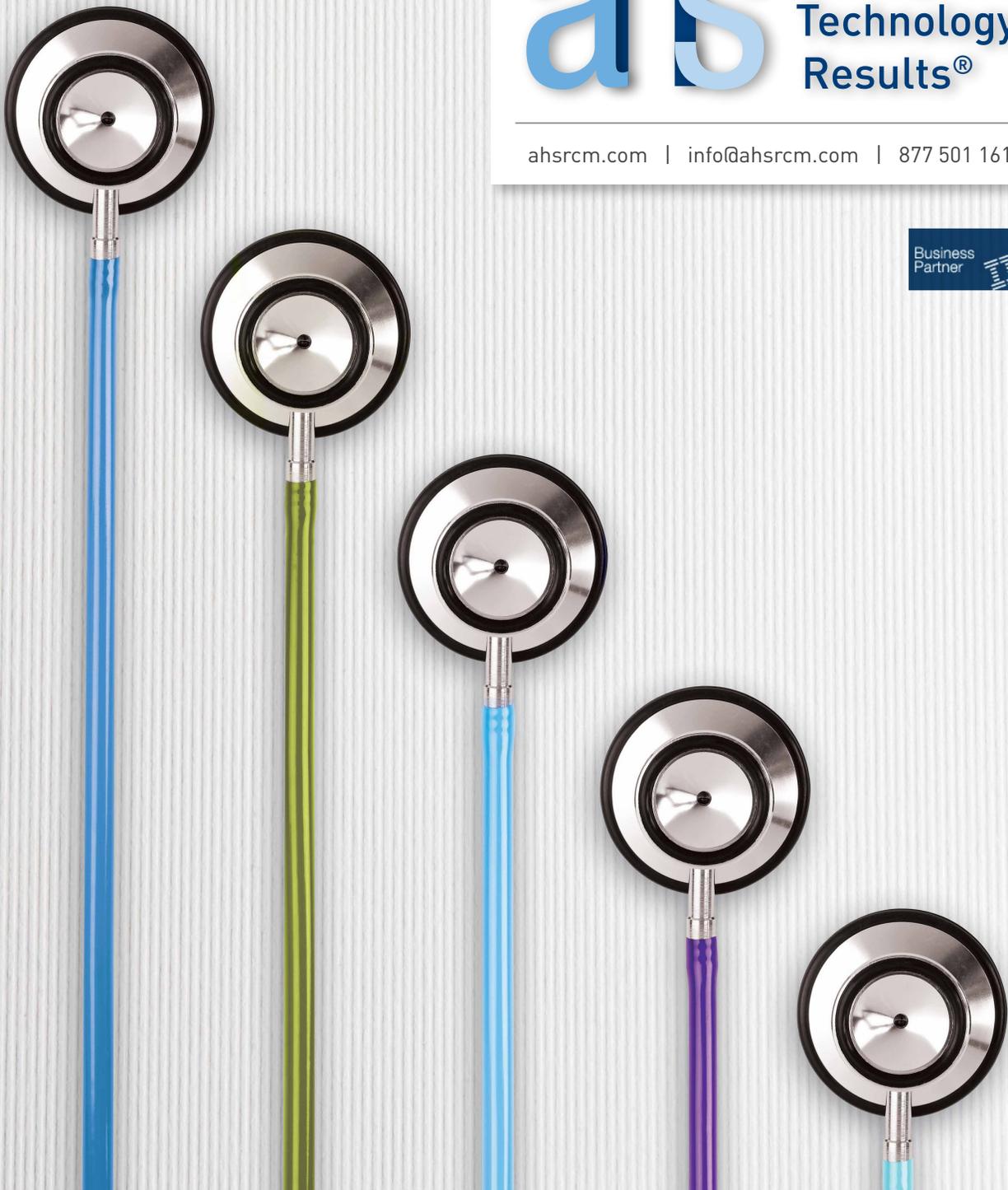


FOUR KEY STEPS TO IMPROVE ASC BILLING AND INCREASE ASC COLLECTIONS

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It is clear that ASC billing is becoming more complex every day, even without the impending effects of health care reform. At best, reimbursement trends are flat and probably headed down, with most private payer negotiations resulting in lower rates and pressures on out-of-network (OON) centers to move in-network. At the same time, cost trends are heading up at an alarming rate. The inevitability of these factors means that each center must become more and more efficient.

AT A GLANCE:

1. Billing is a process.
2. Be patient-centric.
3. Be staff-centric.
4. Don't forget compliance.

One of the issues driving reimbursement levels is the decline of traditional insurance plans and the increase in high deductible plans (HDHP). Compared to 2009, 2010 health maintenance organization (HMO) and point of service (POS) plans saw a 3 percent decline. Commercial preferred provider organization (PPO) plans declined at 7 percent, and Blue Cross/Blue Shield plans decreased at 9 percent.

At the same time, high deductible plans grew over 20 percent, and accounted for 11 percent of all new purchases in January 2010. There were only one million people covered by HDHPs in 2005. In early 2010, this number skyrocketed to 10 million.

The cause is evident: lower premiums. More and more companies have moved to HDHP to partially offset double digit increases in health care costs. For individuals buying their own insurance, the lower premiums of an HDHP are more affordable.

On the cost side, in some areas, it is becoming more difficult and/or more expensive to find and retain skilled billing staff, despite record levels of unemployment. The specialized knowledge needed for effective and compliant coding and billing for an ASC is simply not available in every location. Plus, all centers are seeing employee cost increases related to health care costs and other benefits.

Looking down the road, the demands on coding and billing staff will accelerate. The effective date for HIPAA's 5010 standards for electronic claims is Jan. 1, 2012, and ICD-10 code sets are positioned to go into effect in 2013. As of Oct. 1, 2010, the Affordable Care Act (ACA) requires that



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Medicaid claims incorporate the methodologies of the National Correct Coding Initiative (NCCI). Plus there are unique state and payor requirements that change regularly.

With reimbursement trends flat, the portion of collections from patients rising, increased billing and coding complexity, and decreased availability of skilled staff, it's little wonder that most ASCs are looking for ways to become more efficient. With these pressures in mind, here are four steps that can be implemented in your ASC to improve billing results.

■ BILLING IS A PROCESS.

First, be sure that you and your staff focus on billing as a process, a well-defined set of steps to follow consistently. The process that you put in place doesn't have to be complicated, but it does need to be well-defined, well-understood, and followed.

Make your billing process a series of simple steps. Familiarize everyone in the office with the "end-to-end" process--everything from the first patient contact at the surgeon's office through the final payment. All employees, especially those who manage scheduling and check-in, must know they are an important part of the end-to-end process, since an early error can ripple throughout the entire process. It's crucial that each person knows their specific role in the process and is aware that errors in billing usually happen at the seams, i.e. handoffs, between individuals and groups.

To clarify your process, make a simple diagram that's easy to read and follow. Train every new staff member on it, and post it where it is easy to see. Make sure that each person knows how to perform their functions using your management software and any other automation tools in your center. Create job aids and scripts where the system doesn't provide clear structure for the process.

Of course, the end-to-end process includes the billing and coding staff as well. However, they require a more detailed process for their piece of the work. Much of this might be implemented inside your management software, but don't take it for granted. Draw out the process and make sure the software is configured consistent with your process.

■ PATIENT-CENTRIC.

The next step is to overlay your customers' perspective on the process. Many centers have been successful in making the clinical process more comfortable for their patients. The next step is to do the same for the administrative process, especially considering HDHPs.

Think about how each of your patients might be feeling. What are they hearing? Perceiving?



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Most times, particularly on the day of surgery, the patient is much more focused on the clinical issues than anything else, and simply assumes that insurance will cover the cost. This means that the center needs to assume a proactive role in talking to patients about payment alongside the clinical information. You can never start too early in the process.

When scheduling appointments, discuss with the patient how they plan to pay their portion of the cost for the procedure. Additionally, have the front office employee collect insurance information and conduct an eligibility check. Send information packets that include common reimbursement examples to the patient. Even better, have your surgeons provide the packet when they recommend surgery.

Offer the patient payment options: a credit card, any available financing options, or—as a last resort—payment plans. It's also very helpful for patients to have an estimate of how much they'll owe going into the procedure. In many cases, you can even collect a good faith estimate of what the patient owes at time of surgery. A 2009 McKinsey study found that two-thirds of patients are willing to pay a good faith estimate of their obligation at time of service.

While it can be a complex process, eligibility checks will usually show not only co-pay, but any co-insurance. For an HDHP, it might show the patient's remaining deductible amount. However, each plan is different, and the amount of data received will vary if you are in-network vs. out-of-network. If possible, send a confirmation tailored to the individual patient (i.e., co-pay vs. HDHP) when confirming the appointment. Waiting until the day of the procedure to confirm all of the details related to billing is very complicated—and the patient will not be focused on payment.

Finally, be prepared for questions after the surgery. When handling patient collections, be timely and consistent. The best results occur when the bill the patient receives after insurance matches what your center told them before surgery.

One other suggestion: When you follow up the day after surgery, ask the patient how everything went and if they have any questions or concerns. Then remind them that the bill for their surgery has been submitted to their insurance company, and they will receive a bill for their portion in a few weeks.

■ STAFF-CENTRIC.

An effective patient-centric process requires a staff-centric focus and attitude. Only well-trained staff, with the right skills and education in the right positions, can effectively deal with patients



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and follow your defined processes. While many of us might do this intuitively, it is helpful to create a list of the skills and responsibilities required for each role on your team. For example, the scheduler, front desk staff, and A/R follow-up staff must each be able to ask for a payment effectively, while only a coder needs ASC coding knowledge.

Once you have the list, compare it to the skills of your current staff. Be sure to focus on what you can do well with the staff you have in place, and consider hiring specialists if the current skills aren't top-notch. Billing work is one area that can be effectively hired out without disrupting the end-to-end process.

Some centers find it difficult to have enough experts on-site who have time to do all of the coding, billing and analysis required for first-rate collections results. As coding and billing become more complex in the form of new payment models and quality metrics, it will become even more important to have deep billing expertise.

■ COMPLIANCE.

Compliance is a critical factor in center operations that is easy to overlook. Improving your compliance program might not immediately increase your revenue, but it can help your center avoid major costs. And, if viewed as a process improvement effort, it might actually help increase revenue in the long run.

Sooner or later, a compliance plan will be mandatory. Right now, the Affordable Care Act leaves timing to be determined by the Centers for Medicare & Medicaid Services (CMS). Don't wait until it's mandatory. Begin putting a compliance program in place now, and integrate it into your process and employee training.

Examples of compliance-related matters that are mandatory now include recent CMS regulations for both Medicare and Medicaid that require that refunds be issued within 60 days of the refund being identified. Also, the penalties for breaches of protected health care information (PHI) are much more severe as a result of last year's Health Information Technology for Economic and Clinical Health (HITECH) act. All breaches must be recorded, and larger ones must be publicly reported. The "Red Flag" rules have been postponed but might still apply. And there are Payment Card Industry (PCI) requirements for handling credit cards. None of these requirements need to be onerous, but they do need to be included in center processes and training. A formal compliance plan and program is the most efficient way to do so.



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As we all know, Medicare is increasing its enforcement efforts substantially. This translates into more audits, which means the odds of your center being audited are steadily increasing. When an audit does occur, your compliance plan and evidence of it being followed will minimize the impact.

We recommend an annual external compliance audit to see how well your center is doing. The good news: when implemented, most compliance efforts will only improve your billing processes.

■ CONCLUSION

Implementing these four steps will improve billing and increase collections at your ASC. In order to be successful, billing needs to be a well-defined and well-understood process. This process, as well as the related operations and training for staff, must be designed around the patient. Many patients seen by your center do not fully understand their own insurance plans, so make sure your staff is available to assist them. Having the right people in the right roles will help make this easier. If you don't have the experts already at your ASC, consider hiring specialists to do the job. Finally, remember to include compliance in your entire operation. Building it in at the start is much easier (and in the long run, less expensive) than fixing a compliance problem.