Maximizing Patient Collections through Trained Staff and Informed Consumers

Focus Paper

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Introduction

Patient collections in a medical practice are an integral part of the revenue cycle. The depth of knowledge of the staff and the engagement of the patient, or lack thereof, have direct relationships to the bottom line. The focus of this paper is to examine how these factors impact the ability to appropriately collect payments at the time of service and later when past due balances are owed by patients. This paper identifies tactics to educate and train staff to the concepts of insurance products, benefit verification, plan benefits and estimating amounts due. This paper also identifies tactics in informing and educating patients to their financial responsibility so they are prepared to pay their part at the time services are rendered.

The research methodology used in this paper includes literature from experts in fields of the physician billing process, patient collections and practice management. Research also comes from multiple on-line articles focused on topics including running the practice like a business, establishing metrics, identifying ways staff can improve collections, and engaging the patient in the collection process. Finally, personal experience with these processes contributed to the findings for this paper.

Background

Collecting from patients for medical services has evolved over the last decades from the simplicity of fee for services, to 80/20 plans, to the complicated era of copays, coinsurance and deductible amounts. Without understanding the differences of each plan type, untrained staff are unaware of the monies that will be billed to patients after claims adjudication, costing the practice additional expenses when balance billing and post-service collection are required. Patients who do not understand their plans or their financial responsibility may be left owing balances for services received resulting in financial stress. In a 2016 survey conducted by TransUnion of more than 1500 consumers regarding healthcare costs, 60% said rising costs have added financial
strain, while 65% said they were more concerned than last year about their out-of-pocket costs for copays and deductibles. (TransUnion 2016)

Stakeholders in this process include the providers in the practice, the practice management team, the staff and the patients.

The ability of a practice to successfully educate both staff and patients has a positive impact on the revenue stream, as well as creates opportunities to ease the financial stress patients may feel when they do not understand why monies are owed after claims are paid. Failure to do so results in increased account receivables and creates challenges when collecting from patients, particularly as accounts age greater than 60 days. (Sprey 2016) According to Ken Hertz, practice management consultant and Principal with the Medical Group Management Association, practices “should track patient accounts receivables in a separate report. Because it’s much harder to collect on accounts that are over 90 days, that’s where practices should focus its attention first, (then) trend the information over a period of three to six months to gauge collection effectiveness.” (Sprey 2016) Further inability to collect causes bad debt to rise and billing expenditures to increase, including statement expenses and the cost of employing follow up staff. Lack of proactive communication and education with patients creates an expectation they do not need to be financially prepared at the time of the visit.

Statement of the Problem

Most staff in clinical practices responsible for collecting monies from patients present with two handicaps from the outset: requirements for hire typically do not include more than a high school diploma and knowledge of the workings of health insurance is low. According to Stephen Dickens, senior consultant with Volunteer Mutual Insurance Company, “a lot of practices think anybody can sit at the front desk and that’s really not true.” (Sprey 2015)
staff members play a critical role in the success or failure of a practice to stay financially sound. As a result, the patients receiving services also may not understand their financial obligations and are less willing to pay their part at the time of service if they are even asked for it. Costs rise when billing for balances happen after the fact and collection rates drop 50-70% once a patient walks out the door. (Freiwat 2015) This trend can be reduced through the appropriate education, training and application of insurance and collection concepts to staff, and through the engagement of the patient in pre-service financial discussions.

Discussion

Medical practices require clinical and business leadership. Auren Weinberg, MD states, “You must run your practice like a business to ensure long-term practice success.” He suggests focusing on key areas and activities to keep the practice viable. (Auren Weinberg 2016)

To overcome the problem deficiencies with patient collections, it is important for the practice administrator to review the current account receivable trends in an effort to identify the collection opportunities in the practice. There are many touch points for effective collections. Requesting payment of copays at the time of check-in, when the dollar value is fixed relative to the visit, is easy to identify and implement. Estimating coinsurance and deductible amounts requires more finesse and typically occurs after the visit when billing codes are known. Asking patients to pay once services are rendered presents more of a challenge to staff, and must be communicated to the patient in a way that recognizes the value of services received; however, successful implementation of techniques can translate into growth for the practice’s bottom line. When these are done well, the aging self-pay bucket will be less, but staff should also be taught how to ask for these past due balances and successfully collect when the patient is present.
The practice administrator must also evaluate the knowledge base of the staff and identify the areas needing education. Training may be done within the practice if the resources are available or webinars and off-site programs may also be considered.

The focus of this paper is to provide the practice administrator with a five-week roadmap to educate and train the staff responsible for collecting copays, coinsurances, deductibles and past due balances from patients, to educate the consumer in the process, and to demonstrate real world results based on its application. This roadmap can be easily implemented through collaborative efforts of the practice administrator, billing manager and/or financial manager who have the foundational knowledge in each of the areas listed. Prior to implementation of these steps, the practice administrator should meet with the staff to discuss the goal of the program. The findings of the financial review should be discussed with the team, the opportunities for improvements should be illuminated, and the roll out of the program should be explained. As the staff are educated to the goals, they will be more engaged in the process of solving the problem. Regular feedback of their progress will ensure the team is headed in the right direction or highlight areas for course corrections.

**The Roadmap - Concepts**

Each week of the five-week roadmap has a specific objective designed to build upon the previous week. Week one starts with the basics of insurance products. The structure of the managed care plans, including typical patient eligibility (such as through an employer), primary care physician requirements, referral requirements, and out-of-pocket expenses can be easily demonstrated with a comparative grid of the products. The same can be done for the federal plans such as Medicare, Medicaid, and other governmental plans that cover military retirees and their dependents. Combining the concepts of managed care with Medicare and Medicaid to
discuss managed Medicare and managed Medicaid will require understanding of how and why patients opt-out of the federal programs into the managed care style programs, and that the patient is not on both at the same time. It is imperative there is a clear understanding that these managed federal plans have networks and requirements that do not exist with the traditional federal products, and that the patient’s decision to opt into a managed federal program may now exclude themselves from coverage in the practice. With this, staff must be taught what it means when any plan is non-contracted with the practice and how this impacts the patient. They should also be made aware of the consequences of accepting a non-contracted plan by the practice and the results to the bottom line. A list of plans that are contracted with the practice should be compiled in detail so all staff and providers have a resource. This “managed care guidelines” should list each plan, the product type, and for which services the practice is contracted. It should also include information about where patients may receive ancillary services such as lab and radiology. Details about referral and/or authorization requirements and claim submission requirements should be listed. A physician participation roster, a companion to the managed care guidelines, should also be created. This reference will outline each plan the provider is contracted with and will include the add dates and term dates for each provider per plan. It is helpful to have this roster available for sorting by plan and by provider. At the conclusion of week one, staff should have an understanding of the insurance products so they are prepared to explain how insurance works to patients. (Westgate 2015)

Week two is designed to make use of the managed care guidelines and physician participation roster. During this week, staff will learn how to identify the plan types as presented by patients and will learn how to determine whether or not the practice is contracted with the plan. Staff should have clear direction about what to do when patients present with non-contracted insurance and the options the patients may be given. Staff should also be educated on what to do when patients have no insurance. From there, staff will learn how to accurately enter
the insurance information into the patient demographics. It should be emphasized how transposition of just one number or letter can prevent a claim from being recognized by the payer, delaying payment and possibly missing filing deadlines if not corrected immediately. Staff will be educated to insurance filing order and how to determine primary payer based on covered member, employer, employment status or age. The proper completion of the Medicare Secondary Payer Questionnaire (MSPQ) will be reviewed technically and theoretically so staff understand how to complete it and why it is used to determine whether or not Medicare should truly be in the second position behind other insurance. At the end of week two, the staff should be able to accurately identify contracted and non-contracted plans and register insurance.

Week three teaches the staff how to verify insurance so that eligibility is determined, benefits are obtained, and requirements are determined. Once insurance is entered in the system, staff will learn how to submit an on-line query through the electronic medical record (EMR) to the payer for eligibility information. If the EMR functionality does not allow for this, or the payer is not set up to provide responses within the EMR, staff will be trained how to use other web tools or how to manually verify insurance via phone. (Other web resources will require set up by the practice administrator for the staff.) Interpreting the data from the payer is the next step. Staff will recognize whether or not the patient is covered by the plan and will be instructed what to do if they are not. When the patient is covered, the staff will learn how to interpret the responses from the payers. This will allow them to determine whether or not the service being provided is a covered benefit, what referral or authorization requirements may be needed for the service, and what the patient’s financial responsibility for the service will be. It should be clear to the staff who in the practice is responsible for obtaining any referrals or authorizations and how to communicate this to those team members if not directly responsible for obtaining those. Eligibility and benefit information will now be translated into the designated fields in the EMR (either in discreet fields or in management designated fields) so that the information is consistent
and readily available as patients check in and out. At the end of week three, the staff should be able to verify insurance eligibility using a number of tools, recognize when referrals or authorizations are required for services that will be received, and accurately translate this information into the appropriate fields in the EMR.

Week four teaches the staff how to determine what patients will owe at the time of service. Elizabeth Woodcock, FACMPE, says “Because of the complexity of insurance, the expected amount of the time-of-service payment may be different for every patient.” (Elizabeth W. Woodcock 2011) Armed with the financial requirements gathered during insurance verification, the staff can now apply copays at the time of check-in, determine percentages for coinsurance amounts and calculate amounts required to meet deductibles. To do this, staff need to be aware of the associated billing codes for services and where to locate the fees and insurance allowed amounts per contract. This information can be uploaded into the EMR for easy access if functionality allows. Otherwise, a comprehensive matrix with this information must be provided to the staff. Many EMR systems have estimator tools built in that allow for uploading of the expected billing codes. (Other web services are available that provide this functionality if it is not resident in the EMR.) The billing codes for applicable services are then bumped up against the benefit information and insurance contracted rates to produce a cost estimate for patients. Generally, estimates created prior to services use billing codes based on the most frequently used code or code sets for services. This helps provide the patient with a relatively accurate estimate prior to services being rendered. After the service, and when billing codes now reflect services provided, estimates can be updated as needed to best calculate the expected patient amount due.

Regardless of the method by which estimates are created, staff should understand how coinsurance and deductible amounts are calculated. Not only does this reinforce their knowledge, it gives them tools to perform manual calculations should automated resources be unavailable. To calculate coinsurance amounts, this formula is applied:
allowable amount x coinsurance percentage = coinsurance amount due

example: $100 x 20% = $20

When calculating the deductible amount, the entire allowable amount is applied to the patient amount due, up to the annual deductible amount. For example, if the patient has an annual $500 deductible and has not met any to date then receives a service where the allowable amount is $350, the entire $350 is applied to the patient’s deductible and should be collected at the time of service. The patient now has $150 remaining on the deductible that must be met before the coinsurance percentage will start to apply. In situations where the patient reaches the deductible because the allowable amount is greater than the unmet amount, the deductible is satisfied then the coinsurance percentage is applied to the rest. In this example, the same patient receives a service where the allowable amount is $200. Of that, $150 is applied to the deductible and the 20% coinsurance is applied to the remaining $50 yielding $10. The patient would be asked to pay $160 which satisfies the deductible for the year, starts the patient in the coinsurance cycle for the future services, and continues until the maximum out-of-pocket amount is paid by the patient (a value determined by the payer). When that happens, insurance pays 100% of the allowable and the patient owes nothing.

Some services received by patients are not covered benefits by the insurance plans. Through the benefit verification process, this information should be known prior to the patient receiving services. At that time, it should be discussed with the patient whether they want to receive the service or not and what it will cost them if they choose to proceed. Estimated patient amounts due should be calculated on charge values, not allowable values, since the service is not part of the benefit plan. Patients who want to receive the service should sign a non-covered
services waiver indicating they have been informed of such, choose to receive the service, and accept financial responsibility.

When patients do not have insurance coverage, or services received are not part of the benefit plan, the practice may choose to extend a self-pay discount to patients. This should be a fixed percentage applied to all patients in these categories uniformly. For example, a practice may choose 25% for their self-pay discount amount. A patient receiving a $300 service with a 25% discount would receive $75 off the charge and be asked to pay $225 at the time of service.

For patients receiving non-covered services or when a self-pay discount is applied, as with other estimates, preliminary estimates should be created based on known billing codes or code sets for the services then updated after services are received and billing codes are known.

At the end of week four, the staff should be able to look up fees and allowable amounts for services provided, create cost estimates for patients either electronically or by manual calculation, and apply self-pay discounts when appropriate.

Week five is the practical application of what the staff has learned about calculating the patient amounts due through the demonstration of their knowledge of copays, deductibles and coinsurances by explanation to the patients. Staff will also be educated to identification of any past due balances and how to interpret their derivation so these can be discussed with patients. In addition to the technical aspects of collections, the finesse of asking for money goes a long way. “The more confident and collected staff appears when asking for payment, the more likely it is patients will pay,” says Aubrey Westgate. (Westgate 2013) Being able to explain to patients how the amount due was calculated demonstrates knowledge and confidence that creates less room for objections. Subsequently, staff should ask patients how they want to pay for the services, because the patients will have a clear understanding of the breakdown of charges and should have options for methods of payment. “If the patient is coming in for a service, the patient knows that there
will be a payment for that service, and requesting that the patient pays their piece of it is a normal, natural part of the process,” according to Jim Akimchuk, vice president of revenue cycle services at healthcare consultancy Culbert Healthcare Solutions. (Westgate 2013) Staff will also be trained on how to overcome objections when patients can’t or won’t pay at the time of service. Scripting various scenarios can be of great assistance to staff that are new at collecting or are becoming more comfortable with collecting. Having the proper collection policies in place and applying them confidently leaves less opportunity for the patient to avoid payment at the time services are rendered. At the end of week five, the staff should have the knowledge to begin having meaningful and productive conversations with patients about what they owe, why they owe it, and how these amounts will be collected.

Engaging and educating the patients is the second critical key to maximizing patient collections. As consumers, 57% of patients are more concerned now than in previous years about what their health insurance covers and how it impacts their payments, 47% of patients placed more attention on their healthcare bills, and 70% of patients said estimated costs would help them to budget for payments. (TransUnion 2016) Effective communication with patients translates into a positive bottom line for the practice. Prior to patients arriving for visits, reviewing and explaining insurance benefits with them helps them understand how their insurance works. Patients whose plans require referrals should understand what that means, from where they need to be obtained, who is responsible for getting them, and what happens if they are not received by the time of the visits. Patients should be informed what their expected out-of-pocket amounts due will be and what payment methods are accepted by the practice. (Martin 2016) It is also critical patients understand the estimated amounts may not represent the patient’s total portion due after insurance adjudicates the claim.

Before the visit is also a good time to review the practice’s financial policies and expectations with the patients. This allows for clarity regarding what will be collected at the time
of service, what payment methods are accepted, what late fees may be applied, and what options are available to patients with financial hardships. These policies can be given to the patients in writing at the time of the visits as well as posted on the practice’s website or patient portal. (Wood 2015)

When patients arrive for their visits, they should be well informed and prepared to pay at the time of the visit. “Once people walk out of the office, the ability to collect starts to erode,” says Jeff Wood, vice president of product management at Navicure, Inc. “We feel that collecting at the time of service is really the ideal time.” (Sprey 2015) Making a connection for the patients with the quality of the care they will receive helps them to make a connection with the payment they will make. Staff can state to the patient, “Mr. Jones, for the service Dr. Smith is going to provide you, your copay is $50. Let’s take care of that now so you can focus on your visit with Dr. Smith.” Taking the time to highlight the care being received before collecting the payment reassures the patient that it’s not all about money. (Kathuna Hopkins 2016)

**The Roadmap – Outline**

As a summary for the practice administrator, the following outline of the roadmap will serve as quick-reference guide as the practice implements these concepts.

I. Billing and Collection Objectives for Clinical Staff
   A. Week 1 – Laying the Foundation
      i. Understand the managed care plans: HMO, PPO, POS
      ii. Understand the federal plans: Medicare, Medicaid, military retiree plans and Private Fee For Service (PFFS) plans
      iii. Understand Medicare and Medicaid managed care replacement plans
      iv. Understand non-contracted plans
v. Identify references available
   1. Managed care guidelines for contracted plans
   2. Physician managed care participation rosters

B. Week 2 – Do we take this plan?
   i. Understand how to identify plans (contracted versus non-contracted)
   ii. Understand when/how to appropriately add/update insurance coverage
   iii. Understand filing order and how to determine priority
   iv. Understand Medicare Secondary Payer Questionnaire and how to complete it
   v. Demonstrate proficiency with hands on experience

C. Week 3 – Is the patient covered?
   i. Understand how to electronically verify insurance in the electronic medical record (EMR)
   ii. Understand how to use other tools to manually verify insurance
   iii. Understand how to interpret the insurance responses
   iv. Understand how to recognize plans that require referrals and/or authorizations
   v. Understand how to translate insurance information into appropriate fields in the EMR
   vi. Demonstrate proficiency with hands on experience

D. Week 4 – What will the patient owe?
   i. Understand how to look up fees for services
   ii. Understand how to create cost estimates for patients
   iii. Understand how to recognize the need for a non-covered services waiver
iv. Understand how to apply a self-pay discount
v. Demonstrate proficiency with hands on experience

E. Week 5 – Show me the money!
   i. Understand how to explain and ask for a copay
   ii. Understand how to explain and ask for a coinsurance amount
   iii. Understand how to explain and ask for a deductible amount
   iv. Understand how to explain and ask for a past due balance
   v. Demonstrate proficiency with hands on experience

II. Engage and Educate the Patient
   A. Review and explain insurance coverage and benefits with the patient
   B. Communicate referral requirements and responsibility to obtain referrals with patient
   C. Review out of pocket expenses and payments due at the time of service with patient
   D. Communicate acceptable payment methods to patient
   E. Provide payment options to patients with financial hardships

Real World Results

A specialty medicine practice in an academic setting was experiencing low patient collections. The academic medical center was home to 21 clinical departments, 15 multi-disciplinary clinical centers, and provided mostly tertiary and quaternary care. The specialty practice had fifty providers, both physicians and advanced practice providers, with a payer mix of 55% managed care, 35% Medicare and 10% other payers. The clinic manager was recently retired from the military and had limited knowledge of insurance and the revenue cycle. The front line
The clinic staff were all entry level employees who received broad-level insurance training conducted by the University’s training team during their onboarding. The billing team for the specialty consisted of the billing manager who had 16 years of experience in the practice, including four years supervising the clinic. The billing staff were mid-level billers, all of whom had previous experience working in the clinic. Ongoing education was required for the billing team as part of their job requirements.

The practice’s annual point of service collections were $94,619. The billing manager brought the problem to the attention of the department’s leadership: the administrator and financial manager. She informed them there were numerous types of collections being missed at the point of service. The lack of staff knowledge of insurance and financial issues, as well as lack of training in collection practices, were contributing factors. Staff were misinterpreting the collection policies so they were not being applied appropriately. Patients were not being engaged in financial discussions ahead of visits. She also informed them there was an issue with the EMR that prevented the copay information from populating on the check-in screens. Departmental leadership asked the clinic manager and billing manager for their recommended solutions to these issues.

The clinic manager recommended sending the staff back through the University training on insurance. He would keep in touch with the billing manager about the issues and would utilize the native reports in the EMR to track progress. He would provide feedback to the leadership team when requested. He would allow current clinic staff to train new clinic staff to the specialty specifics when new staff were on boarded.

The billing manager recommended creating a new training program for the clinic staff utilizing billing and collection objectives that were more detailed than training provided by the University. Clinic staff would be paired one-on-one with billing staff who would be involved in
the training and mentoring of the clinic staff. Classroom, hands-on, and real time training would allow the clinic staff to practice learned objectives, and they would be required to demonstrate proficiency of the objectives. New staff would be required to complete the same in-depth training, work with a mentor, and be checked off on objectives. Compliance with the collection policies would be required. New reports would be created to better track the data which would be done daily, weekly, monthly and annually. Monthly and annual goals would be created and progress would be reported to the clinic, billing and leadership teams weekly, monthly and annually.

The department’s administrative leadership considered the two proposals. The clinic manager’s proposal would be a relatively quick process utilizing available training resources and reports. Clinic staff would only have to attend one training session; however, the training was too broad in scope and lacked specialty specific detail and direction. Those nuances would still have to be trained locally and there was concern the clinic manager did not have that knowledge to impart on the staff. For reporting, utilizing the available reports in the EMR provided some level of information but did not provide the level of detail that would allow leadership to track staff progress on a higher level.

The billing manager’s proposal would provide enhanced training by billing/insurance experts who were knowledgeable of the specialty; however, it would be time intensive. The training program would have to be written, the billing staff would have to be engaged with the process, and the implementation could impact the billing staff’s other responsibilities. Creation of new reports would better illuminate progress, highlight opportunities and ultimately reduce billing expenditures, but would also take time to create. Enforcement of collection policies would help address questions by patients and provide staff with clear direction.
The department administrator and financial manager ultimately decided to accept the proposal made by the billing manager. While the overall process to implement and ramp up would take more time, leadership felt the more in-depth training would be an investment in the staff and the process, would involve the patient more productively, and would lead to greater returns for the bottom line. Leadership also felt tapping into the clinical experience of the billing team would contribute positively to the revenue cycle knowledge of the clinic staff. In an unprecedented move, the department administrator and financial manager reorganized the clinic check-in and check-out staff to directly report to the billing manager and tasked the billing manager with increasing point of service collections. This restructuring would give the billing manager complete autonomy to train and direct the staff who were responsible for patient collections. The clinic manager was incredulous at this decision and assumed a “wait and see” position.

The billing manager created the *Billing and Collection Objectives for Clinical Staff* and created new reports to track collection progress daily, weekly, monthly and annually. She worked with the EMR team to resolve the issue of copay amounts not populating on the check in screens. She met with the billing staff to inform them of the changes and to explain the important role they would play in mentoring the clinic staff and improving patient collections. The staff was highly engaged in the process, worked through coverage issues for their own billing assignments, and worked out a schedule for in-clinic mentoring. Subsequently, the billing manager merged the clinic staff and billing staff for introductions. She reviewed the reorganization and the reasons for doing such and discussed any questions or concerns. The clinic staff and billing staff were paired into their mentoring teams and everyone participated in a team building exercise. Expectations for the training were reviewed and collection goals were established. It was understood by all that feedback on progress would be provided regularly and any course corrections needed would be made immediately. The clinic staff responded positively.
to the changes, commenting they “had no idea what they were doing” and were excited for direction.

Over the next five weeks, the billing manager worked closely with the billing staff to ensure the objectives for each week were clear, all materials needed were available, and the transmission of information was done uniformly. The billing mentors met one-on-one with their clinic partners in a classroom setting to go over the objectives, identify resources, follow processes through the EMR and answer questions. Once the objectives were taught, teams returned to the check-in and check-out stations with the billing mentor in the driver’s seat. The billing mentor performed all functions for that week’s objectives, highlighting and discussing them with the clinic staff as they were performed. The team mates then switched seats with the clinic staff performing all functions and the billing mentor providing guidance and direction if and when needed. This process continued until the billing mentor was able to confirm the clinic staff understood and could demonstrate the concepts for that week. The billing manager subsequently checked off the clinic staff and the process was repeated each week with the next set of objectives.

The final step in the training process was teaching the staff how to effectively engage with the patients ahead of the visits so the patients had a chance to receive the information regarding their benefits, their referral responsibilities, their out of pocket expenses, and ask questions about any of those components. Patients were also made aware of any outstanding balances owed and the staff were trained how to dig into these details if questions arose. Scripting was provided to the staff with multiple ways to communicate these topics, which were in anticipation of real world scenarios. Staff were instructed to inform patients of the acceptable methods of payments and ask the patients how they would pay at the time of service. Staff would make note of this on the visit so, at check-in, the staff could say, “I see you’ll be paying with your Visa today.” Staff were trained how to set up payment plans in the event patients expressed
concern about financial hardship. The staff were also instructed how to connect the patients with the University’s financial office if the patients were unable to meet the requirements of the payment plan. There it would be determined if the patients were eligible for other assistance.

Role playing was done with the staff and billing mentors, as well as the billing manager, to help work out the kinks in the dialogue and help the staff gain confidence in their communication. They were taught how to identify the objections the patients may express and how to overcome them. Staff learned how to frame their responses to patients as what *could* be done rather than what *could not* be done.

To enhance the check in process, staff were provided with handouts to be given to patients that provided complimentary information to the pre-visit discussions. These handouts provided an easy-to-understand breakdown of insurance products, financial expectations, and methods to pay for services that were applicable to all patients. Staff were also taught how to generate the current statement and present it to the patient for those who had an outstanding balance due. This served to provide printed detail of the account, reinforce the discussion that had occurred prior to the visit, and facilitate collection of the past due balance.

To ensure accuracy of the estimates, staff were educated how to double check the estimates at the time of check-out. If different billing codes were selected by the provider than what were used to generate the estimate, the staff learned how to update the estimate, provide the new information to the patient and collect the additional monies due or refund the difference.

After the completion of the five weeks, it became clear the training made a positive impact. Collections quickly rose from $10K in a month to $10K in a week. Auditing of the payments taken indicated the staff were collecting appropriately based on the benefits of the patients. Staff and leadership were provided the regular feedback as promised, and the staff took the results as a challenge to further improve their efforts. They took daily polls of themselves to
see how much each had collected and how much they lacked to reach the goals they set for themselves and for those set by the billing manager. With each success, the teams were recognized for their efforts and a celebration was held at the end of the fiscal year. Overall collections were recognized, individual collections were recognized, and the “top collector” was awarded. The teams discussed the factors contributing to their success and their desire to do even more.

The department administrator and financial manager also recognized the success of the program and discussed ways to ensure the ongoing success with the billing manager. The decision was made to release the clinic manager and for the billing manager to assume responsibility for all clinical operations as the practice manager. The billing staff and billing supervisor were moved from their off-site location and imbedded in the clinic. All new staff responsible for point of service collections would be trained one-on-one with the billing supervisor and checked off on the objectives. Any billing updates or changes would be communicated real time, and in person, to all staff to ensure there were no questions. Billing and clinic staff were encouraged to provide feedback on process changes to ensure maximum discussion and understanding. Changes that required updates to the training content were also made.

Patient participation in the financial discussion was bolstered by efforts at the University level. Financial counselors were added to the practice by the University. Supervised and trained by the director of business operations for the practice plan, the financial counselors were placed in the clinical buildings and assigned to individual clinics. Patients now had a local point of contact rather than being redirected to the financial office. The financial counselors were tasked to reach out to patients who had outstanding balances needing attention and to be available to patients who needed to discuss financial options. The financial counselors worked to proactively engage patients by phone ahead of visits when their overall balance exceeded $500. Their goal
was to help patients resolve their debt through payment plans, qualification of debt reduction or other financial assistance. In situations when they could not reach patients ahead of visits, or when patients could not meet their obligation, the financial counselors worked in close contact with the billing supervisor and clinic staff to close the communication loop with the patient. Often, the financial counselor would come to the clinic to greet the patient and discuss, in person, solutions that would work for all parties. If a reasonable solution could not be reached, or the patient was unwilling to make arrangements, visits were rescheduled with provider input.

Over the next several years, University enhanced collection policies gave more teeth to support staff efforts. New patients, with whom the practice had no relationship, were required to pay their portion at the time of service or were rescheduled until such time as they could pay. Established patients were required to pay their portion at the time of service or be rescheduled, unless the provider indicated the service was medically urgent and could not be postponed while financial arrangements were reached. Patients who could not pay at the time of service, or who had outstanding balances for which they had received at least one statement, were now required to discuss options with a financial counselor. Visits were scheduled once acceptable arrangements were made. Clinic staff retained the tools to set up patients for payment plans when the requirements were met. This helped facilitate a reasonable solution on the spot and allowed patients to receive the care they sought. (Navicure 2016)

The culmination of these continued efforts produced significant outcomes over the next several years and continues to show positive results. Point of service collections rose from $94,619 at implementation to over $1M in the last complete fiscal year:
To date, the same practice is expected to collect over $1.2M in point of service collections for the current fiscal year. Aging accounts receivable for outstanding patient balances has also taken a downturn as a result of these focused collection efforts. With good service estimates, balances left owed by patients are smaller than in previous years. Expenditures for statements and follow up staff are reduced. Collection goals continue to be set and exceeded, feedback continues to be given regularly, and staff continue to be recognized for their efforts.

Other medicine practices within the institution took notice of the progress of this specialty practice and requested the framework and reports that were created to achieve this success. It is now the goal of the University to collect 90% of the estimated amounts due at the time of service which is achievable when these techniques are consistently applied and patients are properly and timely engaged.

**Conclusion**

Point of service collections can be done successfully even with staff who have no experience in healthcare or with insurance and with patients who do not yet understand their benefits or financial responsibility. The integration of the billing staff with the clinic staff provides a much needed dialogue about insurance and patient financial responsibility. This
broadening of knowledge sets the stage for ease of discussions with patients, and the ability to successfully collect what is owed at the time services are rendered.

In this academic practice example, point of service collections grew over 1,000% in four years. Consistency in the application of billing and collection objectives has allowed the practice to surpass every annual stretch goal set for them. Patients are clear when they arrive as to what they owe, how payment will be made, and what other balances may be due from them after insurance adjudication. Patients understand how they can resolve those outstanding balances through the electronic medical record or at their next appointment. Staff have the tools to educate patients, to overcome objections, and to provide assistance to patients who need financial options. Additionally, clearly written policies for patients and staff help reinforce the expectation that payment is due and will be collected when services are rendered. The regular feedback to the staff has played a major role in the success of the team. Staff understand the expectations, know this is being regularly monitored, and strive as individuals and a team to reach the collection targets.

The identification of the factors preventing a practice from achieving optimal collections is an essential step in determining the course of action to make improvements. Once these issues are uncovered, having a plan for overcoming them is a must. Implementation of the plan coupled with regular data reporting and feedback to the staff can yield significant results. It can allow the practice manager to track trends, identify issues as they arise, and implement immediate corrective action when needed. Finally, including the patients in financial conversations about their care increases their ability to understand and to plan for their medical expenses, meet the requirements on time, and focus on their health rather than their debt.
Bibliography


