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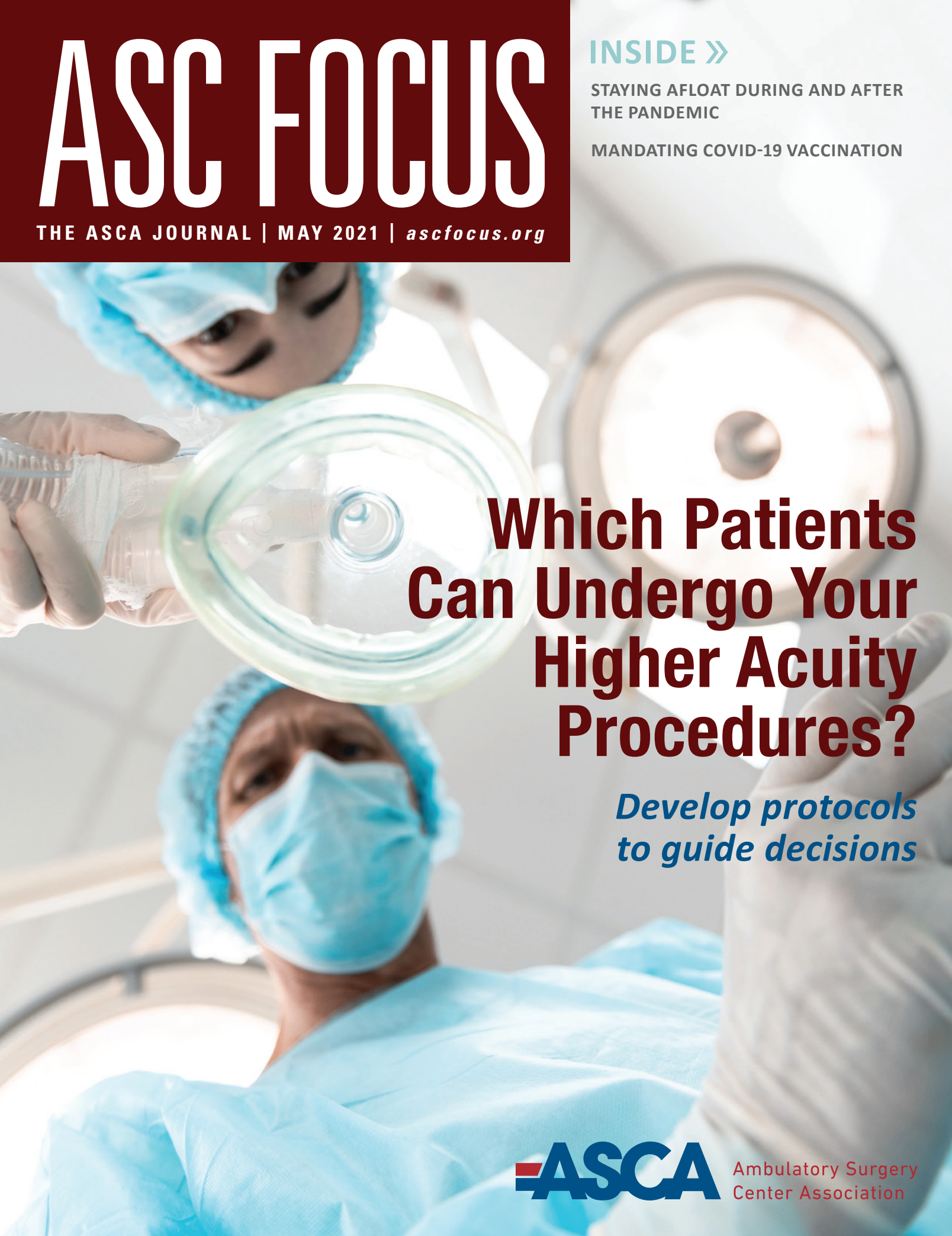

Which Patients Can Undergo Your Higher Acuity Procedures?

Develop protocols to guide decisions

ASCA Ambulatory Surgery Center Association

Improve Your Revenue Cycle Performance

Graduate from 'good enough' to 'great' **BY ANGELA MATTIODA**

To get paid, ASCs must perform a series of functions, including insurance verification, authorization, chart prep, dictation and transcription, coding, claim submission and payment posting. When centers complete these in a reasonably efficient manner, the revenue cycle should generate enough income to cover expenses, give employees occasional raises, make periodic new investments and deliver consistent distributions. All in all, these sound like acceptable results.

ASCs, however, do not need to settle for a revenue cycle performance that is just "good enough" when greatness might be not that far out of reach.

Reconcile Your Schedule

A priority for any ASC must be reconciliation of the schedule to ensure claims are submitted. While this might sound elementary, centers often leave significant dollars on the table because they fail to consistently complete this step.

Claims can be submitted improperly for many reasons. Simple reasons could be that a team member forgets to click the "submit" button within the clearinghouse or the system rejects the attempted claim submission. Other causes of claim rejections can include mismatched payer, claims out of balance or a typographical error in a patient's identification or date of birth that prevents the system from finding the patient's file.

As important as it is to try to reduce the likelihood of rejections, they will happen. What matters more is ensuring processes are in place for reviewing and addressing them in a timely manner. Requiring staff to address rejections within 24 hours is a valuable best practice.

Another critical aspect of schedule reconciliation is ensuring all charges are submitted. Reconciling all implants used during procedures is particularly important. Since ASCs purchase implants upfront, failure to bill for them will cause a center to lose revenue—potentially a lot of it. Yet it is common to see instances when implants are not captured during charge entry.

To better ensure implant reconciliation, ASCs should document implants purchased in the inventory module of their practice management system. This process will allow staff to print an implant log and cross-reference it so every implant is billed.

In a similar vein, ASCs are increasingly incorporating pain blocks into cases, especially for orthopedics cases. Pain blocks are covered by Medicare and most managed care contracts, so they should be billed but are often omitted from claims.

Pain blocks are typically performed by anesthesia providers. When a surgeon finishes a case with a pain block, they might not mention the pain block in their dictation. If the billing team is unaware that a pain block was administered, it could easily be left off the claim. While a single missed billing of a pain block is not likely to make a significant difference on the reimbursement for a large orthopedic case, repeated omissions will add up.

Consider these steps to help reduce the likelihood of missing an opportunity to bill for pain blocks. If you know a pain block will be ordered with a procedure, include the block's code in the schedule. Oftentimes, a pain block is added during a procedure. In these instances, the business office should add an alert in the practice manage-

ment system to inform billing that the block was performed. The billing team also can review anesthesia provider reports to identify when pain blocks were ordered and reconcile the charge accordingly. In all instances, it is essential for the surgeon's operative note to detail that a pain block was ordered and the reason(s) why.

Improve Upfront Processes

All ASCs experience denials. Even the best-performing ASCs will typically have a 5–10 percent initial denial rate. Submitting appeals and fighting denials should be built into the revenue cycle process, and an ASC's denial write-off percentage should be less than 1 percent. ASCs should rarely fail in their efforts to get paid for denied claims.

Even an ASC that enjoys a write-off rate that low should strive to avoid future denials. My mantra is that ASCs should always try to submit a clean claim because it usually takes extensive time and resources to rework a claim. Essential to achieving this objective are strong upfront processes. One upfront area where ASCs can come up short is misunderstanding payer clinical policy requirements.

For example, at least one national payer requires patients to undergo a psychiatric evaluation before receiving a neurostimulator. A failure to ensure the patient receives the evaluation before getting the trial neurostimulator will likely lead to denied payment for the neurostimulator—potentially costing the ASC thousands of dollars. Ensure that your payers' clinical policies are carefully reviewed and reviewed when updated, with all requirements concerning your procedures understood and consistently followed by surgeons and staff.

Another upfront process that can trigger denials concerns submission of patient medical records. Your revenue cycle management team should know which payers require medical records with the submission of a claim and how those payers want records submitted. Some payers want records submitted with the claim. Others want them separately.

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>
> *—Angela Mattioda Surgical Notes*

In addition, ASCs should submit medical records electronically through a payer's portal whenever possible. One reason this is preferable to submitting via paper or a clearinghouse is that records submitted via a payer portal are assigned a tracking number that is given to the ASC. If the payer denies a claim due to lack of medical records, the ASC can provide the tracking number, which should expedite the appeal. Without that tracking number, the ASC will likely need to resubmit the medical records, which takes time and delays payment by at least a few weeks.

A final upfront issue that regularly trips up ASCs concerns local coverage determination (LCD) and medical necessity requirements. For ASCs that do not address these upfront, a denial is inevitable. The cause of these issues is typically a matter of verbiage—more specifically, not including enough information in the operative note to code to the highest level of specificity.

For example, documenting that a patient received a lumbar injection is important, but that alone is likely not enough information. The operative note should include the specific level in the lumbar spine that received the injection. Doing so enables a coder to then issue a more specific ICD-10 code that will support medical necessity. Educating providers about what is needed to meet LCD and medical necessity requirements will help ensure claims get paid.

Going for Greatness

Working to take your revenue cycle performance from good to great is not just about growing your bottom line. Elevating performance will give you the ability to reward employees more significantly and frequently, helping improve retention and performance; make ongoing capital investments that improve quality of care and drive growth; and deliver increasing distributions to owners. An elevated performance also helps ASCs reduce avoidable problems, which can create challenges for patients and require additional work for staff.

Revenue cycle greatness should be the goal for all ASCs. The right people, processes and knowledge can make it achievable. «

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