Ambulatory surgery centers (ASC) are generally set up to serve the needs of their patient communities while maximizing revenue for their physician, investor, or hospital owners. Take away those incentives, and it is reasonable for an ASC manager to ask, “What are we doing here?”

Yet with falling reimbursement rates and uncertainty over the impact of insurance reform, it is necessary to take that view on a regular basis and adjust operations to reflect an ever-changing reality.

Industry experts tend to agree that in the near future, the most vulnerable specialties will be gastroenterology, ophthalmology and pain management, based on continuing declines in Medicare reimbursement rates. Orthopedics will benefit from moderate increases and the growing willingness of the Centers for Medicare and Medicaid Services (CMS) to consider the cost of implants in awarding payments.

They also agree that a change in payment rates alone will not cause ASCs to suddenly shift to other specialties; there are too many other factors in such choices, from the specialties of the surgeons to a center’s location.

Meanwhile, some centers have cut back on staffing or put expansion plans on hold as a recessionary economy has reduced demand for elective procedures and made credit scarce (OR Manager, November 2009).

Pay attention to the numbers
Still, there is no need to feel discouraged. ASC managers can head to their business offices and find areas where they can influence both reimbursement and effectiveness. Caryl Serbin, RN, BSN, LHRM, is president of Serbin Surgery Center Billing in Fort Myers, Florida. In an article titled “ASC Reimbursement: How It’s Changing,” posted on www.surgistategies.com, Serbin describes ways in which ASCs can control, or at least manage, factors affecting reimbursement.

She notes that ASCs control their own revenue in more ways than may be apparent at first. For example, every ASC sets its own fee schedule. “If structured correctly,” Serbin says, “this is a benchmark on which ASCs can measure the appropriateness of their managed care contracts, predict their contractual adjustments, and forecast their profit margins.”

Negotiate hard
While patients may have little leverage over fees, insurance companies are another matter.

Specifically, Serbin says, ASCs need to negotiate hard with health maintenance organizations and insurance companies. They should determine what payment levels they need to make a profit and understand how the insurer sets its rate structure. A good bargaining chip for an ASC, she notes,
is any health services it provides that are not available elsewhere in the area. The insurer will need to consider providing these services to its customers, either in or out of network. Reimbursement levels will of course be higher if the ASC is deemed “in network,” but Serbin says insurers are doing their best to restrict payments with stricter rules and the lowest possible rates.

“Be prepared to walk away from a contract if you cannot agree on terms,” she advises, but be sure to “balance the pros and cons” of that decision.

**Check up on coding, billing**

Regardless of who the final payer will be, the patient, insurer, or government, the ASC’s business manager has an important weapon in the effort to maximize revenue: the accounts receivable department.

“The coders, billers, payment posters, and collectors in your office are the ones who can make the difference between just getting by and financial success,” she says. While many ASCs elect to outsource accounts receivable to a billing specialist, those who hire their own staff should seek highly qualified people and pay them well.

**Strive for ‘clean claims’**

When it comes to CMS requirements for reimbursement, Serbin says, ASCs may not have much choice of payment rates, but they can improve chances of prompt payment by submitting “clean claims” that are properly coded. The same is true for workers’ compensation claims subject to state regulations. Electronic submission requirements and the growing use of electronic payments are likely to improve cash flow as well.

The Ambulatory Surgical Center at Stevens Point (Wisconsin) became a client of Serbin’s in early 2008 after noticing volume and revenue were declining, and an audit showed inefficiencies in billing and collections.

Administrator Becky Ziegler-Otis recently addressed a webinar, “Meeting Today’s Reimbursement Challenges: A Case Study for Success,” sponsored by Becker’s ASC Review.

She recalls that the ASC’s 2 ORs were seeing only 100 cases per month, yet with multiple specialties, they presented coders with a multitude of rules. The coders were on loan from a nearby clinic, and the billing software was designed for physician practices rather than ASCs. There was no upfront payment policy, and there was insufficient staff to follow up on unpaid bills and insurance claims.

“Our revenue stream was reduced to a trickle,” Ziegler-Otis says.

The board decided to outsource billing and coding as an alternative to hiring more people. In addition, the center purchased ASC billing software, revised the fee schedule, obtained copies of insurance contracts, hired a verifier to review them, and began collecting co-pays prior to treatment.

One year after the changes were in place, Stevens Point’s average monthly collections had risen to $250,000 from $160,000, and average days in accounts receivable had decreased 25% to 44 from 79. Average monthly gross charges rose to $584,055 from $333,860, a 65% increase.

“We’re now increasing our caseload and adding new physicians,” Ziegler-Otis says.

**Stay ahead of changes**

Another way ASCs can improve their prospects for getting paid consistently is to prepare for upcoming changes.
According to Armand Paladino, an ASC specialist with the health care alliance VHA, Inc, Irving, Texas, 2 upcoming Medicare policy changes that will affect ASCs are:

- a plan in the new health care reform law to extend pay-for-performance rules (also called “value-based purchasing”) to ASCs
- CMS plans to begin auditing Medicare providers for improper billing.

Value-based purchasing ties part of Medicare reimbursement to performance on quality measures.

The audits could come under the government’s program for recovery audit contractors (RACs), which audits Medicare providers for improper payments. Though the program so far has mostly affected hospitals, it’s possible ASCs could be affected.

To prepare, Paladino advises ASCs to begin now to conduct internal audits, “before the government comes in.”

Another way ASCs can try to stay ahead of change is to monitor the trajectory of health care reform.

Paladino and others say there is no way to know how a huge increase in the insured population, or any of the other features of health care reform, would change the number, regulatory status, or popularity of surgery centers. The major expansion in coverage won’t come until 2014.

“There’s been a lot of speculation and a lot of concern,” he notes.

Cherry picking: wise or no?

Medicare reimbursement rates will continue to go down and will go down most rapidly for procedures that are not considered as complex as others, according to Gunter Wessels, PhD, a partner in the consulting firm Total Innovation Group, Tampa, Florida.

“Specialties like ophthalmology and GI are most negatively affected,” Wessels says. “However, from our viewpoint, it is unlikely that a bunch more ASCs will sprout up to try and cherry-pick reimbursement.”

What is happening, he says, is that more hospitals are acquiring ASCs to increase their overall procedure volume and to provide greater access to physicians. ASCs that remain independent should be aware that courting patient volume, as an industry, could backfire. “Patient demand is actually correlated with reimbursement cuts,” Wessels explains. “GI and ophthalmology procedures have high utilization, and this is where cuts can have the most effect for CMS.” He notes the “decimated” payments for diagnostic imaging following overutilization of nonhospital radiology centers.

For some procedures, the highest reimbursement rate does not translate to the highest profit: Wessels cites orthopedics, a specialty that commands generous payments but also carries a higher risk and requires more OR time.

Dermatology and plastic surgery are also what Wessels terms “high-value” specialties, though not from the Medicare perspective.

Seizing the moment

Sometimes ASCs are able to seize the moment when a particular specialty becomes both popular and profitable.

Eastside Surgery Center, Columbus, Ohio, offers 7 specialties including urology in its 4 ORs and 1 procedure room. Recently, Eastside began recruiting more urologists because that specialty is currently well reimbursed, according to administrator Theresa Palicki, MHA, MBA, CASC.
“In urology, many of the cases are device intensive,” Palicki explains. An example is neurostimulation therapy for bladder incontinence, which involves a battery implant costing $9,000, that is fully reimbursed. The procedure itself is reimbursed at $15,000 to $22,000.

“Our profit is about $5,000 to $6,000 per case, she says.

Eastside also is trying to recruit more cosmetic surgeons. It isn’t that the local population is affluent, Palicki notes, but cosmetic procedures are patient paid. To make patients more willing to travel farther, Eastside markets to the physicians and strives to impress the people they refer.

“Our nurses are over-the-top friendly,” she says, “and our patients feel pampered from the time they walk in to the time they leave.”

Two trends to look for

By their reimbursement policies, government and private insurers have driven procedures of growing complexity out of the hospital and into outpatient settings such as ASCs. That trend will continue, Wessels believes, citing cardiac catheterization as the next candidate. Advancing technology could reduce the risk, making outpatient nonacute treatment more practical.

Taking a procedure from inpatient to outpatient or otherwise reducing the length of stay results in initial rewards in relatively higher reimbursement. Later, the procedure’s growing popularity and efficiency lead payment rates to drop.

But that is not the only influence on payment trends, according to Wessels. He sees health care reform as hinging on a systemwide conversion to pay-for-performance.

“A guiding principle of health care reform is to pay for outcomes,” he says. ASCs may benefit because their OR cost per minute often is half that of a hospital. Beyond cost, they will be evaluated on quality measures.

Shifting toward outcomes

Be ready for the day when the payment system shifts toward outcomes, Wessels advises: “The best course of action is to deliver quality care. We want people to be fixed as quickly as possible. Quality reduces costs for everyone.”

Regardless of the uncertainty of the moment, ASCs are well positioned to lead the movement toward a new focus on quick, effective, economical care. ❖

—Paula DeJohn