Patient Collection Question #1: How Do I Know What to Collect at Check-Out?

My book on front-end collections has been doing really well and I'm pleased that a number of people have called me or emailed me with questions. Here's one question that a number of people have asked – "Can you tell me more about knowing what to collect from the patient at check-out"?

Hopefully, you have followed my advice and collected co-pays and previous balances before the visit. The portion that you collect after the visit is the co-insurance and the deductible.

The guideline on collecting after the visit is directly related to the allowables on the services the patient received. Allowables are the amount that payers consider payment in full. Of the total allowable, a portion will come from the payer and the balance will come from the patient. Knowing that percentage is the secret to collecting at the check-out desk. **The percentage of the allowable that the patient will pay is the critical piece of information you need to successfully and accurately collect after the visit.**

Allowables fall into three categories:

1. The Medicare allowable for your area of the country, or state, for the current year. If you participate with Medicare, you have an allowable, if you do not participate with Medicare, you have a limiting charge that you must use for Medicare patients.
2. The allowables for the payers with whom you have contracts and have agreed to accept their rate for their subscribers.
3. The rates paid by payers with whom you do not have a

contract. Their payment for out-of-network services (non-contracted physicians) will determine the amount owed by the patient.

How Do You Collect This Information – Medicare

Medicare allowables are published every year, both in the federal register and online at the CMS (Centers for Medicare and Medicaid) website. If you are fortunate enough to have a practice management system that loads this information automatically for you, you are golden. If not, you will need to enter these manually. The good news is that very few practices need to add more than 50 – 100 allowables to get started.

You can also use a paper cheat sheet to fill in your top 50 – 100 codes. Make a chart with your fee, the Medicare allowable, and the 20% of the allowable that Medicare patients must pay at every visit. A note of caution – many Medicare patients have secondary coverage and it can be difficult to know what the secondary coverage will pay. Most practices will not collect anything for patients with secondary coverage because it can mean a lot of refunds have to be written when the secondary payments come in.

How Do You Collect This Information – Payers You Have Contracted With

If you have a contract with a payer, they must furnish you with a full allowable fee schedule, or with an payment model. For example, their payment model may be 150% of the 2007 Medicare schedule. You will need to go to the **CMS lookup page here** and get these allowables for your services for 2007 and multiply it out.

Example: the 2007 allowable for 99213 established patient office visit is $56.98 for North Carolina (use your locality)

If the payer is paying 150% of that allowable, it will be

$85.47, and if the patient has to pay 20% of that allowable, they will owe $17.09. Don't forget to include the deductible in this equation, as the patient will need to satisfy the deductible before the payer will pay you 80% of their allowable.

Some practice management systems will have the ability to take that information and calculate it for you, so be sure to ask your vendor about this before you do the work.

If you are constructing a manual cheat sheet, you'll have your fee (even though it doesn't come into play, I suggest practices always keep their fee on cheat sheets, so staff can bring anything unusual to the administrator's attention. Also as you increase fees, you have a handy visual.) Add the payer's allowable, and calculate the percentage the patient will owe.

Use this same sheet for your payment posters to make sure you are getting paid the correct amount if your practice management system doesn't do this for you.

By the way, if an insurance company that you have contracted with refuses to give you a schedule of allowables or a payment model, contact your state medical society, your state insurance commisioner, or your state legislators for help.

How Do You Collect This Information – Payers You Have Not Contracted With

If you do not have a contract with a payer, getting information on their allowables can be tough. Some practices will have the patient pay in full and either file the claim for the patient, or give/mail the patient a claim form for them to submit. In this case, you do not need the allowables. If your specialty has higher in-office fees due to tests, etc., it may be difficult for a patient to pay $250 – $500 in full at time of service. You may want to consider one of these strategies for collecting at time of service:

1. Collect a deposit based on the total charge. Let the patient know it is an estimate and that more or less may be owed. I do not believe in sending statements. In my book I recommend using a payment portal to securely store patient credit cards, and adjust the remaining balance up or down according to the actual payment. As payments come in you can develop a knowledge base for what different payers and plans will pay. This will assist you in estimating the patient's portion more accurately over time.
2. You can give patients information about the services they most likely will receive at their visit and ask them to call their payer and get information on payment. This is a great strategy. If patients are shocked about their portion, they may want to reconsider becoming your patient. The last thing you want is a patient who is surprised by the payment due after they have received the services. Some payers supply subscribers with allowable information on their website.
3. You can usually get the allowable information by phone if you have the subscriber's information, or if you have the subscriber on a three-way conference call, or in the room with you. This is more typically done when the subscriber is contemplating surgery or an expensive procedure and you are working on a payment plan, or outside financing with them.

Knowing what the patient owes and making arrangements for payment in full at time of service is one of the most significant things you can do to increase your receipts and decrease your accounts receivable. No practice can afford to "wait and see what insurance pays" and bill the patient months after the service has been rendered.

Click here to view "The Smart Manager's Guide to Collecting at Check-Out."