# Navigating the Maze of ASC Claim Denials:

Proven Strategies for a Seamless Process

As ambulatory surgical centers (ASCs) experience a surge in case volume due to a growing recognition of the efficiency, cost-effectiveness, and patient convenience they offer, the potential for revenue growth is matched by the heightened risk of billing and coding errors, making the fight against denials more daunting than ever.
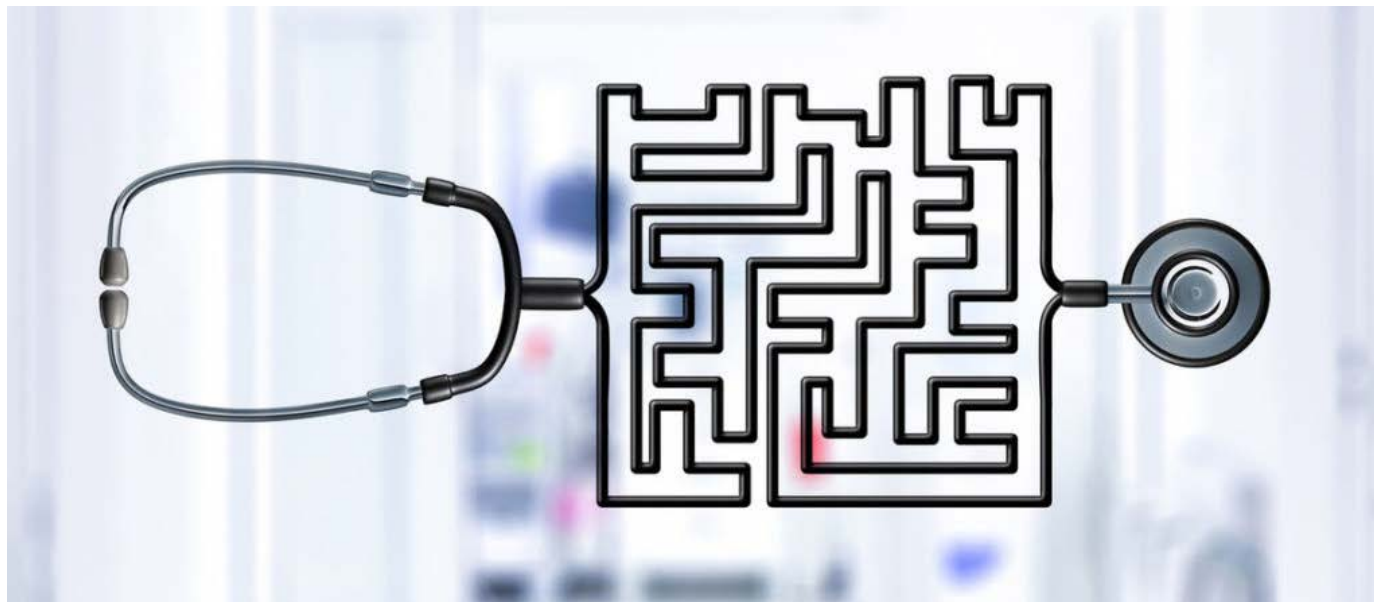
The intricacies of surgical billing, compounded by the complexities of navigating payor contracts and guidelines, underscore the pressing need for ASCs to adopt a strategic approach to denial management.

Understanding the Multifaceted Causes of Claim Denials in ASCs

The reasons for claim denials in ASCs are manifold, but they often stem from administrative challenges brought on by complex billing and a constantly changing regulatory environment.

On the coding side of the equation, surgical billing is complex. It encompasses a broad range of services and supplies, from the use of the surgical establishment itself to the medications administered, the surgical equipment used, and any implants or prosthetics.

Each component requires accurate and specific coding to ensure payors process claims correctly. This complexity opens the door for errors and discrepancies, leading to a higher likelihood of claim denials.

On the regulatory side of the equation, because ASCs perform a wide array of procedures, it's not uncommon that misunderstandings about a patient's benefits or a lack of awareness of the insurer's policy changes end in unintentional billing of non-covered services.

For example, payors may not cover certain cosmetic procedures, experimental treatments, or treatments at a specific location. Many insurance plans also require pre-authorization or specific procedures and services to ensure they are medically necessary before they occur. Failing to obtain this preauthorization can lead to claim denials because the insurer deems the procedure unauthorized.

Payors may also deny claims due to missing or insufficient information about the patient or the services provided. These discrepancies can include incomplete patient demographics, inaccurate insurance policy numbers, missing referrals or physician orders, or inadequate documentation of the procedure performed.

Even simple errors, such as typographical mistakes in a patient's name or date of birth, can lead to claim rejections. Pertaining to services, "insufficient documentation" may refer to not providing enough detail about the procedure to justify the medical necessity.

To address the multifaceted reasons for claim denials, comprehensive denial management strategies encompassing thorough training, meticulous documentation, and leveraging advanced technologies are often necessary.

Traditional, manual processes, although somewhat effective, are inherently time-consuming and prone to human error, making them increasingly impractical in ASCs, given the increase in administrative burdens. The necessity for precise coding, accurate patient and service information, and adherence to complex payor guidelines calls for solutions that can streamline these processes, reduce errors, and enhance efficiency.

In this context, artificial intelligence (AI)-powered automated technology is a formidable tool. AI can significantly transform the denial management process by automating the identification and correction of coding errors, verifying insurance eligibility in real-time, and ensuring compliance with payor-specific billing rules.

These technologies can analyze vast amounts of data to identify patterns and commonalities in denied claims, enabling ASCs to address issues that may lead to denials proactively. Furthermore, AI can assist in the preauthorization process by automatically submitting requests and tracking their status, reducing the likelihood of denials due to lack of preauthorization.

Adopting AI and automation in denial management also facilitates a shift toward predictive analytics, enabling ASCs to anticipate and mitigate potential denial reasons before claims are submitted. These technologies can predict which claims will likely be denied and why by analyzing historical data and current trends, allowing for preemptive correction and submission optimization.

The Critical Role of Communication in Preventing ASC Claim Denials

In addition to adopting technologies, clear and effective communication between ASCs, payors, and patients is essential for navigating the intricacies of surgical billing, ensuring the accuracy of claims, and ultimately reducing the likelihood of denials.

For ASCs, this means establishing open lines of communication with insurance payors to verify coverage, understand billing requirements, and clarify any ambiguities regarding pre-authorization procedures. Similarly, transparent communication with patients about their coverage, expected out-of-pocket costs, and the necessity for certain procedures helps set realistic expectations and minimize billing surprises.

Leveraging modern communication tools, such as robust patient portals, can significantly enhance the effectiveness of interactions with patients as they offer a direct channel for ensuring correct demographic and insurance information, obtaining required documentation, and informing patients of billing processes.

On the payor front, ASCs must continuously update their understanding of payor contracts, coverage criteria, and policy changes. This requires regular communication with payors and a strategic approach to contract negotiation and management.

By actively engaging with payors to clarify and negotiate terms, ASCs can better align their billing practices with payor expectations, reducing the risk of denials due to policy misinterpretations or outdated information.

Strategic and Effective Contract Management

Effective payor contract management forms the backbone of financial stability for ASCs and plays a pivotal role in underpay-

ments and denial avoidance.

Access to robust data is crucial for negotiating favorable terms with payors. This data must provide evidence to support claims for higher reimbursement rates or more advantageous terms. Understanding the competitive landscape is also essential, as it offers insight into market rates and helps ASCs position their negotiations effectively.

Once a contract is in place, the focus shifts to ensuring compliance with its terms—a significant aspect of denial management and an overall healthy revenue cycle. ASCs should undergo a meticulous review process and regularly audit payments and reimbursements against the agreed terms. Such vigilance helps identify discrepancies early and allows for timely resolutions.

Contract management systems can significantly aid in this process, automating many aspects of compliance monitoring and freeing up valuable administrative resources. These systems can track payment timelines, flag underpayments, and even predict potential issues before they arise.

Ongoing Documentation and Policy Review

Another aspect of mitigating denials is the ongoing review of all policies and documentation.

Because accurate and complete documentation underpins successful claim submissions, ASCs must implement strategies to meticulously record every aspect of patient care, from initial consultation to post-operative follow-up.

Utilizing electronic health record (EHR) systems effectively, adopting standardized documentation templates, and employing real-time documentation practices can minimize gaps in patient records. Additionally, leveraging technology to automate the capture and verification of patient information reduces errors and enhances the accuracy of claims.

Investing in regular staff training is essential for maintaining high documentation standards. Training programs should cover the latest coding standards, payor-specific documentation requirements, and best practices in medical record keeping.

Empowering staff with knowledge and resources to accurately document patient encounters and surgical procedures ensures that claims are substantiated with the necessary medical evidence, reducing the likelihood of denials due to inadequate documentation.

A Holistic Approach to Strengthening ASC Revenue Cycles

As ASCs capitalize on their growing role in healthcare, driven by efficiency, cost-effectiveness, and patient preference, they confront the escalating challenge of claim denials.

Adopting holistic strategies for denial management not only addresses the immediate challenges of claim denials but also enhances the overall health of the revenue cycle.

By prioritizing the practices and technology previously discussed, health leaders can navigate billing and coding complexities, anticipate and mitigate potential issues before they escalate, and thrive in an ever-evolving industry.

Teri Gatchel-Schmidt is the Vice President of Consulting & Business Development at SYNERGEN Health.

Teri Gatchel-Schmidt, MBA, CPC, brings over 28 years of experience in the healthcare industry as a practice administrator, operational leader, and revenue cycle optimization consultant to large health systems and physician organizations. Ms. Schmidt has worked during the past 18 years consulting extensively with healthcare systems to enhance their financial performance in academic and physician ambulatory-based settings.

As Vice President of Consulting, Ms. Schmidt is responsible for helping organizations reach their strategic, operational performance and financial goals through technology-led revenue cycle transformation. Her extensive hands-on knowledge of end-to-end revenue cycle processes gives her the ability to identify workflow redesign and overall performance improvement opportunities with an eye toward financial improvement and increased efficiency.

To learn more, visit www.synergenhealth.com.