MAXIMIZING REIMBURSEMENT
and Increasing Efficiency in the Revenue Cycle

By Maggie Dean and Regina Boore

With the cost of doing business steadily increasing, it is more important than ever to take advantage of every opportunity to maximize reimbursement and increase efficiency in your ASC's revenue cycle. The following tips can help ensure your facility is on the right track.

Know Your Contracts

Invest the time to educate your coder, biller and payment poster to ensure revenue does not slip through the cracks. Billing staff should be familiar with your payor contracts to maximize your revenue opportunity. If a payor disallows a code, or reimburses it below your negotiated rate, an uninformed payment poster may believe the claim was properly paid. It can be intimidating to call and argue underpayments with insurance companies. Arming your staff with the knowledge of what your facility should be paid for each service is a must. A fee schedule with all your contracted rates is an important reference that should be available to your business office staff. The schedule should also include information such as reductions for additional procedures.

Reassess your contract reimbursement for each procedure annually. Some payors base reimbursement on a grouper system. This methodology may result in costly procedures being reimbursed at a rate significantly less than Medicare and other payors who base their schedule on the Medicare fee schedule. Create a spreadsheet comparing Medicare's current reimbursement to your other payors' contract rates. This is a good way to identify codes that

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may be underpaying. Take a closer look at these codes and compare the reimbursement to average cost per case for that procedure. Note any concerns and initiate renegotiations four to six months prior to your contract's renewal date.

Encourage Communication Between Your Billing Staff and Materials Manager

Ongoing communication between these two key players can help identify high-ticket items that may be separately reimbursable. Cost per case, even for the same procedure, can vary based on surgeon preference. Your coder will not be able to glean all of the supply information from the intra-operative record alone. Therefore it is important that expensive supply items are identified and somehow communicated to the billing staff. Remember that even though you cannot bill Medicare separately for these items, some of your contracts may provide reimbursement. If the supply item is not reimbursable, does the procedure payment cover the cost of the procedure including the high-priced supply? If not, try to obtain a carve-out during your next contract renegotiation.

Adding a New Specialty

It is especially important to keep an eye on your contracts when adding a new specialty. Contact the contracting manager at each company to make them aware beforehand. Ask for a fee schedule for the new codes you will be billing. Research what new disposables, supplies and implants will be used and if they are separately billable under your current contracts. If your staff is not familiar with billing the new specialty, try to network to get tips from someone with experience in that field. You will most likely have to renegotiate your contracts at this point. Keep notes of your concerns for each contract and a spreadsheet comparing each contract allowable as a comparison.

Insurance Verification

Insurance should be verified at least five days prior to a patient's surgery date. As soon as insurance is verified, a patient's estimated deductible/coinsurance or copay portion should be calculated. A phone call placed at least three days prior to the date of service is courteous and allows time to prepare if the amount is high. In lieu of payment plans or allowing a patient to pay after insurance is billed, consider signing up with a healthcare financing

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company and offer that as an alternative if a patient states they cannot pay on their surgery date.

Proper Coding

It is important to note that the proper way to code an encounter can vary based on the payor. The same implant HCPCS code can require different revenue codes contract to contract. Some insurance companies may require an invoice to reimburse for certain implants or supplies. Knowing these specific requirements can help improve your revenue cycle. Failing to follow payor-specific billing guidelines can unnecessarily delay payment and use additional business office hours to re-bill and appeal the claim. A good way to help ensure your claims are going out correctly is to create a spreadsheet to organize this information for quick reference at the time of billing. It is important to note: billing supply codes to a payor that does not allow the code may cause the claim to be denied, pending receipt of additional information. If you already know they will not pay no matter how much information you send them, you might as well get paid for the allowable codes in a timely manner.

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Taking Write-Offs at the Time of Billing

If you are able to load your contracts into your billing software, we suggest utilizing this feature. If not, create a contractual write-off spreadsheet and require your billing staff to take the contractual write-off at the time of billing. This is invaluable for two reasons. First, your accounts receivable (AR) is an accurate reflection of what you truly expect to be able to collect. Second, when payment is received, it is easier to identify an underpayment by the insurance company.

Clearinghouse

Make sure your billing staff is familiar with all of the features offered by your clearinghouse. Simply sending claims and pulling reports is a must, but most clearinghouses have advanced features that can help with claim status and tracking an unpaid claim. Ask your clearinghouse to set up a webinar training session for your billing staff.

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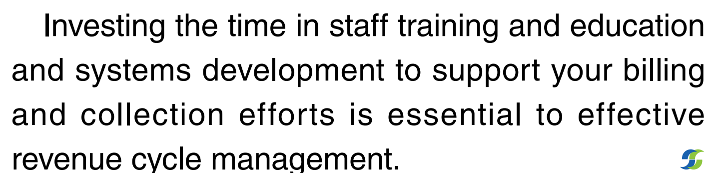
Utilize Online Payor Websites

Using insurance companies' online tools can be helpful when verifying insurance or following up on claim status. To maximize productivity, we encourage staff to use an online tool while on hold with a payor that only has phone-based resources available. It is important to note that when checking benefits for ASCs online, make sure that the website specifically says benefits for ambulatory surgery center. If you only see benefits quoted for outpatient surgery, it is possible that the ASC benefits are different. It is a good idea to call and verify to make sure an additional copay or deductible is not required at an ASC.

Payor Follow-Up

After taking all the necessary steps to ensure your claim was coded and billed properly, there can still be problems getting paid on time. The insurance companies are hoping enough of you will be too busy to follow up within the proper timeframe. Every claim should be reviewed by the time they are 30 days old – and then at least every 28 days after that. HMOs typically take 45 days to pay, but it is still important that claim status is checked to ensure the claim is on file with the payor. Using the online payor websites is fine for claim status, as long as you can obtain a claim number and see that the claim is in process. Using a tickler file or electronic calendar reminder for subsequent follow-up is a great idea to ensure claims are continually worked.

Investing the time in staff training and education and systems development to support your billing and collection efforts is essential to effective revenue cycle management.



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