FHS’ 10 tips for increasing LTC insurance approvals

This tool by FHS SeniorCare Payment Solutions® provides guidance on how to work effectively with LTC insurance policies. It shows that while each insurance carrier may differ, and specific policy language will govern, the following tips may help:

1. **Two or more ADL’s** – Policyholders who need assistance with 2+ Activities of Daily Living are more likely to receive approval. (i.e., Dressing, bathing, eating, toileting, transferring and continence management.)

2. **Cognitive issues** – If the policyholder has Alzheimer’s, dementia or other cognitive disease, this will increase their chances of approval. Be sure to conduct a cognitive impairment test or provide other documentation if applicable.

3. **Ensure an objective assessment** – Many carriers will require a telephonic or in-person assessment prior to approving a claim. However, policyholders are often too proud to admit that they need help with daily activities. Encourage a family member or Power of Attorney to participate in the assessment to ensure the client is open and objective about their needs.

4. **No such thing as “too much information”** – When completing claim forms, do not feel confined to the questions or fields on the form. Provide as much information as you can, even if the form does not ask for it specifically.

5. **Document, document, document** – You will likely need to contact carriers multiple times to resolve claim questions. It is imperative to document every single interaction to help you piece the puzzle together and provide a reference in the event of future questions.

6. **Call, call and call again** – Since you are likely to speak with different carrier service reps each time, it may help to triangulate and cross-check the information you are given. Some carriers employ Benefit Analysts or Care Managers; these people are in charge of managing the claims. They are often your best source of information on the policy.

7. **Ask the right questions** – Knowing the right questions to ask will get you the right answers. Carrier customerservice reps may not offer all the information you need, so you must elicit that information. For example, the carrier may require agencies to hold a state license, and caregivers to hold CNA or HHA licensure. But sometimes the caregivers are covered by the agency license and do not require licensing on an individual level.

8. **Organize your information** – It takes a great deal of proof upfront to open a claim. Before you submit a claim, help your client’s family gather documentation including medical records, caregiver activity logs, cognitive impairment tests, nurse assessments, discharge papers and so on.

9. **Provide necessary information on claims** – Most policies will have specific triggers, such as assistance with two or more ADL’s. Whatever the triggers are, they must be documented in the caregiver activity logs that you submit along with every claim. Just showing that a caregiver worked for 8 hours is not enough. They must specify the ADLs with which they assisted during each shift.

10. **Submit claims weekly** – Some agencies only submit claims monthly, but carriers may only review claims once a month. If you miss that cutoff, the carrier may not review your claim for yet another month after that. Because some carriers may take 90+ days to review, the more frequently you submit claims, the less time you wait for reimbursement.

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