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Demystifying Insurance Coverage For Prospective Patients

BY NATHAN RISLEY

Over this past summer, I was struck with the dread of having to get my wisdom teeth removed.

Putting it off until I was in unbearable pain was entirely my fault, but surely not out of the ordinary for so many who do not want to deal with the financial puzzle and coordination of medical attention.

My dentist wrote my prescription and pointed me toward a local oral surgery center that they were fairly certain took my insurance. Upon setting up the appointment and filling out my intake forms, I was told I would also need a prescription from my primary care physician to satisfy the insurance coverage. At this point, my consultation with the oral surgeon was set back a week so that I could get an appointment with my doctor to be able to verify that I was in fact in excruciating pain and would benefit from having my wisdom teeth removed, as earlier suggested by my dentist. Ok, great.

The visit to my primary care physician resulted in a new surgical date now two weeks later than the originally planned date. The Tuesday prior, I got to the consult, met my surgeon, set the appointment for a later time slot so I could miss the minimum amount of work possible. Last thing to do was to confirm the appointment with the front desk.

I knew something was amiss when the light chit chat stopped with a sudden "oh no" from the administrator setting up my appointment. It turns out that they did not take my insurance. A simple mistake by the person working with my intake information a week prior meant that I was either on the hook for \$3,000 or I had to find another facility. They were kind enough to half my consult fee, but I felt entirely defeated in the moment. Pushed back another week, I was able to find a facility that took my insurance, set up the surgery, and got out with having most of the procedure covered. Just \$1,400 for the anesthesia and an untold number of pudding cups later, I was back to work without the jaw pain I had begun to feel over a month earlier.

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This is not a story unique to me. What was probably more surprising is that I was entirely unprepared for the comedy of missteps I endured, especially given it is my job to help others avoid those pitfalls.

UNDERSTANDING MEDICAL BENEFITS

For many, physical therapy is thought of as a luxury until the issue at hand is further along than we would have preferred before they set up their first appointment with us. The excuses are not usually original: "I thought I was just supposed to live with this," or, "I did not prioritize the pain in my knee against my busy schedule." Among all of the anxieties of seeking medical attention, one that might be the most common is the daunting task of a patient understanding their medical benefits from their insurance provider.

Helping patients understand their insurance benefits is one of the best gifts we can give to them. This is not only important for potential clients who are in-network with your particular office, but maybe more so for those who have less-than-desirable medical coverage situations. A better-educated patient will more confidently buy into their treatment and wellbeing.

Many of the patients who call our office for physical therapy are unaware of the basics of insurance. They may know that they have a deductible but not understand what that means for their financial responsibilities. Understanding terms such as copay, coinsurance, deductibles, out-of-pocket maximums, visit limits, authorizations, capitations, and calendar versus contract years will empower a patient and hopefully ease some of the reservations that they might have when approaching physical therapy.

MORE KNOWLEDGE MEANS MORE PATIENT CONTROL

As an office that offers self-pay options, verifying benefits for patients with both in- and out-of-network coverage has led to some interesting decision points for those patients. Some decide that they would prefer to forego insurance, even with in-network benefits, to have more control over their treatment plan. Others will choose to come to our office with out-of-network benefits because the services we offer may outweigh going to another clinic that would be in-network with their insurance.

Part of educating our clientele is encouraging them to call their insurance provider to hear their benefits for themselves. This serves two particularly useful advantages. The core is to have the patient as invested in the entire process as possible. This speaks again to their buy-in to their treatment from many angles. The secondary objective is also to catch any anomalies between what benefits the clinic is able to obtain and what the subscriber is told of those coverages. Once both parties have heard the benefits from the proverbial horse's mouth, we can initiate a discussion on potential out-of-pocket costs so that all members are aware and in agreement, eliminating future difficult discussions regarding outstanding balances.

Transparency is key to gaining the trust of any new patient that may be coming to our clinic. We want them to have the best information for making decisions about their health. We believe, if they have all of the information in front of them, they will commit to taking the journey with us to achieve their goals. If they have taken the initiative to seek out treatment then they already have one foot in the door, and it is our mission to make them a partner in achieving those goals.

TRANSPARENCY BUILDS TRUST

My own medical follies this past year have given me a greater appreciation for all the work that we are able to do to establish this partnership before a potential patient even schedules their first appointment. These early steps will go a long way to set a solid foundation for scheduling, billing, and even new patient referrals. Foster the experience for your clients that you would hope to see for yourself or your loved ones. Do your due diligence, keep the client informed every step of the way, and make the transition from prospective client to active patient as easy as possible.



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