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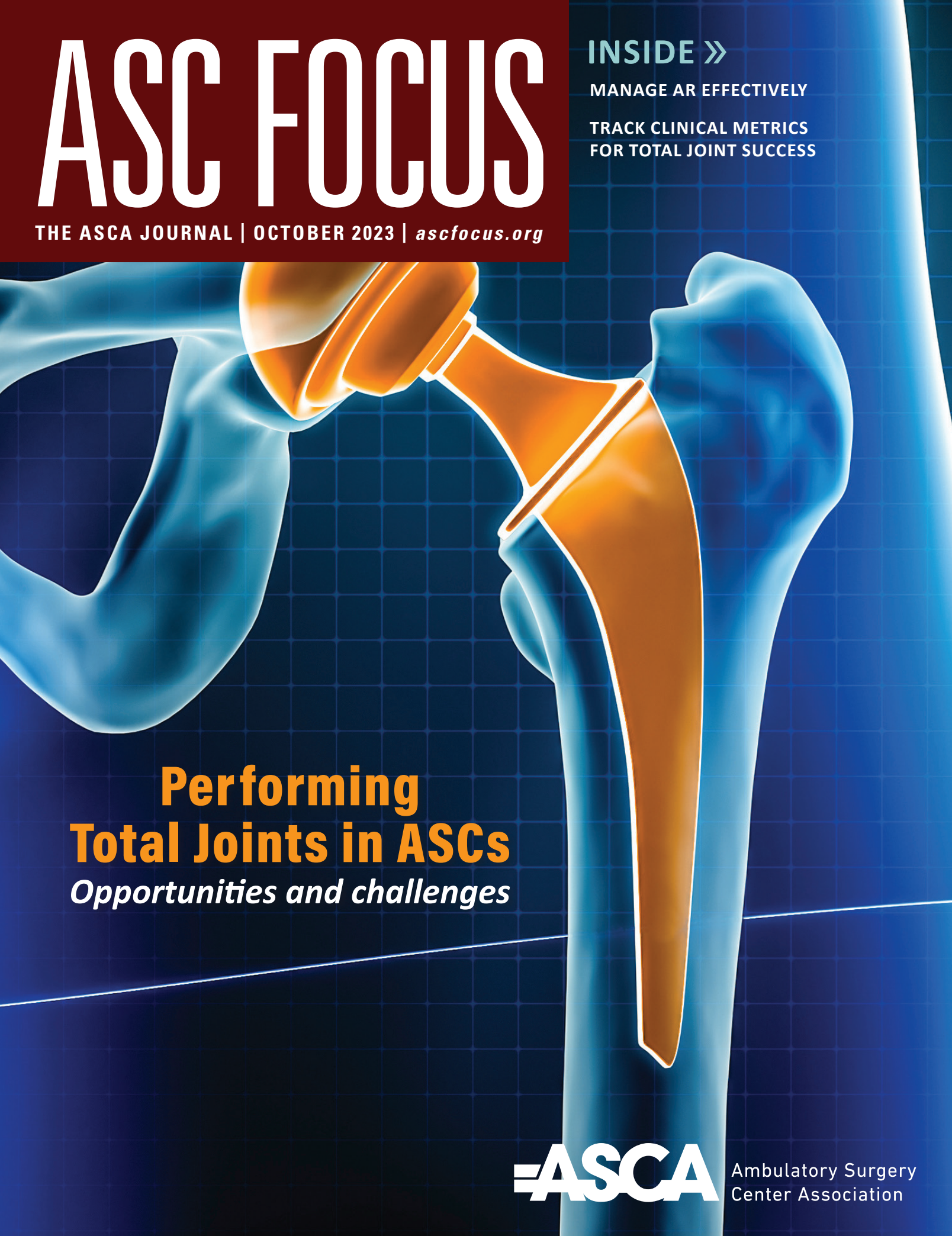


Performing Total Joints in ASCs

Opportunities and challenges

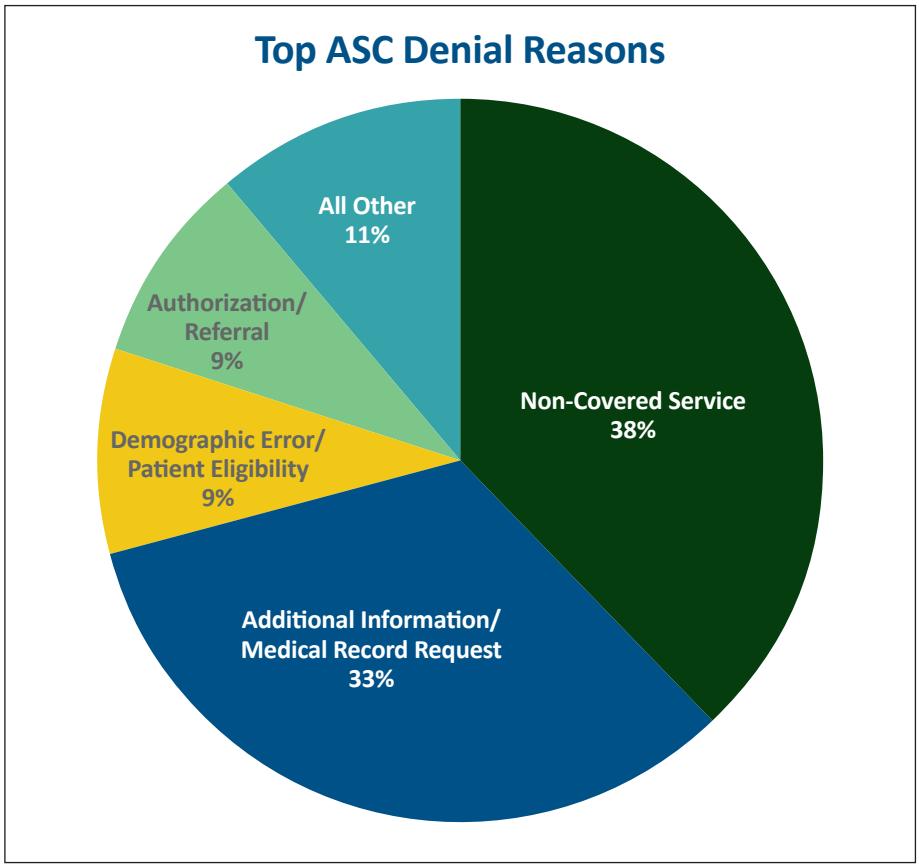
ASCA Ambulatory Surgery Center Association

Exploring Denial Reasons

A revenue cycle analysis **BY SCOTT ALLEN**

With a focus on improving surgery centers' revenue cycle management operations and rate of collections, our business intelligence and analysis team recently conducted a study using a subset of data to investigate common denial reasons for ASCs.

For the year-to-date period ending in June 2023, our company sampled clearinghouse data from ASCs nationwide to identify trends and patterns associated with claim denials. The results of our analysis provide insights into the top reasons for denials and ways to address them effectively.



SOURCE: NIMBLE

1 Non-Covered Service

In the study, the most common reason for claim denials was the patient not being covered. This issue accounted for 38 percent of all denials.

Denial reasons for non-covered service include charges not covered by a patient's plan, cost exceeding the maximum for the period and patient or procedure not being covered at place of service.

ASCs can expect to experience this denial challenge when patients do not have active insurance coverage, when their insurance policy does not include the specific services or procedures requested, or when the facility is out of network.

Consider these preventive measures for non-covered service.

Verify Insurance Coverage

Establish a robust process for verifying patients' insurance coverage prior to scheduling appointments or performing procedures. By doing so, you will avoid any unpleasant surprises during the claim submission process.

Most importantly, do not assume coverage. For example, if you are in-network for Blue Cross Blue Shield (BCBS), but a patient has a narrow network under BCBS, your ASC might be out of network for that patient or service. Unfortunately, even if your staff is well-versed in your facility's payer contract terms, BCBS insurance cards will look identical. You will not be able to tell by looking at an insurance card if a BCBS patient is in-network or part of a narrow network. Therefore, when verifying insurance, do not assume the patient's contract terms. Make sure the patient's benefits extend to your facility, your physicians and to the actual procedure.

Clearly Communicate with Patients

Prior to any procedure, communicate effectively with your patients about their insurance coverage. Ensuring patients understand what services are covered under their plan, plus any potential out-of-pocket expenses, can help avoid misunderstandings and claim denials.

After your staff verifies insurance, confirms the patient's benefits with the payer and addresses any prior authorizations, they can then provide accurate patient estimates and answer any payment questions the patient might have.

This process ensures the patient is covered and is fully aware of any financial obligations. You can then review when the patient should expect to receive a bill for services, plus payment options.

When a patient arrives for a subsequent appointment, ask if any information has changed, such as primary insurance provider, to ensure greater accuracy for each claim.

2 Additional Information/ Medical Record Request

The second most common denial reason, accounting for 33 percent of all denials, was additional information or medical record request. The primary reason for this denial is "attachment required" or "supporting documentation requested."

Our team has observed that these denials are regularly associated with prepayment audits—otherwise known as high dollar audits—in the ASC industry, which is why this denial has proven to impact ASC revenue the most. To start the prepayment claim audit process, the payer will request additional information, which can include medical records, but the payer does not necessarily provide significant direction as to what documentation they are looking for or why.

Typically, the only way to receive clarification from payers on the documentation request is to call and speak to a representative. After speaking with payer representatives, we have found these requests can be for many reasons, including to prove medical necessity; however, we are seeing this trend increase among commercial payers nationwide. In fact, the more costly a claim, the greater likelihood an ASC has of receiving this type of claim denial.

Researchers are actively evaluating the average monetary threshold for prepayment audits and the types of procedures that are most likely to be impacted per payer. Once we know which payers are most likely to flag procedures over a certain dollar amount, we can be more prepared for the denial and proactively offer what is needed. We also are analyzing any patterns regarding the "additional documentation" payers are requesting so we can prepare that material ahead of time and react quickly.

We recommend the following preventive measures for additional information/medical record request.

Complete and Accurate Documentation

Prioritize thorough and accurate documentation of all procedures and services provided. If you notice that you are receiving prepayment audits from a particular payer more frequently or on certain high dollar claims, preparation is key. Having comprehensive medical records readily available to submit with the claim can reduce the likelihood of denial due to missing data. While you cannot predict which claims will be audited, you can organize patient information ahead of time and prepare your team to send any additional information requested as soon as possible to expedite the remittal process.

Since procedures with implants tend to be high-dollar claims, ASCs are experiencing claim denials with "attachment required" or "supporting documentation" during the implant reimbursement process. Implant reimbursement can be a significantly detailed and manual process. For instance, payers often require circling the implant amount in red pen on the invoice and faxing or mailing documentation.

To get implant claim submissions right the first time, know the specific contract terms by payer and follow up frequently to make sure the claim is being received and processed.

Efficient Record Retrieval System

Implementing an efficient record retrieval system can significantly expedite the process of accessing medical records. This can be achieved through chart management software, electronic health record (EHR) systems or secure data-sharing partnerships with other healthcare providers.

Since EHR systems can be cost-prohibitive for many ASCs, many facilities choose chart management software to electronically store and

retrieve information. It also is a time-saver during claim preparation and prepayment audits.

3 Demographic Error/ Patient Eligibility

Coming in at 9 percent of the sample size, demographic errors and patient eligibility are the next most common reasons for denials, including incorrect payer, coverage terminated, billed prior to coverage, patient not identified, and coordination of benefits (COB) update required. These errors often result from mistakes made during the data entry process or misunderstandings about the patient's insurance eligibility.

We find most of these errors originate from manual data entry or existing patient information being inaccurate. For example, a patient's date of birth or secondary insurance being used instead of primary are among some of the most common discrepancies. Prior authorization also factors into patient eligibility and is another common reason for front-end related claim denials.

Consider these preventive measures.

Automate Front-End Processes

While ASCs should invest in regular training and education for their administrative staff on data entry, insurance verification and prior authorization requests, there is still room for human error if your staff is manually entering this information. Storing copies of all files—insurance card, drivers license, etc.—in an efficient EHR or chart management database will help validate all data entry. Automated processes can easily help your staff notice and edit inaccuracies.

Real-Time Eligibility Verification

Using real-time eligibility verification tools can help ASCs confirm a patient's insurance coverage and eligibility status before providing services. This approach minimizes the risk of treating patients who might not be eligible for reimbursement.

Prior Authorizations

Prior authorizations also factor into patient eligibility. While this process is one of the most time-consuming tasks for ASC staff, all aspects of the procedure should be authorized ahead of time to avoid this denial. Authorization denials by themselves are nearly as common as demographic error/patient eligibility denials for the following reasons: authorization being absent, authorization exceeded, different service authorized and referral absent.

Final Thoughts on ASC Claim Data

Our analysis of ASC claim data represents a snapshot of common denial reasons faced by ASCs nationwide. Surgery centers that understand the primary causes of claim denials and implement proactive measures can significantly enhance their revenue cycle management and operational efficiency.

Adopting these strategies will help your ASC streamline its claim submission process, prevent the most common denial reasons and improve your financial stability. «

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