POC Pricing Foundations

Any effective patient payment program begins with collecting the amount due at the time of service. In order to successfully collect payment at the POC, practices must be able to efficiently and accurately determine a patient's financial responsibility for the care provided while he or she is still in the office. Some physician practices may choose to manually calculate patient payments, while others may rely on payer cost estimators or their practice management system (PMS) to perform price determinations. No matter which system your practice uses, it's important that you and your staff understand the key data components required for calculating the price of treatment so that you can easily explain the balance due to patients. All POC price determinations are based on the following elements:

1. **Contract provisions:** Some payer contracts do not permit POC collection. Consult your health insurer contracts to ensure that there are no provisions against upfront collections activity related to POC pricing. If your contract prohibits such collection efforts, you may wish to contact your health insurer for contract renegotiation.

2. **Eligibility information:** A critical step in POC pricing is ensuring that your practice submits an electronic eligibility request directly to the correct health insurer immediately prior to the patient's office visit and receives a response with patient financial responsibility information, including copay, coinsurance and remaining deductible amounts. Be sure to communicate with your PMS vendor, billing service or clearinghouse if you are unable to submit an electronic eligibility request.

3. **Current health plan fee schedule:** Even with current information on the patient's financial responsibility, you cannot provide accurate POC pricing without first determining the amount that the health insurer allows for the services provided. Be sure to contact the health insurer for updated fee schedule information. If relying on your PMS for automated POC pricing calculations, ensure that the most recent fee schedule has been loaded into your PMS.

4. **Patient payment calculation:** Whether your practice manually determines patient payment or relies on a PMS or payer-provided calculation, all POC prices must factor in both the patient's financial responsibility and the allowed amount for a service based on the health plan's fee schedule. The interplay between the various forms of patient financial responsibility and the payer fee schedule in POC pricing calculations is described below. *Note: Not all patient benefit plans will include every element described below, and the elements may vary within a plan depending upon the type of service. For example, some services may be associated with copays, while others are associated with coinsurance amounts. Likewise, benefit plans may have different deductibles for different categories of service.*

   a. **Copays.** There is generally no calculation associated with copay amounts. They are almost always indicated as fixed amounts based upon the terms of the patient's insurance policy, although they may vary based on the type and specialty of the health care provider and where the services were provided: office visit, outpatient facility, etc.

   b. **Coinsurance.** Calculations for coinsurance amounts are based upon the level of coverage that the patient's insurance policy provides. For example, if the patient's insurance policy indicates that the insurance payer covers 90% of the cost for an office visit, the patient is responsible for the remaining 10%. **Caution:** Coinsurance

calculations are based on the contracted fee schedule rate and not the practice's retail charge.

c. **Remaining deductible.** A deductible is a specified amount of money that must be paid before the patient's insurance company will pay money towards a claim. For this reason, it is essential for a practice to determine how much of the patient's deductible remains unmet in order to calculate an accurate price estimate to present to the patient at the time of service. If the contracted rate is less than the remaining deductible, then this amount is more than likely to be the patient's financial responsibility. On the other hand, if the contracted rate is more than the patient's remaining deductible, then ONLY the actual amount of the remaining deductible becomes the patient's responsibility. An example is listed below.

Ex. **If the contracted rate is less than the remaining deductible**

CPT® code	Short descriptor	**Health insurer contracted rate**	Remaining deductible	**Patient owes**
992XX	Office/Outpatient Visit, Established Patient	$74.00	$150.00	$74.00

Ex. **If the contracted rate is more than the remaining deductible**

CPT® code	Short descriptor	**Health insurer contracted rate**	Remaining deductible	**Patient owes**
992XX	Office/Outpatient Visit, Established Patient	$74.00	$25.00	$25.00

The final pricing for a service is determined by combining the calculations for each applicable element of the patient's financial responsibility. The table below provides an example of a POC pricing calculation. **Note:** This example assumes that the copayment amount reduces the allowed amount under the payer fee schedule (rather than being in addition to the contracted rate). Physicians must review their individual contracts as well as the patient-specific financial eligibility information to ensure they are properly calculating the patient's ultimate payment amount.

CPT® code	Short descriptor	**Health insurer contracted rate**	Copay	Coinsurance (10%)	Remaining deductible	**Patient owes**
992XX	Office/Outpatient Visit, Est.	$150.00	$20.00	$15.00	$82.00	$117.00

Additional factors may need to be considered when calculating patient payments for more complex services and claims. Physicians and their staff should remember that each payer has different claim edits and pricing rules that may need to be factored into POC pricing calculations when more than one service will be provided at the office visit. Catalogs of various health plans' edit and payment rules, which are offered by commercial revenue cycle management companies, may be helpful in providing POC pricing for more complex claims.

After taking all of the above precautions to ensure correct POC pricing, there may be occasional situations where the patient's financial responsibility, as calculated by the health plan during claims adjudication, is less than your practice determines at the time of service.

For example, the patient's plan may have a maximum amount for out-of-pocket expenses, and your practice may not be aware that the patient has reached this limit until after the health plan has processed the claim. If the health plan's electronic remittance advice (ERA) indicates that the patient has overpaid your practice, be sure to promptly refund to the patient any amount previously collected at the time of service that was in excess of the patient responsibility amount indicated on the ERA.

POC Pricing Options

Practices have a variety of choices in how they determine patient payments at the time of service, from automated systems to old-fashioned arithmetic. The list below details POC pricing options in increasing order of automation. Remember that no matter which method your practice uses, patient financial responsibility from the electronic verification response and a current payer fee schedule are critical to any accurate POC pricing determination.

1. **Manual calculation:** Using the principles outlined earlier in this resource, practices can manually calculate a patient's financial responsibility based on copay, coinsurance and remaining deductible information provided in the electronic eligibility response and the current fee allowed for the service by the health plan. When manually calculating patient payments, double-check your work to ensure accuracy, and be sure to document information supporting your calculation, the final amount due and the patient's payment.

2. **Health plan cost estimator tools:** Many health plans offer online cost estimation tools on their websites or portals. By entering data about the services you expect to provide to a patient during an office visit, you can obtain estimates of what you should expect to be paid for medical services. These tools may offer the ability to personalize information to reflect the patient's health plan benefits, including real-time account balances and remaining deductibles (when applicable). The information provided by cost estimators is based on available fee schedules and actual contracted rates with physicians and other health care providers. **Note:** The information provided by a health plan's cost estimator tool is not a guarantee of coverage for charges, and the final amount owed by the patient may change from the estimate. If this should occur, patient accounts should be reconciled immediately. In addition, not all health plans permit POC billing based on information provided by cost estimator tools. Be sure to check a health plan's stipulations regarding the use of cost estimator data before requesting patient payment at the time of service.

3. **PMS calculations:** Your PMS system should possess the ability to upload your payer fee schedules in order to help you make patient price determinations. If your PMS system does not allow you to handle immediate eligibility responses from payers and/or does not support POC pricing calculations, you may wish to consider changing PMS vendors. View the AMA's "Selecting a practice management toolkit" for helpful suggestions about choosing a PMS that has all of the functionalities your practice needs to maximize efficiency.

4. **Real-time adjudication (RTA):** As more health insurers offer high-deductible health plans, patients are becoming increasingly concerned about what they will owe out-of-pocket for medical care. RTA, which refers to a payer's immediate adjudication of a claim upon receipt from a health care provider, solves this issue. Unlike the traditional method of submitting and processing claims in batches over a period of weeks to months, RTA completes claims processing during the patient visit and provides a response from the health plan within seconds. The response includes sufficient information to allow the physician to determine the patient's financial responsibility and collect payment including copays, coinsurance and remaining deductible amounts at the time of service. Health plans are beginning to offer RTA to physicians via online portals or through the standard electronic claims transaction. Check with your PMS vendor and the health plans with which you do business to see if they are supporting RTA and let them know that you are interested in this functionality to support POC patient collections.

For more information on developing a strategic plan for collecting payments from your patients at the time of service, visit the AMA's POC Pricing Toolkit.