

The Sense (and Cents!) of Point of Service Collections

The Sense: In the “olden days”, hospitals didn’t have to concern themselves with collecting co-pays or deductibles up front at the time of service. Insurance paid a straight 80-20 with \$100 deductible on inpatient and 100% on outpatient. Anything else was a problem for the doctor’s office. In 2007, that picture has shifted dramatically. Most hospitals now find themselves billing for co-pay, co-insurance and deductibles on routine Lab and Radiology bills, with sliding or ever-changing percentages due for Rehabilitation and other balances after insurance has paid its portion.

The Cents: The cost of a self pay statement includes much more than the ever-increasing postage. Whether you outsource patient statements or print them in house, you pay for supplies – paper, envelopes, toner for the printer – and labor, either human or mechanized. You also pay in AR days: the longer a balance remains in your AR, the harder that balance is to collect and the higher your AR remains. Doesn’t it make sense to collect as much as possible when the service is rendered instead of spending more money on the collections end after the fact?

Estimating patient liabilities accurately is crucial to point of services (POS) collections. Knowing how much a patient owes is not a simple task. Technology can play an important role in organizing this data and helping find an answer. This article will evaluate some of the technologies available to assist in the collection of patient liabilities as well as their benefits and pitfalls.

Using on-line verification technology

Often, a patient’s co-pay or deductible amount is on the insurance card; for instance, an insurance plan may have a \$50 Emergency Department deductible. However, to effectively collect at POS, additional current information is needed. There are several products that provide immediate, on-line verification. Some can also verify self pay patients against Medicaid’s data base. The information posts back into MEDITECH in the form of a text box and is available for viewing in billing as well as admissions and stays with the account during its life. Customer-defined screens can be built to track this information. MEDITECH offers an on-line verification solution, as well as other vendors.

A CDS could look like this:

Precertification			
OR Procedure:	<input type="text"/>		
Insurance Contact Person:	<input type="text"/>		
Insurance Contact Phone Number:	<input type="text"/>		
Doctor's Office Contact Person:	<input type="text"/>		
Verification/Benefits			
In Network Deductible:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
In Network Out of Pocket:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Lifetime Max:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Out of Network Deductible:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Out Network/Out Pocket:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Pre-Existing:	<input type="text"/>	Co Pay: <input type="text"/>	
Allowed Visits Per Year:	<input type="text"/>	Visits Applied to Policy:	<input type="text"/>
Insurance Contact Person:	<input type="text"/>		
Insurance Contact Phone:	<input type="text"/>	Date Contacted:	<input type="text"/>
Insurance Contact FAX:	<input type="text"/>		
Comment:	<input type="text"/>		

Many insurance companies also have web sites on which this information is available to providers. Some hospitals use a combination of a verification vendor and web sites daily in pre-admission, pre-certification and pre-authorization processes, preparing the demographic and financial data for the patient's registration. However, credits on patient accounts can occur if another provider's claim is processed before yours and the deductible is met when you have already collected it. This can come as an unpleasant surprise to Patient Financial Services, who has to process the credit balances. Close collaboration between these areas is very important.

Medical necessity checking can be done through a variety of tools. Some HIS systems have medical necessity checking built in; add-ons or stand-alone tools are available from third-party vendors. Local Coverage Determinations (LCD) can also be made by checking your state's CMS web site. An ABN (Advanced Beneficiary Notice) should be printed for the patient's signature and any non-covered charges should be collected up front.

All payments, all the time

A crucial component of POS collections (or any collections, actually) is the ability to take cash, check, credit or debit card, travelers check or any other method of payment (excluding barter!) at all payment points within your facility. While a credit card machine may charge a three or four per cent fee, this is a small price to pay when you consider

how many consumers travel with a credit or debit card in their pocket all the time. Depending on the volume of transactions, you can also negotiate a lower rate with credit card companies. This also answers many up-front objections to paying, such as “I don’t have that kind of cash” or “I didn’t bring my check book.”

Even though payments on line don’t necessarily apply to POS, it is also becoming a desirable option for many consumers, even in rural areas. 2003 studies indicated that suburban and urban consumers were more likely to have internet access than rural consumers¹, but figures have narrowed by half within the past three years.² In the past, the initial outlay for on line payments could be cost-prohibitive for non-profit organizations such as hospitals, but with the emergence of on line merchant services - low setup and monthly prices and transactional-based fees, this is definitely an option that hospitals could explore fully.³ Many banks and other vendors offer this service.

Check-In kiosk: is it affordable?

Is your patient population sophisticated enough and motivated to use a check-in kiosk? If so, is this an affordable addition to your registration process? Several companies offer a kiosk similar to ones used in airports. Patients use a credit card or other card with a magnetic strip (such as a Sam’s Club card) to identify themselves and can then choose their appointment. In some systems, a customized script can change the patient account from a PRE status to a registered status, eliminating some of the manual process. Many systems are independent of your HCIS so they can be used in any area in which a PC and a network server can be accessed. Screens can be customized to gather changes in patient demographics and insurance and can be used to notify your patient of co-pay or deductibles due. On line payments may also be made through the kiosk.

The cost for this is approximately \$5,000, including hardware. This is considerably less than adding additional registration personnel and could free up existing personnel for the more complex tasks that are inherent in accurately registering patients. The kiosk is not a replacement for personal, human interaction but can enhance the process, making registration more efficient and increasing patient satisfaction by decreasing wait times. To take full advantage of a check-in kiosk, your pre-registration and scheduling process should be robust and include as many departments as possible.

Payment through Access or Financial Counseling

Payment areas should be immediately accessible to patients in order to capitalize on POS collections. Patients shouldn’t be routed to a central location, often far away from the initial registration process, to make payments. Good customer service and good collection practices demand taking the services to the patient and this is particularly important in collecting payments up front. A patient who is reluctant to pay is not going to travel through your facility to “the business office”. Delaying a scheduled appointment for payment is bad for business and for customer service. Having a financial area in or near registration areas removes this objection to paying and adds the convenience of “one-stop shopping” to the hospital visit.

Case Study: In February, 2005, one facility separated the Patient Access and Patient Financial Services departments into separate departments. The financial counseling area was physically moved out of PFS and into a little-used snack bar area in the registration lobby. The financial counselors are able to take payments, provide indigent, Medicaid and Medicare assistance, and are immediately accessible to the patients being registered. Any patients owing deductibles or co-pays found during pre- or registration are routed to this area as soon as registration is complete. Prior to this move, patients had to go to the cashier area in PFS to make a payment, which was not nearly as convenient and conducive to collections as it is now. They are now averaging \$144,000 annually in collections, which includes deposit, co-pay, deductible and payments on existing accounts. The “main” cashier area remained in the PFS area and is accessible to both staff and patients.

Prior to this move, they focused POS efforts in the Emergency Department. The ED was staffed 24/7 with Discharge clerks, who performed much of the financial counseling functions as well as collecting deductibles and co-pays. Results were hard to measure because of the “soft benefits” such as indigent care applications and contracts. They didn’t use hard-core, collection agency-type collecting. There were also issues with convincing the ED nurses of the importance of this discharge counseling, so they frequently didn’t send the patient through discharge. They did collect \$45,000+ in the first year, but the figures clearly show that focusing on another area produced higher results. However, a year later, they saw a significant rise in ED bad debts. After much discussion of the bad debts in the emergency room, the ED registration staff was re-trained in collection procedures and are focusing on collecting deposits from the “true” self pay patients. Next they will move into co-pay and deductibles.

Using the information gathered through registration

All the information in the world is worthless unless it is used!

“Now that we have all this useful information, it would be nice to do something with it. (Actually, it can be emotionally fulfilling just to get the information. This is usually only true, however, if you have the social life of a kumquat.)”

Unix Programmer's Manual

Case Study: One facility invested in an on-line verification program. The system automatically launched during registration and returned verification information for Medicare and Medicaid. The results printed to a printer located in the registration areas and were attached to the paper registration forms. . . *and that’s where it stayed.* Nothing was ever done with the information! They talked about using it and came up with plans and procedures for using it, but never did. Countless dollars in monthly fees and transactions were wasted and all sorts of information about eligibility, co-pays and coinsurances were collected, but they never capitalized on this technology. They finally cancelled the contract, \$30,000+ later. Denials and collections were not affected at all.

One of the strongest benefits to POS verification is immediate gratification. You are able to show your patient information from their insurance company that details the amount due at the point of service. If you are verifying insurance eligibility and benefits, but not sharing this with the patient, you are wasting time and money. If you are not verifying this, you are missing a prime opportunity to collect what will turn into self pay

balances after the service has been rendered. You will then spend more time and money in collection attempts on the back end after insurance has paid.

1. PEW Internet and American Life Project, February, 2004 http://www.pewinternet.org/pdfs/PIP_Rural_Report.pdf
2. PEW Rural Broadband Internet Use, February, 2006 http://www.pewinternet.org/pdfs/PIP_Rural_Broadband.pdf
3. <https://www.paypal.com/cgi-bin/webscr?cmd=display-business-pricing-outside>

Julia Carter was invited to speak at a World Research Group symposium in San Diego, CA in March, 2007, on this topic. This article is a result of that speech.