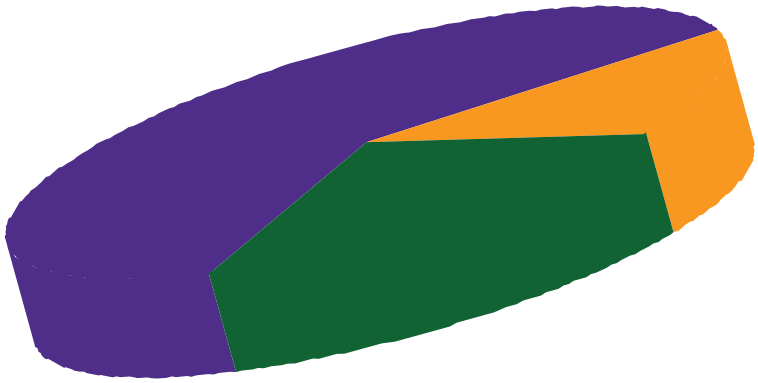
Eligibility Value Statement

Tennessee Oncology

Time frame = 31 days
Insurance eligibility inquiries performed = 4,401
Average claim value = $1,100



2,891 patients eligible = $3,180,100[1]

649 patients not eligible = $713,900[2*]

960 inadequate patient information = $1,056,000[3+]

Dollars at risk = $1,769,900[4]

1. 2,891 x $1,100 = $3,180,100
2. 649 x $1,100 = $713,900
3. 960 x $1,100 = $1,056,000
4. $713,900 + $1,056,000 = $1,769,900
Assumes one transaction per patient.
** Assumes claim is denied by payer.*
+ Assumes claim is rejected by payer.

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Why Verify Patient Insurance Eligibility?

For Nashville-based **Tennessee Oncology**, verifying insurance coverage and benefits on the front end before services are rendered helps ensure the provider gets properly reimbursed for each patient encounter. In one month, Tennessee Oncology ran 4,401 eligibility transactions through Passport Health Communications, Inc.

Because the provider ran eligibility up front, it was able to:

- determine that 15 percent (649) of patients were not covered by the insurer provided by the patient/on record at the facility;
- determine that the data it had for 22 percent (960) of patients was inadequate or did not match the data the payer had;
- address any data discrepancies up front;
- immediately collect accurate up front co-pay and deductible amounts;
- bill self-pay patients directly without spending the time and effort to file a claim that would be denied or rejected later; and
- submit claims with the correct payer and coverage information.

With an average claim value of $1,100, the accounts at risk totaled approximately $1.8 million.

Had the provider NOT verified patient insurance eligibility:

- Commercial insurers, along with Medicare and Medicaid, would have denied 649 claims because the patients were not covered and the value of those claims would have dropped significantly. The collectability of a denied claim is 50 percent or less when providers: a) begin an internal process of researching other possible coverage; b) convert the claims to self-pay and attempt to find and collect from the patients; or c) turn them out to third party collection. In any case, collecting the full amount is highly unlikely.
- Payers would have rejected 960 claims because of bad information and there would have been some cost to reprocess those claims, usually about 2.5 percent.
- There would have been a significant increase in days in AR by having the claims tied up an additional 45 days or longer (estimate based on total time required to re-work and re-submit a claim and receive payment from the insurer).

Best case scenario, after factoring in the decreased value (50 percent) of 649 denials and the costs associated with correcting and rebilling 960 rejections (assuming all rejected claims were for eligible patients and were not denied but ultimately paid in full), Tennessee Oncology probably **would have lost $383,350** during the 31-day period. This does not include any calculation for cost of capital. Another way to look at it is the provider **received $87 of value per eligibility inquiry** ($383,350/4,401).

The value is clear – verifying eligibility up front enables health care providers to avoid significant losses and manage an efficient and accurate revenue cycle.

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Data provided by Tennessee Oncology unless otherwise noted.