

SHOULD I BILL FOR NON-COVERED SERVICES?

By Melissa Romanelli

One of the most frequently asked questions I encounter is “should I bill insurance for services after the patient has exhausted benefits?” This question most commonly comes from Chiropractors, Physical Therapists, and Behavioral Health providers in situations where they are providing on-going care to patients with insurance benefit limitations.

First of all, let me stress that under no circumstances should you bill any insurance company for services that do not meet the definition of medical necessity. According to CMS, medical necessity is defined as:

- An acute condition
- Functional impairment
- Able to show improvement

If these conditions are not met, then the condition is chronic, and is likely to be considered not medically necessary. Patients who have chronic conditions and medical necessity requirements in their coverage contracts should be fee for service (cash) patients.

Now to answer the question: YES! You most definitely should submit bills for medically necessary services that are beyond patient benefits.

You are probably asking yourself why – well there are several simple reasons.

First, flex spending and medical savings accounts are becoming very popular. These plans often require insurance denials in order for the patient to withdraw plan money.

Second, I am a firm believer that insurance companies place limits on patient benefits that do not adequately cover what most patients need to maintain an appropriate level of

wellness. Wellness care in the long run is less expensive than health care, but insurance companies are too shortsighted to recognize this. Over time, by showing that patients benefit from more care than is allowed by most policies, I believe we can change the perspective of insurance coverage in this country.

Now you are probably asking “won’t this trigger a post payment audit”? Maybe, but post payment reviews are an inevitable part of our current reality. However, you should clearly document those services that you did not bill because the patient was in a maintenance or chronic phase of care. And you should clearly document why the services submitted were for acute, medically necessary care. Having complete and quality documentation will help you demonstrate the need for the care you have provided the patient and subsequently billed to the insurance company.

Lastly, if you are working with a billing service, you should not be charged for insurance claims submitted and not paid because of exhausted benefits.