Improving Your ASCs Billing and Collections –
Five Important (And Sometimes Urgent) Areas to Address

By Caryl Serbin, Surgery Consultants of America

Are you doing everything you can to maximize your ASC's reimbursement? Investigate the following key financial areas in your center to pinpoint why reimbursement has decreased or is less that what was predicted.

These areas were chosen because of their ability to directly impact the center's revenue stream, but are certainly not all of the areas that need to be assessed on a regular basis for continued financial success.

Fee Schedule

In most ASCs, the fee schedule is established when the center is opened and essentially ignored from that point forward. Occasionally the Board may decide to do a cost of living increase, but rarely is the fee schedule reviewed

- Do a spreadsheet and compare your fee schedule to reimbursement rates of your managed care contracts. Be sure the fees allow the necessary margin to maintain your budget.

- Assess your fee schedule in light of industry changes - changing Medicare reimbursement rates, increasing implant costs, competitive salary and benefit demands.

- Medicare group-based fee schedules should have carve-out fees for procedures that are time and supply intensive or require non-reimbursable implants.

Revising your fee schedule is fairly straightforward and often results in amazing benefits. Review your fee schedule at least annually and update sooner if necessary.

Managed Care Contracts

Just complaining about low reimbursement rates will not fix the problem. The best way to improve reimbursement is to work with, not against, the managed care companies.

- Identify the representative that can make decisions about reimbursement rates and deal directly with them.
- Determine what areas you need to change, i.e.,
    - Carve-out higher reimbursement rates for high ticket procedures
    - Separate implant reimbursement
    - Multiple procedure allowances and discounts
- Reciprocity is the name of the game - know where you can afford to offer reductions to compensate for what you want increased.
- Be able to support your requests for increased rates by providing case costs.

Most importantly, don't just accept what they offer – negotiate!

Procedure Coding and Charge Entry

Employ certified and experienced surgical coders to optimize your reimbursement. Investing a little more in payroll can often result in thousands of dollars in additional reimbursement while remaining compliant with OIG requirements.

- Remind your surgeons they can assist in revenue enhancement with detailed operative notes demonstrating medical necessity and complexity of procedure(s).
- Claim submission requires knowledge of procedure and diagnosis coding as well as modifiers. In most centers coders perform charge entry and claim submission.
- Important reminders to keep your cash flow ongoing:
    - Timeliness – claims need to be out the door within 48 hours following surgery
    - Accuracy – recheck all areas of claim before submitting
    - State-specific guidelines, i.e., modifiers, form variances, etc.
    - Electronic submission wherever possible

Improving your revenue stream can often be as simple as setting specific goals for your coding and billing staff and rewarding them for meeting or beating those goals.

Payment Posting and Denial Management

Getting paid is one thing - getting paid correctly is another! The more experienced the reimbursement specialist is relates directly to getting paid fully for services rendered.

- Your payment poster needs full access to current managed care contracts. This is key in determining accuracy of payments.
- Start denial process immediately for errors or non-payments.
- Develop a denial log to track reasons for denials. Track trends by payer, by surgeon, by coder, etc.
- If correctly paid, change responsibility for balance owed to secondary insurance or patient and bill immediately.

Denial management is one area where problems often go undetected. Inexperienced or interrupted payment posters often do not identify incorrect payments or a trend in denials. If denials are not followed up immediately, timely filing clauses in your contract may become a reason for the payer to contest liability for the amount due.

Accounts Receivable Management

Accounts receivable is an asset, meaning it’s money that is owed to the center that they anticipate collecting. When A/R is not managed properly it changes from an asset to bad debt. This is not a good thing! Again, experienced personnel are the key for good collections.

- Contact the payer 15 days after submission of an electronic claim to determine status of payment.
- Measure days your claim remains in accounts receivable - recommended 50 days or less.
- Measure percentage of claims still unpaid after 120 days - recommend less than 15%.
- Set achievable goals for your collector – how many accounts to touch per month? What percentage of collections in each area, 30 days, 60 days, etc.?
- Patient collections are often not worked because of time constraints. Evaluate the percentage of monies still owing at 120 days in patient accounts. A phone call to an overdue patient account often results in a credit card number or a promise of payment.

Because of the high percentage of managed care claims that are not paid on a timely basis or are paid incorrectly, collections are an important and sometimes daunting task. Don't expect payments to arrive by themselves - this just doesn't happen anymore - it takes constant effort to get the money you are owed.

Profitable centers don't just happen; they are usually the product of hard work and well-thought-out financial planning. If you are a new center, following these common-sense suggestions will assist you in meeting your financial goals. If your center is an existing center having financial difficulties, explore each of the areas referenced. Chances are you will find at least one area that can be improved.

Caryl A. Serbin, RN, BSN, LHRM
President and Founder
Surgery Consultants of America, Inc.
Surgery Center Billing, LLC

12670 CREEKSIDE LN. SUITE 401
FORT MYERS, FL 33919

Toll Free: 1-866-889-7722

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