Patient Eligibility and Preauthorization Policy

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I. PURPOSE AND SCOPE

A. Purpose

This policy defines comprehensive procedures for verifying patient insurance eligibility, confirming benefit coverage, and obtaining necessary preauthorizations (prior authorizations) and referrals before services are rendered. The objectives of this policy are to:

1. Ensure accurate insurance information is captured before services
2. Minimize claim denials due to eligibility issues or lack of authorization
3. Provide patients with transparent information about their coverage and financial responsibility
4. Optimize revenue cycle efficiency by addressing insurance requirements proactively
5. Comply with payer contractual requirements
6. Reduce administrative burden and re-work caused by preventable denials

B. Scope

This policy applies to:

- All scheduled inpatient admissions and outpatient procedures
- All non-emergent services (emergency services are covered under separate EMTALA protocols)
- All payers (commercial insurance, Medicare Advantage, Medicaid Managed Care, traditional Medicare and Medicaid, workers' compensation, etc.)
- All patient access, scheduling, registration, and authorization staff
- Clinical departments involved in ordering services that require authorization
- Billing and denial management teams

II. DEFINITIONS

Insurance Verification: The process of confirming that a patient's insurance coverage is active and determining the specifics of their benefits (deductible, copay, coinsurance, coverage limits).

Eligibility Check: A real-time electronic or phone inquiry to an insurance company to verify a patient's active coverage on a specific date of service.

Prior Authorization (Preauthorization): Approval from an insurance company obtained before a service is provided, confirming that the service is medically necessary and covered under the patient's plan.

Referral: A written order from a primary care physician (or other authorized provider) required by some insurance plans before a patient can see a specialist or receive certain services.

Authorization Number: A unique reference number issued by the payer when an authorization is granted; must be included on the claim.

Benefit Limits: Restrictions or caps on coverage, such as a maximum number of physical therapy visits per year or a lifetime maximum for certain services.

Deductible: The amount a patient must pay out-of-pocket before insurance begins to pay.

Coinsurance: The patient's share of costs (expressed as a percentage, e.g., 20%) after the deductible is met.

Copayment (Copay): A fixed dollar amount the patient pays for a service (e.g., $30 copay for a specialist visit).

Out-of-Pocket Maximum: The maximum amount a patient will pay in a year; after reaching this, insurance covers 100%.

Retro-authorization: Authorization obtained after a service has been provided (some payers allow this in urgent circumstances).

III. INSURANCE VERIFICATION PROCESS

A. When Verification is Required

Insurance verification must be performed:

- For all scheduled services (surgeries, procedures, imaging, therapy appointments, specialist consults, infusions, etc.) at the time of scheduling or as soon as possible thereafter
- For established patients with recurring visits (e.g., weekly physical therapy), at least monthly or whenever the patient reports a change in coverage
- At the time of admission for inpatient stays
- Before administering high-cost medications or treatments

Insurance verification is also recommended:

- Upon patient registration for the first time
- At annual wellness visits or check-ups
- Whenever a patient mentions a change in employment or insurance

B. Timing of Verification

Ideal Timing:

- **3-5 business days before the scheduled appointment or procedure** to allow time to address any issues discovered

72-Hour Re-verification Rule:

- Benefits should be re-verified within 72 hours prior to the service date to catch any recent changes (e.g., patient changed jobs, policy lapsed, new month's deductible reset, benefits exhausted)

Day-of-Service Verification:

- For walk-in or same-day add-on patients, perform a real-time eligibility check at the time of registration
- Front desk staff should also visually inspect the insurance card and scan a copy for the file (to document the card on file at time of service)

C. Information to Verify

During insurance verification, staff must confirm and document the following:

Patient and Policy Information:

1. Patient's full name (as it appears on insurance card), date of birth, gender
2. Insurance company name and phone number
3. Policy/member ID number and group number
4. Policyholder name (if patient is a dependent)

5. Relationship to policyholder (self, spouse, child)
6. Policy effective dates (start date and any termination date)
7. **Active Coverage Status on the date of service** (most critical: yes or no, is the patient covered?)

Benefit Details: 8. Type of plan (PPO, HMO, EPO, POS, Medicare Advantage, Medicaid Managed Care, etc.) 9. Whether our facility and providers are in-network or out-of-network 10. Deductible amount (individual and family, if applicable) 11. Amount of deductible met to date (remaining deductible) 12. Out-of-pocket maximum and amount met to date 13. Coinsurance percentage for the relevant service category (e.g., 20% for outpatient surgery) 14. Copay amount for the service (if a fixed copay applies instead of coinsurance) 15. Coverage/benefit limits or caps (e.g., therapy visit limits, DME dollar limits) 16. Exclusions or non-covered services

Service-Specific Coverage: 17. Is the specific planned service (procedure, test, etc.) covered under the plan? 18. Are there any frequency limitations? (e.g., one screening colonoscopy every 10 years) 19. Is prior authorization required for this service? 20. Is a referral required? 21. If authorization or referral required, what is the process and timeline?

Claim Submission Information: 22. Payer ID for electronic claims submission 23. Claims mailing address (if paper claims) 24. Timely filing limit (e.g., claims must be submitted within 90 days of service) 25. Any special claim forms or attachments required

Coordination of Benefits (COB): 26. Does the patient have other insurance (secondary or tertiary)? 27. Which insurance is primary, secondary, etc.?

D. Methods of Verification

Electronic Eligibility Systems (Preferred Method):

- Our practice management system is integrated with real-time eligibility vendors (e.g., Availity, Waystar, Optum)
- Staff initiate an electronic eligibility transaction (270/271 EDI transaction) which queries the payer's system
- Results return within seconds showing coverage status and benefit details
- **Advantages:** Fast, accurate, documented electronically, available 24/7
- **Limitations:** Not all benefit details may be included (some payers provide limited data); staff should verify authorization requirements separately if not clear

Phone Verification (When Electronic Not Available):

- Call the payer's provider services line (number on back of insurance card or from payer directory)
- Speak with a representative and request verification of benefits for the patient and date of service
- Ask all questions from the list above and document responses
- **Document:** Date and time of call, name and ID of payer representative, reference number if provided

Payer Web Portals:

- Many payers offer provider portals where eligibility and benefits can be checked
- Staff log in with provider credentials and search by patient ID
- Similar information to electronic eligibility, often more detailed

Best Practice: Use electronic eligibility for initial check, and supplement with a phone call or portal check if:

- Authorization requirements are unclear
- High-cost service (to verbally confirm coverage)
- Patient has unusual circumstances (e.g., out-of-state coverage)

E. Documentation

All eligibility verification must be documented:

- **Electronic Verification:** System automatically saves the 271 response; staff should print or screenshot and attach to patient account if needed for reference
- **Phone Verification:** Staff complete an Eligibility Verification Form noting all information obtained and attach to the patient file
- **Include:** Reference number from the payer (confirmation number), name of rep, date/time, and summary of benefits
- **EHR/PMS Entry:** Key benefit information (deductible, copay, auth required) should be entered into the scheduling or registration system so it's visible to all staff

Retention: Verification documentation must be retained in the patient's financial/administrative record for at least 6 years (or per state requirements) to support claim submissions and address any disputes.

IV. PREAUTHORIZATION (PRIOR AUTHORIZATION) REQUIREMENTS

A. Services That Commonly Require Prior Authorization

Prior authorization requirements vary by payer and plan. Common categories requiring auth include:

Imaging:

- Advanced imaging: MRI, CT, PET scans
- Some payers require auth for all outpatient imaging; others only high-cost or repeated imaging

Surgical Procedures:

- Elective inpatient surgeries
- Many outpatient surgeries (orthopedic, GI, ENT, etc.)
- Bariatric surgery
- Cosmetic or reconstructive procedures

Specialty Services:

- Specialist consultations (especially for HMO plans)
- Physical, occupational, or speech therapy (some plans after initial visits)
- Cardiac rehabilitation
- Home health services

Medications and Treatments:

- High-cost infusions (chemotherapy, biologics, IVIG)
- Durable medical equipment (wheelchairs, CPAP machines, orthotics)
- Prosthetics
- Specialty pharmacy medications

Other Services:

- Genetic testing
- Sleep studies
- Pain management procedures (injections, nerve blocks)
- Transplant evaluation and surgery
- Bariatric surgery

Emergency and Urgent Services: Most payers do NOT require prior auth for true emergencies. However, for emergency admissions expected to extend beyond stabilization (e.g., emergency surgery leading to multi-day stay), some payers require notification or concurrent review within 24-48 hours.

B. Identifying Authorization Requirements

Payer Requirement Lists: Our Authorization Coordinator maintains an up-to-date database/ matrix of:

- Which payers require authorization for which CPT codes or service categories
- Links to each payer's authorization portal or phone number
- Any special forms or clinical criteria required

Verification Process: During insurance verification (see Section III), staff specifically ask: "Does [specific service, e.g., lumbar MRI] require prior authorization for this patient's plan?" If yes, note this and flag the scheduling or registration record for authorization.

Provider Orders: When a provider orders a service that commonly requires auth (e.g., MRI, surgery), the order should include:

- Diagnosis/reason for the service (ICD-10 code)
- Clinical notes or documentation supporting medical necessity
- Any urgency notation (stat, urgent, routine)

The ordering provider's staff or the central authorization team will use this information to request auth.

C. Obtaining Prior Authorization

Timeline: Initiate the authorization request as soon as the service is ordered or scheduled:

- For elective procedures: at least 5-10 business days before the service date (allows time for payer review and any appeals if denied)
- For urgent services: same day or next business day
- **Never delay urgent or emergent care to wait for authorization**; obtain authorization concurrently or retroactively if the clinical situation requires immediate care

Submission Methods:

- **Online Portal:** Most payers have web portals where providers submit authorization requests. Advantage: fast, trackable, often real-time decision for routine requests.
- **Phone:** Call the payer's authorization/utilization management department. May get immediate approval for straightforward requests.
- **Fax:** Submit a completed authorization request form with supporting documentation via fax.

Required Information: Authorization requests typically require:

1. Patient demographic and insurance information
2. Requesting provider name and NPI
3. Servicing provider/facility name and NPI (if different)
4. CPT/HCPCS procedure code(s)
5. ICD-10 diagnosis code(s)
6. Description of service and medical necessity
7. Supporting clinical documentation (progress notes, test results, photos, etc.)

8. Proposed date of service

Clinical Criteria: Many payers use evidence-based criteria (e.g., MCG, InterQual, or proprietary criteria) to determine if a service is medically necessary. Authorization staff should be familiar with common criteria:

- For MRI lumbar spine: typically requires that conservative treatment (PT, medications) was tried first unless red flags (severe neurological symptoms)
- For knee arthroscopy: documentation of pain, imaging showing specific pathology, failed conservative care

If the payer's criteria are not met, the authorization may be denied, or the payer may request additional information or a peer-to-peer review.

D. Authorization Outcomes

Approved:

- Payer issues an authorization number (also called approval number, reference number, or case number)
- Record this number in the patient's account and on the procedure scheduling system
- Note any conditions: e.g., "Authorized for up to 12 PT visits" or "Authorized for procedure on or before [date]"
- The authorization number MUST be included on the claim form (typically in Box 23 of CMS-1500 or corresponding field on UB-04)

Denied:

- Payer does not approve the service, usually with a reason (not medically necessary, alternative treatment available, information insufficient, etc.)
- Options:
  1. **Provide additional information:** If denial is due to missing info, resubmit with more clinical documentation.
  2. **Peer-to-Peer Review:** Request that the ordering physician speak directly with the payer's medical director to explain the case. Often results in overturn of denial.
  3. **Appeal:** File a formal appeal per the payer's process (usually has a deadline, e.g., 30-60 days).
  4. **Patient Choice:** Inform the patient of the denial. The patient may choose to proceed with the service and self-pay, or seek the service from an in-network or approved provider, or forgo the service.

- Document the denial and the patient's decision. If patient proceeds knowing insurance won't pay, have them sign an Advance Beneficiary Notice (ABN) for Medicare, or a similar waiver for other payers, acknowledging financial responsibility.

Pending:

- Authorization request is under review; payer needs more time or information.
- Follow up regularly (every 2-3 days if service is approaching).
- Keep the patient and provider informed of status.
- If service date arrives and auth still pending, discuss with patient and provider whether to reschedule or proceed (proceeding without auth risks denial of payment).

E. Referrals (for HMO and Some Managed Care Plans)

Referral Requirement: Some insurance plans (mainly HMOs) require a referral from the patient's primary care physician (PCP) before seeing a specialist or receiving certain services.

Obtaining a Referral:

- The patient's PCP generates the referral (often through their EHR system, which electronically transmits it to the specialist and payer)
- The referral typically includes: patient name, insurance info, specialist/service being referred to, diagnosis, number of visits or timeframe authorized
- Our scheduling staff should verify with the patient: "Do you have a referral from your PCP?" If not, instruct the patient to contact their PCP before the appointment.

Verification: At the time of the appointment, front desk verifies the referral is on file (either via payer portal, electronic system, or paper copy provided by patient). No valid referral = patient may need to reschedule or pay out-of-pocket.

Duration: Referrals are typically valid for a limited time (e.g., 90 days) or number of visits (e.g., 3 visits). Track expiration and remind patient to obtain a new referral if ongoing care is needed.

V. COMMUNICATION WITH PATIENTS

A. Proactive Communication

At Time of Scheduling: When a patient schedules a service:

- Inform them: "We will verify your insurance and let you know if prior authorization is needed."
- Provide them with a scheduling packet or email including:
  - What to bring (insurance card, photo ID, payment for copay)
  - Any prep instructions for the procedure
  - Contact number if they have questions or changes to insurance

If Authorization Required:

- Contact the patient: "Your insurance requires authorization for this service. We have submitted the request and will notify you once approved. Please do not make travel plans until we confirm."
- If authorization is delayed, keep patient updated weekly.

If Authorization Denied:

- Call the patient promptly to explain the denial and options (appeal, self-pay, alternative treatment, etc.)
- Offer to have a financial counselor discuss cost if patient wants to proceed self-pay

Financial Responsibility Discussion: After verification, if the patient will have significant out-of-pocket cost (high deductible or coinsurance), inform them of the estimated amount (see Price Transparency policy). Offer payment plans or financial assistance information if appropriate.

B. Day-of-Service Confirmation

Check-In Process:

- Greet patient and collect insurance card (even if we have it on file, check for any changes)
- Confirm: "Is your insurance still [plan name]? Any changes since we last verified?"
- Collect copay at time of service (if applicable)
- Have patient update registration information (address, phone, emergency contact) and sign consent forms

If Issue Discovered: If on the day of service we discover coverage lapsed or authorization is missing:

- Inform the patient immediately
- Consult with the provider or department manager: Can we proceed and bill the patient directly, or should we reschedule?
- If rescheduling, assist the patient in resolving the insurance issue or obtaining auth, and reschedule as soon as possible.

VI. ROLES AND RESPONSIBILITIES

A. Patient Access / Scheduling Staff

Responsibilities:

- Schedule appointments and flag any that may require authorization
- Collect initial insurance information from patients
- Perform or initiate insurance verification 3-5 days before appointments
- Enter verified benefit information into the system
- Communicate with patients regarding insurance issues
- Collect copays and update demographic information at check-in

Training: All patient access staff must complete:

- Initial training on insurance verification procedures and use of eligibility systems (3-hour training)
- Training on identifying authorization requirements (payer-specific training)
- Quarterly refresher training on policy updates and common issues
- Annual competency assessment

B. Authorization Coordinator / Team

Responsibilities:

- Submit prior authorization requests to payers
- Track authorization status and follow up on pending requests
- Handle authorization denials: coordinate peer-to-peer reviews, file appeals, communicate with patients and providers
- Maintain the payer authorization requirement database
- Educate clinical staff on payer-specific authorization requirements

Performance Metrics:

- >90% of authorizations obtained before service date
- <5% of services performed without required authorization
- Denial appeal overturn rate >50%

C. Providers (Physicians, APPs)

Responsibilities:

- Provide clear, medically necessary orders with appropriate diagnoses
- Supply clinical documentation to support authorization requests when needed
- Participate in peer-to-peer reviews if a service is denied
- Notify patients if a recommended service may not be covered and discuss alternatives

D. Billing and Denial Management Staff

Responsibilities:

- Ensure authorization numbers are correctly entered on claims
- Monitor denied claims for "no authorization" or "no eligibility" reasons
- Track denial trends and report to management
- Work claim denials: resubmit corrected claims, file appeals, request retro-authorization if applicable

Denial Prevention Goal: Our target is to reduce denials due to eligibility/authorization issues to <3% of all claims submitted.

E. Compliance and Quality Assurance

Audit Process:

- Monthly audits of a random sample of 25 scheduled procedures to verify:
  - Insurance was verified timely (documentation present)
  - Authorization was obtained if required (and documented)
  - Patient was informed of financial responsibility

- Quarterly review of denied claims related to eligibility/authorization to identify root causes and implement corrective actions

Corrective Actions:

- If staff repeatedly fail to verify or obtain authorizations, additional one-on-one training is provided
- System issues (e.g., eligibility vendor downtime) are escalated to IT and alternatives arranged
- Policy updates are communicated immediately via email and staff meetings

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VII. SPECIAL SITUATIONS AND PROBLEM-SOLVING

A. Coverage Lapse or Termed Policy

Scenario: Verification reveals the patient's insurance is no longer active (e.g., termed due to non-payment of premiums, loss of job, aged out of parent's plan).

Action:

1. Contact patient immediately: "We are unable to verify your insurance. Please contact your

insurance company to confirm your coverage status."
2. If patient confirms coverage lapsed: Offer options:
   - Reschedule the appointment to allow time for the patient to obtain new coverage (COBRA, Marketplace, Medicaid)
   - Proceed as self-pay and provide cost estimate and financial assistance information

3. Document the patient's decision.

B. Out-of-Network Provider

Scenario: Verification shows our facility or provider is out-of-network for the patient's plan.

Action:

1. Inform patient: "We are out-of-network for your insurance. Your out-of-pocket costs will be higher. Your plan covers out-of-network at [X]% after a $[Y] deductible." (Provide estimate if possible.)
2. Suggest patient contact insurance to verify out-of-network benefits and whether they can see an in-network provider instead.
3. If patient chooses to proceed out-of-network, document and provide cost estimate.
4. Check if any single-case agreements or gap exceptions can be requested from the payer (some plans allow out-of-network exceptions if no in-network provider available for the needed specialty).

C. Authorization Denied but Provider Believes Service is Necessary

Scenario: Payer denies authorization for a procedure, but the provider believes it is medically necessary.

Action:

1. Provider performs or requests a peer-to-peer review with the payer's medical director.
2. If still denied, consider filing an expedited appeal (if urgent) or standard appeal with additional clinical evidence, literature, etc.
3. Inform patient of the situation and options:
   - Wait for appeal outcome
   - Seek a second opinion
   - Proceed self-pay if patient agrees
   - Pursue alternative treatments covered by insurance

4. Document all steps taken.

D. Retro-Authorization (Post-Service Authorization)

Scenario: A service was provided without prior authorization (e.g., urgent add-on case, authorization request submitted but not responded to in time, or staff oversight).

Action:

1. Contact the payer as soon as possible (within 24-48 hours of service) to request retro-authorization.
2. Provide all clinical documentation supporting the urgency or reason auth wasn't obtained in advance.
3. Some payers allow retro-auth in urgent/emergent situations; others do not.
4. If retro-auth denied, the claim may be denied. Options:
    - File an appeal with explanation
    - Bill the patient (but be mindful of compliance with financial assistance and surprise billing regulations)
    - Write off as provider/facility responsibility if it was a preventable staff error (to maintain patient satisfaction)

E. Changes in Insurance Mid-Treatment

Scenario: A patient undergoing a series of treatments (e.g., physical therapy, chemotherapy) changes insurance mid-course.

Action:

1. Patient notifies us of insurance change; immediately verify new insurance and check authorization requirements.
2. If prior authorizations were in place with old insurance, they are no longer valid. Obtain new authorization from the new payer if required.
3. Adjust billing: Bill the old insurance for dates of service when that coverage was active, and the new insurance for subsequent dates.
4. Ensure continuity of care: If new insurance doesn't cover our facility or has different requirements, assist patient with transition or appeal for continuity of care exception.

VIII. TECHNOLOGY AND SYSTEMS

A. Practice Management System (PMS)

Our PMS system supports eligibility verification and authorization tracking:

- **Eligibility Module:** Integrated with real-time clearinghouse for electronic eligibility checks
- **Authorization Module:** Staff enter authorization requests, track status, and store

authorization numbers linked to patient accounts
- **Alerts:** System alerts scheduling and registration staff if a patient's insurance has not been verified or if an authorization is required and missing

B. Payer Portals

We maintain credentials for major payer portals (e.g., Availity, Navinet, individual payer sites) for verification and authorization submissions. Staff training includes how to navigate each portal.

C. Reporting and Analytics

Monthly Reports Generated:

- Number of eligibility verifications performed vs. number of scheduled procedures (goal: 100% verification rate)
- Number of authorizations requested, approved, denied, pending
- Denial rates by reason code (track "no authorization" and "eligibility" denials)
- Turnaround time for authorization approvals

Use of Data: Leadership reviews reports to identify bottlenecks (e.g., high denial rate with a specific payer prompts a meeting with that payer's rep to clarify requirements).

IX. POLICY COMPLIANCE AND ENFORCEMENT

A. Compliance Monitoring

Key Performance Indicators (KPIs):

- **Verification Rate:** ≥98% of scheduled services have documented insurance verification
- **Authorization Obtainment Rate:** ≥95% of services requiring auth have authorization obtained before service
- **Denial Rate (Eligibility/Auth):** <3% of submitted claims denied for eligibility or authorization issues
- **Patient Satisfaction:** ≥90% of patients surveyed report they were informed about their coverage and costs beforehand

Monthly Compliance Dashboard: Presented to senior leadership showing performance on KPIs and trends.

B. Training and Education

Initial Training: All new patient access and authorization staff undergo a comprehensive 1-week training program covering:

- Insurance basics (types of plans, benefit structures)
- How to perform eligibility verification (hands-on practice with systems)
- Authorization requirements and how to submit requests
- Patient communication and customer service
- Documentation standards

Ongoing Education:

- Quarterly staff meetings with updates on payer policy changes
- Annual competency assessments (staff must pass a test on eligibility and authorization procedures)
- Continuing education opportunities (webinars on revenue cycle topics, certification programs like NAHAM or HFMA)

C. Disciplinary Actions

Failure to follow this policy can result in:

- **Verbal coaching** for first-time minor errors (documented in personnel file)
- **Written warning** for repeat errors or significant oversight (e.g., scheduling a surgery without verifying insurance)
- **Performance improvement plan** for staff with ongoing performance issues
- **Termination** for gross negligence or refusal to follow policy

However, our approach is primarily educational and supportive; mistakes are learning opportunities. We focus on process improvement and system enhancements to prevent errors rather than punitive measures.

X. EXAMPLES AND CASE STUDIES

Example 1: Scheduled Outpatient Surgery (Knee Arthroscopy)

Patient: John Doe, age 52, BCBS PPO insurance

Process:

1. **Scheduling (Day 1):** Orthopedic surgeon's office schedules John for knee arthroscopy in 3 weeks at our ambulatory surgery center.
2. **Insurance Verification (Day 2):**
   Authorization coordinator runs electronic eligibility check:
   - BCBS coverage active, in-network
   - Deductible: $1,500 (met $500, remaining $1,000)
   - Coinsurance: 20% after deductible
   - **Prior auth required for outpatient surgery**

3. **Authorization Request (Day 2):**
   Coordinator logs into BCBS portal, submits auth request with:
   - CPT 29881 (knee arthroscopy, meniscectomy)
   - ICD-10 M23.205 (derangement of meniscus)
   - Operative note from prior MRI and exam notes showing meniscal tear, failed conservative treatment

4. **Authorization Approved (Day 5):** BCBS approves, issues auth #123456789, valid for surgery within 60 days.
5. **Patient Contact (Day 6):** Staff calls John: "Your insurance has approved the surgery. Your estimated out-of-pocket cost is $2,000 ($1,000 deductible + 20% of $5,000 negotiated rate). Please arrive at 6 AM on surgery day."
6. **Day of Surgery (Day 21):** John checks in, staff confirms insurance unchanged, no copay collected (deductible/coinsurance billed after insurance processes). Surgery performed.
7. **Billing (Day 22):** Claim submitted to BCBS with auth #123456789 in Box 23. Claim pays without issues.

Example 2: Emergency Admission (No Prior Auth Possible)

Patient: Jane Smith, age 68, Medicare Advantage (Humana) plan

Process:

1. **ED Visit:** Jane arrives via ambulance with acute chest pain. Diagnosed with NSTEMI (heart attack), admitted to hospital.
2. **Notification:** Within 24 hours of admission, utilization review staff notify Humana of the admission per plan requirements (even though emergency, the plan requires notification for concurrent review).
3. **Concurrent Review:** Each day, hospital submits clinical updates to Humana for continued stay authorization. Humana approves 3-day stay.
4. **Discharge (Day 3):** Jane is stable, discharged home with follow-up appointments.
5. **Billing:** Claim submitted with admission date, discharge date, and notification reference number. No prior auth was required (emergency), but timely notification was documented, so claim is paid.

Example 3: Physical Therapy Series (Utilization Management)

Patient: Sam Lee, age 30, Aetna HMO insurance

Process:

1. **Referral and Initial Auth:** Sam's PCP refers him to PT for low back pain. PT office verifies Aetna HMO, confirms referral on file. Aetna auth: 6 visits authorized initially.
2. **PT Visits 1-6:** Sam attends PT twice a week for 3 weeks. Progress documented.
3. **Request for Additional Visits (Week 4):** PT evaluates Sam, recommends 6 more visits. PT office submits request to Aetna for additional visits, including progress notes showing improvement but not yet at goal.
4. **Additional Auth Approved:** Aetna approves 6 more visits (total 12).
5. **Continued Care:** Sam completes visits 7-12, reaches functional goals, discharged from PT.
6. **Billing:** Each visit billed with the corresponding auth number. All claims paid.
7. **If More Visits Needed:** If after 12 visits, Sam still needed more PT, the clinic would request another extension with updated documentation. If denied, clinic would inform Sam of the option to continue self-pay or appeal.

XI. REFERENCES AND RESOURCES

1. Centers for Medicare & Medicaid Services (CMS): Medicare Coverage and Prior Authorization
2. National Association of Healthcare Access Management (NAHAM): Best Practices for Insurance Verification
3. Healthcare Financial Management Association (HFMA): Revenue Cycle Optimization Resources
4. American Medical Association (AMA): Prior Authorization Reform Resources
5. State Insurance Department Websites: For state-specific regulations on prior authorization timelines and requirements
6. Payer Provider Manuals: Each major payer publishes a provider manual with authorization requirements (accessible on payer websites)

XII. APPENDICES

Appendix A: Insurance Verification Checklist (form used by staff when performing phone verification)

Appendix B: Prior Authorization Request Form Template

Appendix C: Payer Authorization Requirement Matrix (updated quarterly by Authorization Coordinator)

Appendix D: Advance Beneficiary Notice (ABN) Form (for Medicare patients)

Appendix E: Financial Responsibility Waiver (for patients choosing to proceed without authorization or when out-of-network)

Appendix F: List of Payer Contact Numbers and Portal Links

END OF POLICY

For questions, contact:

- Insurance Verification: Patient Access Manager at (555) 100-5000
- Prior Authorization: Authorization Coordinator at (555) 100-5100
- Claim Denials: Denial Management Supervisor at (555) 100-5200
- Policy Questions: Revenue Cycle Director at (555) 100-5300

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