THREE STEPS TO IMPROVE A/R PERFORMANCE IN YOUR ASC

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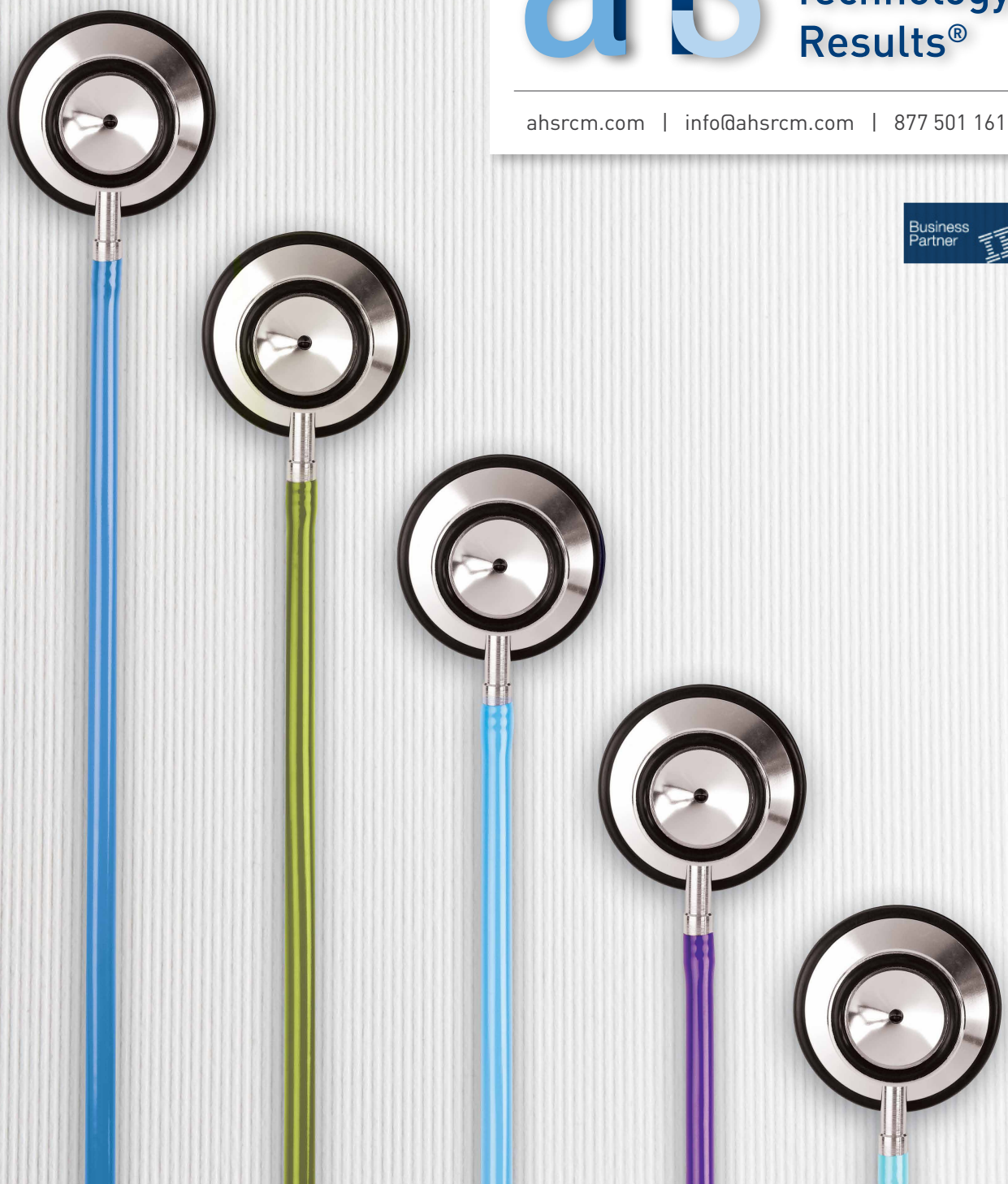

THREE STEPS TO IMPROVE A/R PERFORMANCE IN YOUR ASC

Everyone knows that improving Accounts Receivable (A/R) performance is a good thing. However, many surgery centers find they are hitting a wall without achieving their desired targets. Here are a few suggestions your surgery center can implement to help break down that wall.

AT A GLANCE:

1. Understand A/R trends.
2. Reduce denials.
3. Use formal process improvement plans.

1. UNDERSTAND A/R TRENDS.

Just looking at A/R reports isn't enough--you need to roll up your sleeves and dig! A good example: aged A/R by payer. If your center is like most, payments from some payers will lag significantly compared to others. Some of this lag-time is predictable and needs to be factored into your targets. But increases by a payer are red flags that need attention. Perhaps they changed requirements that you may have missed. Or the number of denials has jumped up. Either way, your center should have a trend analysis of the standard numbers of days to pay for each major carrier so that you can see potential issues early. Waiting until the end of the month to run an A/R report is not frequent enough – it should be done weekly.

Other patterns that deserve similar analysis: A/R by procedure, A/R by physician, and A/R by location (where applicable). In some circumstances, you might even look at A/R by day of week (date of service). Changes in trends are the tipoff that a problem may exist at your surgeon's office, your front desk, or with the payer.

Once you've documented your baseline performance, improvement efforts should result in measurable improvements. Just as important: the improvements can be translated to dollars in order to make them more real to your investors and board members. For example, a one month delay on a $3,000 payment costs the center at least $30 in carrying/opportunity costs plus extra labor costs. As you deploy improvement initiatives, use a control group to measure the initiative against your previous process.

You may also want to compare your performance to industry benchmarks. Keep in mind that benchmarks always come with some caveats. For example, MGMA publishes ASC industry averages for days in A/R and many other metrics. The good news is that you can measure yourself against other centers in your region of the county, your volume of cases, or your specialties (with some limitations). The bad news is the averages only go so far and deviations around the averages can

be very large. For example, a center that is primarily cash (e.g. plastic surgery) will have very low "Days in A/R" and distort the average versus a center primarily reimbursed through insurance.

2. REDUCE DENIALS.

Many centers appoint senior staff members to deal with denials to make sure they are resolved quickly. However, the same centers don't always have metrics in place for denial rates, or an understanding of what causes these denials. Appointing senior staff members to handle denials is not the best use of time if they are merely correcting a denial and re-submitting the claim for payment.

Tracking and analyzing denials, using an approach similar to what has been discussed above is essential. Start with six to 12 months of denial history and causes (from transaction codes or similar data). This data will inevitably show a "90/10" or "80/20" pattern, with a small number of causes resulting in most of the denials. And, many of these common causes are, in fact, preventable.

In a recent analysis that we conducted "patient not insured" was the most common cause of the denials. In most cases, this was incorrect insurance information, such as transposed digits or an old insurance card. This is a good example of a preventable denial—but not by the billing department. Involving the entire staff in preventing denials through process improvements is key.

3. IMPLEMENT FORMAL PROCESS IMPROVEMENT PLANS.

Your efforts to address the above will identify critical areas of improvement which reach far beyond your billing office. How do we engage everyone and, more importantly, assure that improvement efforts stick? The answer starts by educating everyone at the center about their role in improving financial performance: A/R, denials, cashflow, etc. Explain that each handoff of data or information from one department to another is crucial. A good start is to have each staff member understand how their work affects the entire process. For example, if your front desk staff knows exactly how the insurance information they are collecting is used and how it impacts the entire center, they will be much more likely to buy-in to your improvement suggestions.

The other practical bit of advice: start to eliminate one root cause at a time. This will enable staff members to gain insight to the process, recognize some substantial wins, and see the fruits of their labor.

Here are a few examples that have been successful in various centers:

Awareness, training, involvement. Start with front desk and scheduling staff. However, it is imperative to also include staff in your referring physicians' offices. Educating the physicians themselves can also help. Stress that mistakes happen at the seams, i.e. the handoffs between individuals and organizations.

Formal procedures and job aids. Your schedulers probably know that confirming insurance information is important on every call. It's much better if they have a checklist to highlight all of the information. For instance, the primary insurance number is insufficient if the patient has secondary insurance, or if it is a motor vehicle or workers' compensation case.

When the patient presents, the intake person must confirm each piece of information, including a comparison with the patient's insurance card. They should then ask, "Is this insurance still in effect as of today?" and "Who is your current employer?" If they have recently lost their job, ask to see verification that they have enrolled in COBRA and their coverage has not lapsed. In today's economy, someone may be covered when surgery is scheduled, but not when the date of surgery arrives. Of course, it is even better to verify the patient's eligibility when they are scheduled, when they present, or both times.

Physician documentation. Some cases initially denied for medical necessity eventually get paid when incomplete documentation gets updated, but only after a delay (and extra work) that adds to your days in A/R. Encourage and educate your physicians about the importance of clear documentation.

Center open house. An evening Open House for physicians and their staffs can be a positive environment for communication. Consider having your best-performing referring office explain their procedures, and provide attendees with a best practices handout.

Once you start your action plans, carefully monitor A/R performance. You should see a significant improvement, followed by continuous, incremental improvements. As a bonus, you should also see productivity improvements from reduced billing staff time and lower error rates.