECTING DURING INTAKE?

The Patient Intake Process

1. Demographic information
2. Contact information
3. Insurance
4. Emergency contact
5. Responsible party
6. Pharmacy
7. Current physicians
8. Legal forms and consents
9. History of present illness
10. Medical history
11. Screenings
12. Patient education and marketing
13. Image capture
14. Payment capture

PATIENT PROFILING: The Revenue Cycle Version

Patient Information <ul style="list-style-type: none"> Name (exactly as shown on insurance card) DOB Contact information 	Insurance Information <ul style="list-style-type: none"> Insurance carrier Subscriber ID Group number Secondary insurance 	Financial Information <ul style="list-style-type: none"> Copay Coinsurance Deductible 	Administrative Information <ul style="list-style-type: none"> Case type Rendering provider Authorizations Limitations
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**ACCURACY COUNTS!
REMEMBER, GARBAGE IN,
GARBAGE OUT!**

What Could Go Wrong?

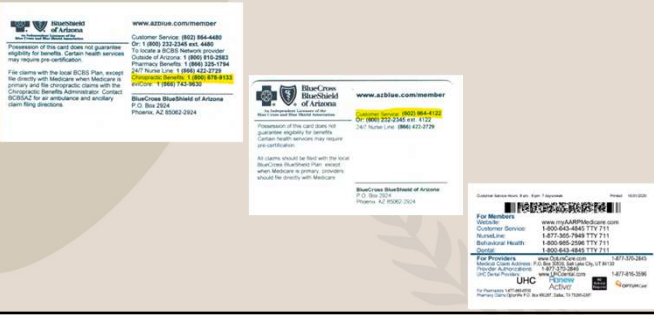
Information Collected	Potential Consequence
Wrong DOB	Eligibility rejection
Wrong Member ID	Claim Rejection
Missing Secondary Insurance	COB denial
Medicare Advantage entered as Medicare	Incorrect billing and payment delays
Missing Authorization	Authorization denial and possible patient liability
Participating Status Not Verified for Rendering Provider	Out-of-network: claim processing, reduced reimbursement, and unexpected patient balance

Most denials are not created when a claim is submitted. They are created when incorrect information is collected.

DON'T ASSUME EMPLOYER HAS THE SAME INSURANCE FOR EVERYONE!



BACK OF CARD CONTAINS IMPORTANT INFO- COPY BOTH SIDES!




MEMBER NAME SHOULD BE ENTERED IN COMPUTER EXACTLY AS IT APPEARS ON THEIR INSURANCE CARD




PAYER ID for E-CLAIMS

Member ID Cards



Health Plan (0340) 911
Member ID: 123456789
Group Number: 98765

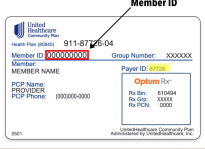
PCP Name: JANE DOE
PCP Phone: (000)000-0000



UnitedHealthcare

Health Plan (00840) 911-87726-04
Member ID: 123456789 Group Number: 98765

Member: JANE DOE
Dependents: JOHN DOE
Payer ID: 12345
UnitedHealthcare Choice Plus




Member ID

Health Plan (011) 87726-04
Member ID: XXXXXXXXX Group Number: XXXXXXXX

Member: MEMBER NAME
Payer ID: 12345

PCP Name: JANE DOE
PCP Phone: (000)000-0000

Some payers have a different payer ID for different types of claims.



MEDICARE HEALTH INSURANCE


Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
PART A
PART B

**PATIENTS WHO HAVE
MEDICARE PART B – DO NOT
USE IF PATIENT HAS A MA
PLAN**

Coverage starts/Cobertura empieza
03-03-2016
03-03-2016



AARP Medicare Supplement Plans
Insured by UnitedHealthcare Insurance Company

MEMBERSHIP ID **123456789-11**
MR JOHN Q SAMPLE
EFFECTIVE DATE: 00-00-000
AARP MEDICARE SUPPLEMENT PLAN F

Insured by UnitedHealthcare Insurance Company (for NY residents, UnitedHealthcare Insurance Company of NY)

This is a Medicare Supplemental Plan, aka Medigap

It is Supplemental to Medicare Part B

Plan "Letter" Determines Level of Payment



arizona complete health
Complete Care Plan

Arizona Health Care Cost Containment System

Member Name:
AHCCCS ID#:

Arizona Complete Health-Complete Care Plan
Member Services: 1-888-788-4408 - TTY/TDY: 711
Nurse Advice Line: 1-866-534-5963

IMPORTANT INFORMATION

In a life threatening emergency call 911 or go to the nearest emergency room. Carry this card with you at all times. Present it when you get services. You may be asked for a picture ID. Using the card inappropriately is a violation of the law. This card is not a guarantee for services. To verify benefits visit:
accorshlth.com/completecare or call 1-888-788-4408


Pharmacy Help Desk: 888-634-3311
 RXBIN: 004336 RXPCN: MCADADV RXGRP: RX6443

Submit Medical Claims to:
 EDI Claims Payer ID: 68069
 PO Box 9010
 Farmington, MO 63640-9010

Provider Services: 1-866-796-0542

SAMPLE MEDICAID CARD.
 MEDICAID PATIENTS NEED TO BE
 CHECKED FOR ELIGIBILITY
 MONTHLY!

HOW DO WE PREVENT THESE ISSUES?



Effective Insurance Verification Helps:

- Confirm active coverage before services are rendered
- Identify patient financial responsibility
- Verify authorization requirements
- Confirm provider network participation
- Reduce claim denials and payment delays
- Improve patient satisfaction and cash flow

Eligibility vs Benefits Verification

Eligibility Verification	Benefits Verification
Is coverage active?	Is the service covered?
Effective date	Copay
Member status (active/inactive)	Deductible
Plan type	Coinsurance
Subscriber information	Visit limitations
Policy status	Authorization requirements

Active insurance does not guarantee covered services.

Questions Every Office Should Ask

Before the Patient's First Visit:

- Is coverage active?
- Is the provider participating?
- Is prior authorization required?
- What is the patient's copay?
- Has the deductible been met?
- What is the coinsurance?
- Are there visit limitations?
- Is there secondary insurance?
- Is this Traditional Medicare or Medicare Advantage?

Top Insurance Verification Mistakes

- VERIFYING ELIGIBILITY BUT NOT BENEFITS
- MISSING AUTHORIZATION REQUIREMENTS
- FAILING TO IDENTIFY SECONDARY INSURANCE
- NOT VERIFYING NETWORK PARTICIPATION
- USING OUTDATED INSURANCE INFORMATION
- ASSUMING MEDICARE ADVANTAGE IS TRADITIONAL MEDICARE

Verification Workflow

1. Obtain an insurance card
2. Identify payer
3. Access the payer portal
4. Verify eligibility
5. Verify benefits
6. Verify authorization requirements
7. Verify network participation
8. Document findings
9. Communicate patient responsibility

Verification Workflow

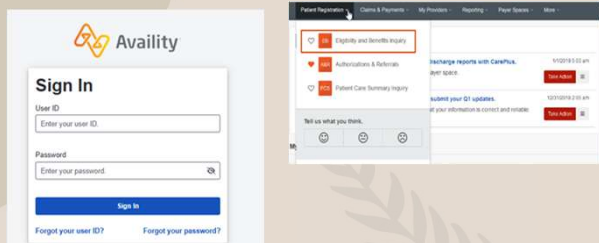
- CHECK BENEFITS ON ALL NEW PATIENTS
- CHECK BENEFITS ON ALL ESTABLISHED PATIENTS WHO HAVE NOT BEEN SEEN IN AT LEAST 3 MONTHS CHECK BENEFITS AT THE START OF EACH CALENDAR YEAR (CY).
- CHECK ALL MARKETPLACE/MEDICAID PLANS MONTHLY
- CHECK BENEFITS AT THE START OF EACH FISCAL YEAR (FY), IF THE PATIENT HAS A FISCAL POLICY
 - Example, School Teachers, college students: Their policies may run from AUG 1 – JULY 31 rather than Jan 1 – Dec 31.

Tools for Eligibility & Benefits Verification

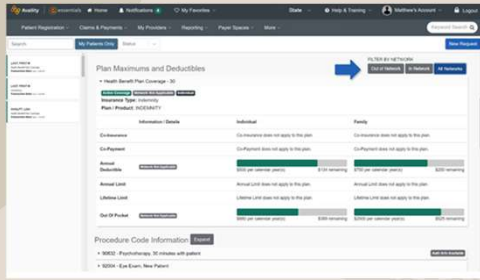
Tool	Best Use
ASHLINK	Commercial payer eligibility & benefits
Availty	Commercial payer eligibility & benefits
Medicare MAC Portal	Traditional Medicare Eligibility
Medicaid Portal (AHCCCS)	Medicaid Eligibility
Payer-specific portals	Eligibility & benefits
UHC Provider Portal	UHC Commercial & Medicare Advantage
PM Software	Eligibility & Benefits

ELIGIBILITY & BENEFITS VERIFICATION

AVAILTY – MOST COMMERCIAL PAYERS
[HTTPS://ESSENTIALS.AVAILTY.COM/STATIC/PUBLIC/ONB/ONBOARDING-UI-APPS/AVAILTY-ER-UI/#/LOGIN](https://essentials.availty.com/static/public/onb/onboarding-ui-apps/availability-ui/#/LOGIN)



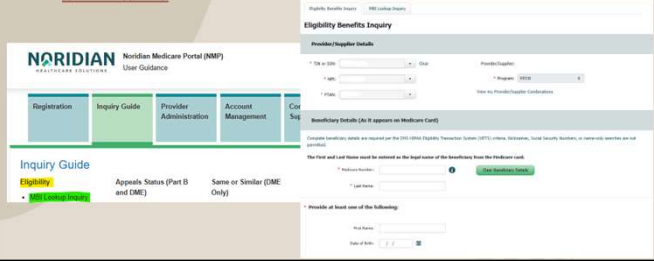
ELIGIBILITY & BENEFITS VERIFICATION



ELIGIBILITY & BENEFITS VERIFICATION

MEDICARE: NORIDIAN – INQUIRY GUIDE → ELIGIBILITY

<https://med.noridianmedicare.com/web/portalguide/inquiry-guide/eligibility>



MEDICAID: AHCCCS – INQUIRY GUIDE → ELIGIBILITY & ENROLLMENT STATUS

<https://www.azahcccs.gov/commercial/Downloads/FFSTechnicalAssistance3.pdf>



<https://ao.azahcccs.gov/Account/Login.aspx?ReturnUrl=%2f>



Traditional Medicare vs Medicare Advantage

Traditional Medicare	Medicare Advantage
Administered by CMS	Administered by private insurance companies
Verify through Medicare MAC Portal	Verify through the payer portal/Availty
Generally no prior authorization for chiropractic CMT	May require prior authorization
No provider network	Provider networks apply
Standard Medicare benefits	Plan-specific benefits and limitations
MBI Required	MBI + Plan Member ID often needed

Key Takeaway: Medicare Advantage should not be verified the same way as Traditional Medicare.

Medicare Basics: What Every Front Desk Professional Should Know

Traditional Medicare

- o Part A = Hospital
- o Part B = Medical
- o Chiropractic Spinal Manipulation (CPT 98940-98942) covered under Part B*

Medicare Supplement

- o Secondary to Traditional Medicare
- o Helps cover patient responsibility

Medicare Advantage

- o Replaces Traditional Medicare
- o Private insurance company administers benefits
- o Verification requirements vary by plan

Coordination of Benefits (COB)

What is COB?

Coordination of Benefits determines:

- Which insurance pays first
- Which insurance pays second
- The patient's remaining responsibility

Why Is It Important?

- Prevents claim denials
- Prevents payment delays
- Ensures claims are billed in the correct order
- Reduces unexpected patient balances

Front Desk Responsibility

- ✓ Identify all active insurance coverage
- ✓ Obtain copies of all insurance cards
- ✓ Verify primary and secondary payer order
- ✓ Update COB information when coverage changes

Common Medicare Coordination of benefits Scenarios

Scenario	Primary	Secondary/Supplements
Traditional Medicare + Medigap	Medicare	Medigap
Traditional Medicare + Commercial Plan	Depends on COB rules	Depends on COB rules
Medicare Advantage + Secondary Plan	Medicare Advantage	Secondary Plan
Traditional Medicare Only	Medicare	None

Medicare Front Desk Takeaways

- Identify the type of Medicare coverage
- ✓ Verify eligibility
- ✓ Identify secondary coverage
- ✓ Verify authorization requirements
- ✓ Document findings
- ✓ Communicate patient responsibility

Front Desk Success Checklist

Patient Intake

- ✓ Collect complete and accurate information
- ✓ Obtain copies of all insurance cards
- ✓ Verify demographic information

Insurance Verification

- ✓ Verify eligibility and benefits
- ✓ Verify authorization requirements
- ✓ Verify network participation

Medicare

- ✓ Identify Traditional Medicare vs Medicare Advantage
- ✓ Identify secondary coverage
- ✓ Understand Coordination of Benefits




We are here to Help!



- ❖ **Billing Company** - Billing Services
- ❖ **Credentialing** - Provider Enrollment Services
- ❖ **Compliance** - Consulting/Chart Audit/Compliance Manuals
- ❖ **Staff Training** - Staff Education
- ❖ **Gold Star Academy** - Video Base Training Platform
- ❖ **Practice Management** - Practice Coaching Services

GOLD STAR
Medical Business Services
"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"



HOW TO REACH US

- ❖ Schedule a Complimentary Consultation
 - Self Service Tool: <https://calendly.com/lmaciejewski/consult>
 - Call our Executive Office at (830)613-8325 or Corporate Office at (866)942-5655
- ❖ <https://www.goldstarmedical.net/contact-us>
- ❖ Website: <https://goldstarmedical.net>
- ❖ Facebook: <https://facebook.com/goldstarmedical>

THANK YOU FOR YOUR ATTENDANCE!

References:

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2. <https://www.cms.gov/medicare/new-medicare-card/understanding-the-mbipdf>
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4. <https://www.noridianmedicareportal.com/web/nmp>
5. <https://www.nvhasphere.com/secure/login>
6. <https://palmettoeba.com/jib>
7. <https://thespt.fcso.com/secure/login>
8. <https://www.wpsgha.com/>
9. <https://identityonehealthcaeid.com/oneapp/index.html#/login>
