



CASE STUDY

IMPROVED REVENUES, LOWER A/R DAYS

Surgical Facility Background

Surgery Center is a two OR freestanding multi-specialty center who shares a medical office building with the physician owners' clinic. The center had been open 18 months and is Medicare certified. The ASC was being self-managed by the governing body. The ASC's president is a non-physician owner who is also the clinic president. They are solely owned by physician and non-physician partners. Most physician partners have offices located in the medical office building on the same site. The ASC is doing approximately 100 cases a month. The specialties served are approximately 50% orthopedics, 25% ophthalmology, 13% pain management, and 6% each of urology and podiatry.

What They Did

The center was experiencing administrative and business office issues and retained Source Medical Revenue Cycle Solutions (RCS) to determine if the center meets billing compliance guidelines and to evaluate business office efficiencies and make recommendations specifically regarding the billing process.

How They Did It

A full financial and business office evaluation was performed by RCS to assess the revenue cycle and determine if there were billing compliance issues. The initial findings were determined from results of the on-site evaluation. The improvements are results obtained after 12 months of reimbursement management by RCS. At the time of the evaluation, the center was facing numerous challenges. Each problem was addressed separately with recommendations for correction. The following is a list of the key observations affecting revenue.

Billing is not up to date

Billing was being done by clinic staff. These personnel were unfamiliar with ASC billing and were overburdened with the amount of claims being generated in addition to clinic billing. Claims were not being submitted in a timely manner, and over four weeks' revenue was unbilled.

Coding was not in compliance

Coding was being outsourced to a coding company; however, findings revealed inaccurate coding with over- and undercharging of several claims. RCS recommended a coding audit be performed by a certified coder and all inaccurate claims be rebilled to carriers with explanation and refund where necessary.



No claim follow-up

There was no specific collector for the ASC claims and no follow-up was being done following submission of claims. RCS recommended an audit to determine what claims are within timely filing limits, what refunds are due to payers and/or patients and move forward immediately with resubmitting claims that have not been paid.

Fee schedule

Fee schedule was not based on cost or Medicare fees, and there was no symmetry in charges for like cases. There were fees that were lower than what payers allowed as well as some that seemed high with no logic applied determining the fee.

RCS recommended a complete review of the fee schedule and provided the center with a copy of Medicare allowances and showed them how to do a mark-up based on these fees and provided information about case costing.

Scheduler has insufficient insurance information

Scheduler was not using a list of Medicare ASC-allowed procedures when scheduling and did not have insurance information on center's contracts.

RCS recommended scheduler have a copy of the newest Medicare ASC approved procedure list to avoid scheduling non-ASC-approved procedures. Scheduler should also be provided with a managed care matrix to determine if the center accepts certain payers. If changes to ASC software, insurance contracts, and allowable fees can be loaded and available to scheduler.

Observation: Patient is unaware of financial responsibility prior to day of surgery

Patients were not notified in advance about deductibles and copays; therefore, these were not collected in advance.

Medicare requires that patients are apprised of their financial responsibilities prior to the day of surgery and need to acknowledge that they have been informed with a written signature. RCS recommends that all patients be called at least three days in advance and advised of how much their insurance will pay and how much will be due by the patient and are asked to bring that copay and/or deductible amount with them on day of surgery.

Following the Evaluation

The governing body decided to accept the recommendations and make the necessary changes including outsourcing their coding and billing to RCS. Their new administrator was extremely helpful in making the transition to a well-run, compliant, and profitable surgery center.

Results – One Year Later

With the help of revenue management by RCS and an enthusiastic and helpful ASC staff, the following changes were accomplished.

Increase in average charge/case – In the year after RCS took over revenue cycle management, the average charge per case went from \$4,285.96 to \$5,603.14. This is a 31% increase in average gross revenue per case (see Figure 1).

Figure 1.

	Case Volume	Gross Revenue	Per Case	Net Revenue	Per Case
Before working with SourceMedical RCS	1,009	\$ 4,324,536	\$ 4,286	\$ 2,616,174	\$ 2,593
After working with SourceMedical RCS	1,097	\$ 6,146,643	\$ 5,603	\$ 3,229,839	\$ 2,944
Source Medical			\$ 1,317		\$ 351
RCS Impact			31%		14%
			<i>Improvement</i>		<i>Improvement</i>

Increase in average net revenue/case – During this same time period, the average revenue per case increased from \$2,592.84 to \$2,944.25. These figures indicate a 14% increase in average net revenue per case (see Figure 1).

Decrease in Days in Accounts Receivable – Days in A/R at the time of evaluation were approximately 97. After one year of revenue management, the A/R days are 41.

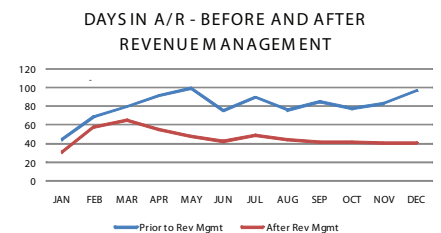
Elimination of billing backlog – RCS audited all previous billing for coding and billing errors. Where there were overpayments, refunds were issued through the ASC along with submission of a corrected claim. Where there were underpayments, claims were resubmitted. If timely filing was an issue, RCS filed an appeal to try and collect the claim due to new center problems. Some were successful, others were not. All claims were followed up on by collectors and resubmitted when the payer did not have a record of receipt. The accounts receivable was brought up to date with payments, refunds, and approved write-offs. Going forward, all claims were submitted and followed on a timely basis.

Compliance in billing – RCS’s certified coders and experienced billing staff reviewed all questionable claims and payments and made the necessary corrections and notified payers and patients.

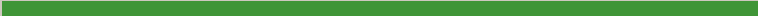
To learn more about how Source Medical Revenue Cycle Solutions can improve your financial performance and eliminate administrative concerns and risks, please contact us via email at revenuecycle.solutions@sourceed.net, or call 866-889-7722.



Figure 2.



The charts on this page reflect the improvements made in the center’s results after the decision was made to partner with SourceMedical revenue cycle Solutions to provide Revenue Cycle management to the center.



About SourceMedical

SourceMedical is the premier provider of outpatient information solutions and revenue cycle management services for ambulatory surgery centers, speciality hospitals, and rehabilitation clinics nationwide. With a 30-year track record and more than 5,000 satisfied customer, SourceMedical is the trusted source for unique, end-to-end systems improve operational efficiency and cash flow while enabling healthcare facilities to deliver a higher quality of patient care.

