Implants are among the most costly items used in surgery. But it’s not always easy to get reimbursed for them. The full cost of implants may not be covered by the flat-rate payments ambulatory surgery centers (ASCs) receive for many of their services.

To improve the odds of recouping their costs, ASCs need to keep a close eye on their insurance contracts, have well-thought processes to capture implant use consistently, and be sure billing is done correctly.

Here are some expert strategies for improving implant reimbursement.

Know your payer contracts

There is no rule of thumb for how payers reimburse for implants. You need to know each payer’s contract and its terms for implant payment, notes Dawn Gray, CPC, CCP, business office manager and managed care specialist for Surgery Center Billing (www.ascbilling.com), an ASC billing firm in Fort Myers, Fla. That can be a big job because some ASCs contract with dozens of payers.

Some insurers pay for implants based on a percentage of billed charges. Others pay the invoice amount. (“Be sure to include shipping and handling in your charge,” Gray advises.) Still others pay for implant charges over a certain dollar amount.

“On the West Coast, some payers are trying to get away from paying additional amounts for implants and supplies. They say their grouper rates are sufficient to cover that,” notes Shannon Smith, CPA, of The Rush Group (www.therush-group.com), San Francisco, who consults on financial and managed care issues. These payers figure that on average, an ASC’s reimbursement for the group will balance out—the ASC may lose on some procedures but make up for the loss with others in which implants are not used.

“If there is one trend I see, it is that third-party payers are limiting reimbursement to the cost of the implant and implementing caps,” Smith says. One of the nation’s largest insurers has limited implant reimbursement to $850.

If your ASC has many contracts, focus on your big payers first, she suggests. “You’ll find 20% of your payers probably drive 80% of your business. Go for the biggest bang for your buck—make sure you absolutely have your processes down for your major payers.”

She recommends creating a matrix for the billing staff that lists the major payers with each of their terms for implant payment. Then work with them to see if they will standardize their implant billing methods. That makes the billing process more routine and improves the accuracy of claims.

Know Medicare’s rules

Medicare has a limited list of approved implant HCPCS codes that it will consider for reimbursement, Gray notes. In most cases, Medicare will reimburse only when these HCPCS implant/supply codes are billed with the appropriate CPT-4 procedure codes. The guidelines for billing for these HCPCS codes seem to vary by state.

Smith says implants are often billed using revenue codes rather than HCPCS. Some payers specify revenue codes 274, 275, and 278. “I would advise confirming billing practices with each payer,” she says.

Ask for carve-outs for implants

“When negotiating a new contract, ask for a carve-out for implants up front,” says Gray. “If you don’t ask for it, you probably won’t get it.”

It is much easier to request carve-outs when the contract being is negotiated than
to try to amend the contract later. To prepare for negotiations, know the specialties your ASC performs and the implants you normally use.

“You never know when a provider will want to schedule a case that will require an implant that is above the normal cost of performing the procedure. That person will be much happier if you can accommodate it,” she says.

Key information to know from payers is what is classified as an implant and how the payer is set up to pay such claims. “Have it all documented in your contracts so there is no misunderstanding,” says Johnna Nichols, CMM, business office manager/privacy officer for the Harmony Surgical Center LLC, Fort Collins, Colo.

Find out who the payer’s contact person is, such as the provider relations representative, so you contact them if necessary.

Harmony has audit trails, especially for high-dollar implants such as spinal cord stimulators. The original invoice goes to the certified coder, a copy is mailed with the claim to the carrier, and a copy is given to the insurance coordinator for follow up. The accounts receivable coordinator has copies of all contract information to use in reviewing payments received. The senior accountant reviews high-dollar invoices to make sure the facility is at least paid for its costs. Any discrepancies are given to Nichols to review and to discuss with the staff and the insurance company if necessary.

If you were not able to negotiate a carve-out at the beginning of the contract, try to do it when renegotiating for renewal.

**Carve-out language**

Make sure the carve-out language specifies:

- How an implant is defined.
- What code the payer requires if there is not an assigned HCPCS code for the implant:
  - 99070: Supplies and materials over and above those usually used. (This code is not necessarily for physician billing only; it can be used by the facility if required by the payer.)
  - L8699: Implant, not otherwise specified.
- What revenue code the payer wants used on the UB-92 forms.
- Whether the payer requires an invoice to be submitted with each implant billed or whether the ASC should just keep the invoice in the patient’s file.

Smith recommends whenever possible negotiating terms that don’t require submitting invoices. “Put the onus on the payers so they have to come in and audit the medical record to make sure the implant used is documented,” she says.

Waiting for an invoice can hold up the billing process.

“A best billing practice is to submit bills to payers within 48 hours of the procedure,” Smith says. But invoices are not always submitted that quickly. As an alternative, a payer will sometimes accept an invoice that is not specific to the implant used. For example, if an ASC uses a lot of knee allografts, the payer may accept a copy of a similar invoice.

**New technology**

A difficult area is negotiating carve-outs for new technology the ASC plans to use but isn’t using yet. Smith encountered this situation when working on a contract for a group of pain specialists who want to begin using implantable pain pumps, which cost about $18,000 each. Before approving a carve-out, the payer wanted invoices for devices that had actually been used.

“The payer wants to see that you actually are purchasing the supplies you are trying to negotiate a payment for,” she says. “That makes it hard if you are trying to develop a practice for a center and want to make sure you actually can be paid for these costly devices.”

The reason payers insist on invoices is to avoid fraud and abuse, Smith explains. In some cases, billing for pain pumps has been abused. One provider billed for $18,000 pain pumps when actually using $200 external pain pumps.

**What if payers won’t negotiate carve-outs?**

Some payers resist carve-outs for administrative reasons. They say carve-outs
hold up the claims process because they require more handling.

“We are finding more payers adopting this policy,” Gray comments.

In this situation, it may be possible to negotiate a higher payment rate (grouper rate) for procedures using implants.

To do this, you need excellent records of your implant usage. You will need to determine which cases you perform that require implants, which implants are most commonly used for those procedures, and what they cost. You then need to determine under which grouper rate the payer would reimburse for these procedures.

“You should then go to the plan with this information and negotiate a higher reimbursement for these groupers,” she says.

“The downside is that you probably will not get the payer to increase reimbursement for the group enough to cover all of your implant costs. But the loss may be recaptured from procedures in that group that do not require use of implants.”

Gray notes that some payers will develop additional payment groups to move these procedures into to assist ASCs in capturing reimbursement for supplies and implants.

**Have a good system for documenting implant use**

A good system begins with documentation by the nursing staff and includes tracking of invoices and reimbursement.

Coach the nursing staff to be diligent and consistent in documenting supplies and implants used, Smith advises. That includes monitoring implants vendors may bring in the day of the case. Also make sure accurate invoices are on file for each implant used.

In addition, Gray recommends creating a method for tracking reimbursement such as a spreadsheet. “By doing this, you can determine which payers are reimbursing you adequately and which payers you need to negotiate a higher payment with.”

The tracking form should include:
- name of the implant used
- manufacturer
- cost of the implant
- billed charge
- reimbursement
- physician or specialty using the implant
- payer.

Smith encourages facilities that have an information system to use the system to track implants rather than creating a separate process.

“Automate processes whenever possible,” she advises. “Too many ASC managers don’t utilize their information systems to the fullest capacity. That’s unfortunate because the work-arounds they develop typically are more time consuming and costly than learning to use their existing systems for this purpose.”

**Implant cost management**

Physician profiling is a strategy some ASCs are using to manage costs of implants.

One of Smith’s clients compared preference cards for its high-volume procedures.

“They lined them up side by side, minus the physicians’ names and showed them the range in supplies used and the costs. Then they asked them, ‘Can we refine and standardize the supplies being used?’” she says. This strategy is even more effective if the ASC has access to outcomes information for the procedures being performed.

Realistically, implant reimbursement overall is unlikely to increase dramatically because insurers are trying to create incentives for providers to control costs, Smith comments.

The purpose of flat-rate reimbursement is to encourage ASCs and surgeons to choose treatments that stay within the payment limits.

“We are not going to see huge increases in reimbursement,” she says. “ASCs need
to apply basic business principles and be cost conscious.”

Though ASCs may not be able to expect much more in the way of payment, they can take steps to improve their implant payments by making sure the nursing staff is educated about implant documentation and has good documentation tools as well as by making sure the facility has good tracking and billing systems in place.

“The only way a center is going to stay profitable is by managing its costs and developing effective processes,” Smith says.

The Rush Group provides discounts for on-line learning to members of the American Association for Ambulatory Surgery Centers (AAASC).

Tips for successful implant billing

• Negotiate contracts that clearly spell out the terms and process for implant reimbursement.
• Keep all invoices on file.
• Track implant reimbursement and compare to costs.
• Make sure implants used for Medicare patients are on Medicare’s approved list and will be covered for the procedure being performed.
• Include implants in the process for verification of insurance benefits and preauthorization.