



Guide For Third Party Reimbursement Of Facility Fees



*American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
Committee for Insurance and Reimbursement
John Pitman III, M.D. Chair*



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This article contains information about reimbursement matters for ASCs. Any legal information provided in this article is not legal advice. Legal advice must be tailored to the specific circumstances of each reader. In addition, although AAAASF and the author have made every effort to ensure that the information in this article is accurate, the healthcare regulatory landscape changes daily and may vary considerably by jurisdiction. AAAASF and the author strongly recommend that investors in and users of ASCs seek individual legal counsel to review their ownership structure and billing practices for compliance.

Introduction to Insurance Reimbursement for AAAASF Accredited Ambulatory Surgical Centers

The last quarter century has seen a dramatic shift in surgical practice across all specialties. With advances in anesthesia safety, a better understanding of the physiologic response to surgery, the use of prophylactic antibiotics, and less invasive surgical techniques surgeons are now able to safely perform the majority of cases in the outpatient setting. Third party payors and the federal government are keenly aware that outcome studies continually demonstrate that outpatient surgery performed in an accredited ambulatory surgery center (ASC) leads to excellent outcomes at a cost significantly below that of hospital based facilities. In fact it is federal CMS policy to encourage case shifting to ASC care whenever possible primarily because of the lower cost. As an owner or shareholder in an ASC the prudent surgeon can take advantage of this circumstance to provide the best possible surgical experience for the patient and do so in the most efficient and reasonably profitable manner.

AAAASF accredited ASCs have taken many forms. In some cases they can be as simple as a single provider office based surgical suite. In other cases they can as complex as a large multi-specialty, multiple surgeon facility. No matter what form is taken the performance of appropriate cases reimbursed by third party payers will have a significant number of salutatory effects. First and foremost, third party payors are always looking to control costs and are increasingly supportive of shifting care to an ASC. As a general rule, they are very willing to reimburse the ASC facility fees well beyond what they pay for surgeons fees alone. Increasingly surgeons are finding that cases that pay only a surgeon's fee are barely profitable. However, when a facility fee is added these cases can return to significant profitability. In addition the practitioner is now empowered to tightly focus on control of both safety and cost. The use of the AAAASF guidelines enables the surgeon to attain a proactive stance towards safety issues and correct potential problems in a much more timely and direct fashion than the typical hospital committee structure. In addition, prudent ASC management virtually demands careful tracking of costs. Most surgeons have little knowledge of the cost factors in a typical case they perform. By being directly involved in these issues surgeons find that they are able to be very helpful in cost control measures without compromising safety. The surgeon also will typically find much greater convenience and improved time management when utilizing their own ASC. By keeping cases "in house" the ASC will allow the utilization of assistants familiar with the surgeon's needs leading much greater efficiency in case time. Struggles with scheduling and long drives to multiple hospitals as well as emergency cases "bumping" cases on the elective schedule is virtually eliminated. These efficiencies can allow the surgeon to increase his/her caseload without a significant change in work hours.

The use of a AAAASF accredited ASC is also empowering for the practitioner when it comes to negotiating with third party payers as both parties now share a mutual interest in cost control for the patients and the surgeon now has a means of providing lower cost

care for the payer. This allows even the solo practitioner to attract much more favorable third party payer contracts. Instead of having case reimbursement virtually dictated to the practitioner most third party payors are willing to discuss facility reimbursement. Charitable care also can become less financially onerous. Many practitioners and patients find that a single price to cover pre and post-operative care, operating room and anesthesia fees (an arrangement familiar to cosmetic surgeons) can be worked out reasonably and equitably in advance. In point of fact, ASC licensure by some states requires a certain percentage of charitable care to be performed in the facility. However, by providing a lower cost setting, patients lacking adequate coverage can find that their care becomes more affordable. In addition, in the setting of a profitable ASC these cases can become less financially taxing for the operating surgeon.

When taken together the surgeon owner/shareholder of an ASC will find that both gross and net income can rise substantially. This derives from several sources. Income can rise directly from facility fees. More favorable contracts can improve revenues for the surgeon's office overall. Finally, "downstream income" can improve dramatically with the typical improvement in efficiency experienced by surgeons participating in ASC ownership/use. This guide is meant to serve as a very basic introduction to facility fee reimbursement in AAAASF accredited ASCs. The opinions expressed in this guide are not definitive and cannot substitute for sound legal and professional advice (please refer to disclaimer on page 2).

Legal Matters

It cannot be stressed enough that when the provider embarks on the adventure of seeking reimbursement for an ASC there is a virtual minefield of rules and regulations unique to ambulatory surgery. This chapter cannot substitute for sound legal advice but is intended only as a very brief and general guide to some of the governing principles. The ASC owner/operator is strongly urged to seek sound and experienced legal advice *proactively*. It is easy to make very expensive mistakes or place oneself in significant legal and financial jeopardy if these issues are not carefully addressed well in advance of any attempt at collecting facility fees. Attempting to fix damage retroactively can cost enormous amounts of time and money both in potentially lost revenues, legal defense and in possible cessation of ASC operations while these issues are being sorted out. Also it is axiomatic that ignorance of the law is not a valid legal defense. The ASC operator/owner must be aware that a whole host of state and federal laws are always involved and each state is different in how it approaches ASC regulation. Some states require licensure of an ASC and some states require a Certificate of Need (CON). It is foolhardy for the physician owner/operator/shareholder to not get sound legal advice when setting up an ASC for reimbursement and familiarize him/herself with the applicable legal concepts. A multitude of legal concepts apply to ASC reimbursement and operation and include (but are not limited to) contractual law, restraint of trade, conflict of interest, anti-kickback statutes, anti-self referral rules(e.g. Stark), state licensure, CON, reimbursement rules, contract language, dispute mediation, and “governing law” a concept where the state the ASC is operating is not the state which governs contract rules. The legal complexity and corresponding peril rises even higher if an ASC attempts to bill government providers such as Medicare, Medicaid and Tricare. Recent changes in anti-fraud legislations can attach criminal penalties to billing errors for certain government based payers. It is possible that some state rules directly conflict with federal rules, particularly healthcare fraud and abuse laws and regulations such as anti-kickback statutes and self referral laws such as Stark. These rules can be so complex that multiple interpretations of meaning and effect are common and multiple legal opinions are frequent. The ASC owner/operator is warned that these conflicts can preclude a true “safe harbor” from these so called fraud and abuse laws. It is essential that the owner/operators of an ASC understand that AAAASF certification does not in any way change the above requirements and they must be pursued as a matter separate from accreditation. On the other hand the growth in physician owned and operated ASC’s is rapid and substantial so it is apparent that many physicians have been able to negotiate this legal and financial minefield and have found that this form of reimbursement is possible and very rewarding.

As a legal entity the ASC can exist in a number of forms. For example it can simply be part of a physician’s office and simply integrate into the normal daily operation of the physicians practice. Billing and reimbursement would occur within the context of the daily operation of the physician practice. In some states this arrangement is considered “office based surgery” and is a separate entity from a true ASC. This is a frequently employed possible safe harbor against healthcare fraud and abuse laws. In states where

there are CON requirements this form of billing can sometimes bypass those requirements as well. In the setting of an existing CON the practitioner will typically bill on form HCFA 1500 and the third party payer will reimburse at a higher rate that includes facility fees. These arrangements are almost universally contractually based prior to performing the procedures and billing for them. This type of arrangement can also bypass separate liability for the ASC in some cases but obviously this needs to be discussed with the liability carrier and tends to vary significantly from state to state. For these and other reasons some third party payors prefer this type of arrangement. Government providers (e.g. Medicare, Medicaid, Tricare) typically do not provide for this pathway for reimbursement as they cannot negotiate with individual ASC owner/operators. This tends to be more suited to individual practitioners with an AAAASF accredited office based surgical suite.

The second possibility is that the ASC exists as a stand alone legal entity that generates its own revenue, usually under a separate provider number. Once this occurs the owner operator must be aware that the ASC is likely to incur its own liability and is very likely to fall under the same state laws that regulate hospitals and stand alone ASC's. This is also the type of entity that can more typically bill government third party payers. The size/number of providers is not necessarily relevant but the legal basis for existence is. Once a physician has a relationship with such an entity federal healthcare fraud and abuse laws and regulations almost invariably come into play. A separate contract between private payers and the ASC are almost mandatory in this case. These facilities sometimes require state licensure and concomitant state regulation. In states where a CON law exists these entities typically require obtaining such a certificate (which can be a very onerous process). It is imperative that the owner/operator addresses these issues in advance of any consideration of facility reimbursement or perhaps even construction. There have been cases in which third party payers have demanded high six figure refunds when these issues weren't properly addressed in advance. These entities typically bill on form UB92 under a unique provider number.

Medicare publishes a list of services by CPT code reimbursable to ASC's and private payers typically model the codes they will pay for after this list. The list is subject to review semiannually by the Center for Medicare and Medicaid Services (CMS). It is wise for the ASC owner/operator to become intimately familiar with this list prior to commencing facility fee reimbursement procedures. The owner/operator should realize that there are several legal issues associated with this list that most surgeons are unaware of. If a provider performs a non-listed service in an ASC the third party payor may have the legal right to deny payment depending on contract language. In the case where the third party payor is federal (e.g. Medicare) the ASC can run afoul of federal healthcare fraud and abuse laws if it can be shown that the provider intended to perform the procedure free of charge. In addition when surgeons operate in an ASC who are not owner/shareholders Stark rules can apply if there is a perceived financial inducement. So "fee splitting" arrangements in which the ASC splits facility fees with providers are strongly discouraged. The facility director is strongly encouraged to learn about the Health and Human Services (HHS) Office of Inspector General (OIG) safe harbors for ASC reimbursement.

The ASC owner/operator is also cautioned about billing practices that are overly creative and/or aggressive. Since the number of ASC's is relatively small they have a much higher likelihood of closer scrutiny by both private and government third party payors than the typical physician's office. Audits are much more likely to be triggered if billing is perceived as out of the norm. The most common cause for an audit is perceived "unbundling" of services. The physician owner/shareholder is usually familiar with correctly coding procedures but unbundling in an ASC can also involve improperly billing for ancillary services and materials (e.g. splints and medications) that are considered to be included in the basic facility fee and not eligible for additional reimbursement. To make matters worse criminal penalties can be attached under fraud and abuse statutes when government third party payors are involved. This liability can even extend to all partners in an ASC. Fortunately there are new insurance policies on the market that may provide some comfort to owner/operators. It's called "compliance insurance" and it can pay for the cost of defending yourself and even negotiate and pay for settlement with Medicare or Medicaid if you are investigated for billing improprieties.

Another legal problem arises when private carriers are billed out of network or off the ASC list. Insurance companies may have their corporate offices in another state. The ASC may find itself with little legal recourse if the plan refuses to pay even if the procedure was preauthorized. In fact, the plan can require that dispute resolution take place in the home state of the corporate headquarters. Although this doesn't in and of itself present legal problems the provider has much less protection against non-payment than if there is a contractual relationship.

Managing Overhead Expenses

The most common purpose for accepting third party reimbursement in an ASC is to enhance practitioner profitability. The most essential ingredient in a financially successful ASC is precise information on profit and loss. Since most third party payers reimburse the ASC with a flat fee per CPT code the ASC can best achieve profitability by controlling the cost of procedures. This can only be done by carefully tracking and analyzing every cost involved with performing a procedure. Although ASC failure is uncommon it does occur. The most common cause of ASC failure is non-profitability which occurs without relation to facility size or level of utilization. The cost involved in operating a facility are numerous but fortunately highly controllable and with careful attention can be made quite manageable.

There are three basic categories of expenses for the facility:

- Fixed (costs that occur irrespective of case type or volume)
- Variable (costs that vary with case type and volume)
- Personnel (these can be fixed or variable depending on how staffing is utilized and maintained).

Fixed Expenses: The calculation of these expenses depends on whether the ASC is a stand-alone facility or is physically or functionally part of a medical office. If part of an office then they should be calculated as a percentage of the overall square footage, otherwise the calculation is straightforward.

- ❖ Rent
- ❖ Utilities
- ❖ Insurance (e.g. non medical liability, property loss etc.)
- ❖ Liability insurance (if facility carries a separate policy)
- ❖ Janitorial
- ❖ Hazardous waste disposal
- ❖ Routine Equipment inspection and maintenance
- ❖ Telephone Service
- ❖ Transcription
- ❖ Equipment Lease
- ❖ Loans (e.g. build out). If facility is part of an office then loans can be apportioned by percent square footage
- ❖ Depreciation of facility and equipment
- ❖ Any service provided as a fixed monthly expense (e.g. scrubs, oxygen).

Variable Expenses: These expenses vary by the volume, length and type of case. These are also the ones most subject to control or conversely overrun.

- ❖ Anesthesia supplies and medications
- ❖ Local Anesthetics

- ❖ Suture
- ❖ IV fluids and administration supplies
- ❖ Implants (if used)
- ❖ Splints
- ❖ Plates and screws
- ❖ Electrocautery supplies
- ❖ Scalpels and drains
- ❖ Needles
- ❖ Transcription services
- ❖ Laboratory services (if not billed to the patient)
- ❖ Linen (e.g. gowns, drapes and towels)
- ❖ Hazardous waste disposal
- ❖ Stationary
- ❖ Dressings, binders and garments
- ❖ Photographic services
- ❖ Medical records
- ❖ Pre-op and recovery room medications
- ❖ Sharps
- ❖ Cleaning supplies specific to OR cleaning and maintenance
- ❖ Liquid waste disposal
- ❖ Paper cost for pre- and post-op forms

Personnel Costs: These expenses vary depending on whether or not personnel are utilized on an as needed (prn) basis for each case or are part of the overall office function. Remember to include the costs of benefit packages when calculating personnel costs. Typical personnel are as follows:

- ❖ Or director (RN or higher by AAAASF standards)
- ❖ Recovery room
- ❖ Scrub technicians
- ❖ Instrument technicians
- ❖ Circulator
- ❖ Anesthesia personnel (unless billing separately)
- ❖ Scheduling personnel

Cost Containment Strategies: Typically, the largest single area of cost for an ASC is personnel. This is the trickiest area to manage because several factors are virtually always in play and require careful monitoring. It is always in the facilities best interest to attract and retain highly qualified and highly productive personnel. It is also a fact of life that an ASC run efficiently can accommodate a higher case load leading to greater revenues. On the other hand in most cases facilities will see some variability in utilization as well as significant variability in case by case reimbursement. Successful facility directors juggle these competing factors effectively but to do so wisely takes constant analysis of actual revenues, case numbers, turn-around times, start times, and day to day profitability. The more information the facility director monitors the better. It is also helpful to use realistic growth projections and to be as realistic as possible in

looking at case numbers. It is short sighted to utilize cuts in staff as a cost control measure if that leads to a drop in efficiency. Again careful analysis of the effect of personnel numbers on case times and efficiency should be reviewed frequently. Also keep an eye on patient satisfaction as a staff stretched too thin is less able to give patients the attention they require to be satisfied with your facility. Although it seems that using the fewest personnel and paying them as little as possible is the best course from a financial perspective that frequently turns out to be a false hope and unwise course.

The area of variable cost that has the highest risk/reward ratio is ordering supplies. The cost of medical supplies varies widely depending on the source and types used. Maintaining a large inventory of supplies can leave dollars sitting on the shelf yet constantly ordering supplies piecemeal can avoid the savings that ordering volume can bring. Personnel that are ordering supplies can literally make or break an ASC in a very short period of time and this activity must be monitored closely and revisited frequently. Employees rarely have an incentive to assume the responsibility of shopping around for the best price and will generally gravitate towards comfort and convenience. Sometimes contracts with suppliers can be written with lowered cost for the most frequently used supplies. In fact hospitals will often let staff physicians “piggy back” onto their ordering at the lower cost these larger entities are able to negotiate.

Potential areas of variable cost saving: The following is a list of areas identified as more common ways to save money on variable costs.

- ❖ Reprocessing- many items that are normally single use or would be discarded because they were not used during a procedure can be safely reprocessed. Gas sterilization provides a means of sterilized unused items like sutures and paper drapes. Most facilities find that gas sterilizers pay for themselves in a very short period of time. It is the responsibility of the facility director to ensure the safety of this method, however.
- ❖ Group purchasing alliances- the prices that large hospital chains pay for medical items is a fraction of retail. Alliance with a hospital or other such entity can yield very substantial savings. There is one such plan affiliated with AAAASF. Please call the central office for more information.
- ❖ Bulk purchasing- buying in volume is a double edged sword because large inventories simply sit on the shelf and if an item is bought in bulk that is not used in bulk a facility can be stuck with expiring items. Alliance with other area ASC’s or hospitals can help in that obsolescing items can be “swapped” around and used prior to expiration.
- ❖ Sharing items with other facilities- Infrequently used equipment can be shared or bulk purchases can be divided. Expensive drug requirements like Dantrolene® can be purchased with other facilities and shared.
- ❖ Equipment rental-infrequently used high cost items like c-arms, lasers, endoscopes, dermatomes can often be rented. This is another area where cost can vastly exceed revenue and facilities must be very realistic about how often “big ticket” items are used and facilities should address these procedures in advance of performing them.

- ❖ Avoiding obsolescence- frequent inventory is a must so items nearing expiration are used. This requires maintaining accurate inventory and checking it frequently and rotating stock accordingly.
- ❖ In house services vs. outsourcing- laundry is a good example. Although seemingly inexpensive, surgical scrubs can be a major expense in a busy ASC and in some cases ownership of scrubs and drapes and the use of in house laundry can yield large savings when compared to rental.
- ❖ Consignment-consignment services are a means of controlling stocking without purchase. These arrangements are really ideal for a busy ASC. Facility directors must be vigilant because these can lead to very “choppy” cash flow as items are used quickly and the bills mount quickly.
- ❖ Comparison shopping-in particular ordering personnel must be monitored closely. There is little incentive for staff to search for best price much less continue to negotiate the most favorable terms in real time. In particular be wary of a single vendor arrangement as often certain “loss leaders” will be used to entice a relationship and simply made up elsewhere. This area requires constant vigilance by the facility director.

As a general rule at least ten cases per CPT code should be audited on a regular basis for payment vs. cost. This number should be multiplied by the number of surgeons utilizing the ASC as each surgeon should be looked at separately. As physicians we are unaccustomed to having our costs looked at closely but the reality is that facility costs can vary substantially from one surgeon to another even for the same case. With time and attention most prudent facility managers find that surgeons become very adept at cost control once they know what items and their alternatives cost and the entire cost picture becomes clarified. Sometimes the cost of using a favored high expense item can be offset by savings elsewhere. The other area of cost control is ensuring that the cases are performed in the most efficient manner possible. Simply looking for lowered cost can sometimes lead to longer case and/or turn around times. Although this may yield higher profit on a single case the overall financial picture can suffer. It is sometimes better to accept lower profits per case when this allows more cases to be done in a time efficient manner. A 20% profit on five cases may be better cash flow for a facility than a 30% profit on 3 cases.

It cannot be overemphasized that constant vigilance combined with clear and frequent communication is a must. The successful facility director will ensure that staff and operating surgeons function as a team to maximize profitability, efficacy and safety.

Billing Considerations

There is probably no more important activity that affects the financial health of an ASC than effective billing. This sounds simple but most ASC managers would agree that it is the most vexing aspect of managing third party reimbursement. The prudent physician/owner is well advised to monitor this activity very closely. The fundamental problem for most ASC's is that a significant cost is accrued with each case performed in a busy facility. These costs can add up very quickly. At the same time third party payers rarely have an incentive to pay facility fees in a timely fashion. In fact it is a known "dirty little secret" that one of the business models payers utilize is "benign neglect." By delaying payment a certain percentage of claims will be ignored by the ASC in addition to the interest accrued by the carrier on cash reserves retained by delaying payment. As payments are delayed costs continue to accrue. In a short period of time a substantial operating deficit can be developed and without accurate, timely and aggressive collections an ASC can quickly become insolvent. There are several steps in the billing process of an ASC that are critical to understand.

Pre-Authorization: With the addition of ASC facility fee billing this process has several unique aspects beyond preauthorizing a surgeon's fee. Some third party payors still fail to recognize the validity of accredited ambulatory surgical centers. For this reason it is wise to pre-authorize procedures for any payor with whom the facility does not have a contractual relationship. For those payors who fail to recognize AAAASF as a legitimate deeming authority but recognizes others (e.g. AAAHC) please contact the central office. It is also critical to realize that some CPT codes are *not* reimbursable in an ASC. A list of covered procedures should be obtained from each carrier. The Center for Medicare and Medicaid Services (CMS) publishes one such list applicable to the government carriers and most private payors mimic this list with some modifications. The provider *must* ensure that the carrier supports reimbursement of ASC billing for the given procedure. Even if a procedure is preauthorized carriers will typically only cover procedures on a predetermined list. Some carriers require that only a facility under contract be used. Finally, many procedures have additional fees beyond the basic facility fee associated with ASC billing such as splints, implants, radiology etc. and it is important that these costs are also pre-authorized.

Flat-Fee per CPT Code Method: Virtually all government third party payers and most HMO, IPA, and PPO payors insist on this method. Although simpler to use there is potentially greater financial pressure exerted on a facility by this method depending on the profit margin for each case. It is critical that facility managers accurately track each CPT code to ensure that payments are both accurate and timely. Frequent checks of Explanation of Benefit (EOB) forms can be done but a better method is to develop a tracking sheet that determines if facility fees were paid properly for each CPT code for every paid case.

Submission of Billing: In a busy facility cash flow becomes much more acute than a typical office as there are larger payments being tendered and much larger costs being generated. The proactive facility director will have a number of arrangements in place with his major carriers prior to submitting billing for reimbursement. These will be discussed in the section on Contracts later in this booklet. If your facility accepts payments typical for an ASC you will accept around 50-60% of hospital level reimbursement per CPT code. The ASC payment schedule published by CMS also provides a rough guide. In 1983 the Center for Medicare and Medicaid Services (CMS) published the Healthcare Common Procedure Coding System (HCPCS). There are two levels of codes. Level I is the American Medical Association Current Procedural Terminology Codes (e.g. CPT). These will cover the basic surgeon and facility fees. Level II codes classify services/supplies not covered by CPT codes. These codes cover a number of items like splints, implants and certain medications. The prudent facility director will familiarize him/herself with these codes and their use. There are two general categories of level II HCPCS codes that are frequently used in the ASC setting. Codes beginning with the letter J or L are most frequently used. J codes encompass drugs administered and L codes cover Orthotic and prosthetic procedures and devices. Alloderm® (J7344) and breast implants (L8600) are examples. There are also some modifiers unique to the ASC. Coding for surgical first assistants such as a Physician Assistant uses either modifier AS or 80. In some cases coding for a facility fee requires the use of modifier TC (e.g. Technical Component). Coding for anesthesia services are billed in a number of different ways. MD providers typically bill separately for themselves but CRNA's can be billed for under separate anesthesia CPT codes if IV sedation is given under the direction of the operating surgeon. Finally, the use of certain types of equipment such as C-arm, magnification and lasers can be billed for. It is critical that the facility director have a full and complete understanding of when and how and when these types of services are billed for.

Time based and flat fee billing: These arrangements are becoming increasingly rare. In some cases these can fail to cover expenses while in others they can be very remunerative. One should seek expert advice on how to proceed if this is offered by a carrier.

Medicare Billing: All Medicare billing for ASC reimbursement is limited to the list of Medicare-covered ASC procedures. This list is available on the CMS website. It should be noted that most private payors use various modifications of the same list and it is unwise to perform procedures not on the ASC list as they are subject to exclusion from payment. CMS publishes a Correct Coding Initiative (CCI) every quarter and ASC reimbursement is subject to CCI edits. These are revised every quarter so the facility director must keep track of these. www.cms.hhs.gov/physicians/cciedits/ is the site to check these. It is critical to understand that all Medicare billing is subject to audit and that billing deemed fraudulent regardless of intent is subject to criminal penalties. Also, if a facility is out of compliance with Medicare rules it can be shut down, even to non-Medicare patients. Any facility director that considers performing procedures on Medicare patients is responsible for knowing these rules. Also, remember that the

number of facilities that bill for Medicare is limited and most likely subject to much greater scrutiny than a physician is accustomed to.

Getting Reimbursed in a Timely Fashion: This is undoubtedly the most vexing and difficult problem facing any physician's office and the problems are only multiplied in a busy ASC. Third party payors have little incentive to pay in a timely fashion and many carriers appear to reject a certain percentage of claims *a priori*. Stories of "lost claim", "sent to the wrong office", "never got the claim", "sent to the wrong person" occur so frequently that mere coincidence appears unlikely. The best way to deal with this issue is to obtain contract language that spells out timely payment with accurate ("clean") claims. Automatic payment deposit into an account owned by the ASC is even faster. Electronic tracking (typically internet) and a close working relationship with the provider representative is helpful and the ASC manager should get names, phone numbers and email addresses for the provider representative for as many carriers as possible. Most states have regulations that require carriers to pay in a timely fashion, typically 30- 45 days depending on the state. Some carriers will frequently wait till the time limit has almost expired and then deny claims for dubious reasons. The problem for the ASC is that once a claim is denied follow up phone calls or resubmission of billing only restarts the time limit clock. A better way to proceed is to develop a "warning package". A copy of the original claim with a correct quote of state rules on timely reimbursement coupled with a threat to go to the state insurance commissioner is a one such aggressive tactic. The package can also include a legal citation. In *Alsobrook v. National Travelers Life Ins. Co.* an award of \$126,239 was awarded (\$100,000 in punitive damages!) to the plaintiff against an insurer for unreasonable delaying payment of health insurance claims. This case specifically found the insurer liable for delaying claims when they received proper proof of loss and that bad faith applies not only to unpaid claims but also to claims whose payments are simply delayed. A citation of this case is an excellent motivator for a third party carrier when enclosed with a warning package.

Conducting Self Audits: This is a good practice as it avoids problems arising if your ASC is audited. If you find that you have been overpaid it is important that these payments are returned with an accompanying letter of explanation. By performing these maneuvers one can avoid very expensive mistakes later on if an audit is performed. There are a number of publications that explain this concept further. This practice is particularly helpful if the ASC finds itself being audited externally. As a general rule the ASC will find itself standing on much firmer ground if it has already performed internal self audits.

Acquiring Participation with Private Carriers

Probably the most important step for an ASC after accreditation is the acquisition of contracts with area PPO's, HMO's etc. This is somewhat simplified in smaller (e.g. single provider) facilities as the physician will frequently already have acquired participation with a number of these and adding the technical component (facility fee) is a simple matter of expanding services. Larger facilities will frequently have to acquire participation as a separate entity. The existence of CON laws makes this a much more complex task which will vary from state to state. Generally this type of contracting will need to be done on an individual provider basis. Most physicians find negotiating with insurance carriers to be a one-sided process and generally fruitless unless one is a member of a large group or is hospital based. The physician owner/operator of an ASC, even if he/she is a solo practitioner, can find the tables turn in his/her favor quite a bit. An ASC has several advantages for both the provider and the carrier. Following below are some guidelines for negotiating with third party payors.

Cost of Care: The first and foremost advantage of an ASC to a third party payor is cost. By limiting (or eliminating) the cost of operating on non-payers (a.k.a "self pay) the burden of finding sufficient excess profits elsewhere (known as cost shifting) by the ASC is obviated. Second, participating surgeons can be monitored closely on a case by case basis to ensure that they are functioning in a cost effective manner for the facility. Thirdly poorly reimbursing or excessively expensive procedures can be eliminated from the ASC. Finally the prudent facility director can find a multitude of ways to control variable costs as noted earlier in this manual. All of these factors combine to allow the facility to approach the carrier as an entity that has the ability to save substantial dollars by offering lower cost to the third party payor while the ASC still maintains an acceptable profit margin.

Safety: As an AAAASF accredited facility there is a certainty of safety that is unmatched among ASC's. This was elegantly demonstrated in two recent publications in Plastic and Reconstructive Surgery (113: 1760, 2004). As an entity under constant peer review AAAASF facilities have no equal in identifying and quantifying the complication rate for procedures performed in our facilities. We have demonstrated unequivocally that outpatient surgery with a very low complication rate can be performed in our facilities. No other deeming entity requires the rigorous quality assurance combined with data collection that we do. Safe surgery with minimized complications is very cost effective to the provider as the cost of a single complication generally far exceeds the cost of initial care. This should be factored in by every payor when contracts are negotiated. In addition the push for "pay for performance" has left AAAASF facilities uniquely positioned for success in this area as it becomes more prevalent.

Case Mix: The prudent facility director can look very carefully at existing levels of ASC reimbursement for different specialties and avoid poorly reimbursing ones. For example ENT, Gynecology, Plastic Surgery, Orthopedic Surgery, Hand Surgery, General Surgery, Podiatry, and Pain Management are all proven performers from an economic standpoint

nationwide. Urology, Ophthalmology, Vascular Surgery tends to perform poorly. There are of course regional differences in all of these and certain cases in all specialties tend to perform better than others. In this fashion by encouraging more profitable specialties to use the facility one can achieve a higher profit margin and perhaps accept somewhat lower facility fees overall when negotiating with carriers.

Legal Structure for ASC Reimbursement: The legal basis upon which the facility is formed can have a substantial impact on reimbursement. In states where CON rules exist the facility is faced with several options. Obtaining the CON is possible but will usually be granted only over the objection of area hospitals and competing ASC's that have deeper pockets and more political clout. CON laws were originally developed in the 1970's when Medicare reimbursed individual facilities on an annual basis. Now that Medicare pays per procedure CON laws are essentially obsolete. However 14 states have retained these laws as a means of (theoretically) controlling costs by prevention of overbuilding. The real effect this has had is the stifling of competition and allowed continued growth of politically favored entities such as hospitals at the expense of newly developing ASC's. The best advice on obtaining a CON can be obtained from other ASC's who have been successful in this venture. It tends to be a daunting process. However, in CON states there are usually a much smaller number of facilities providing ambulatory surgical services because of reduced competition. For this reason the physician owner may have much more bargaining power than he/she may realize. CON laws generally do not restrict how physicians are paid so in many CON states arrangements can be made to receive an enhanced fee for procedures performed in a physician owned ASC which bypasses the CON mandate. Usually billing is on form HCFA 1500 and the TC modifier is used. This must be set up with each individual carrier and it is critical that the provider get sound legal advice prior to embarking on this strategy. It should be noted in states where this type of arrangement has been challenged the provider, not the state, has usually prevailed. In states where there are no CON restrictions most facility directors agree that the ASC should be set up as a separate entity with it's own tax ID number, business license etc. It is felt that this improves ones negotiating position and that bargaining power is enhanced. Again good legal advice must precede any negotiation.

Potential Pitfalls in Contracts with Third Party Payors: There are a number of potential pitfalls for contracts any ASC has with third party payors and avoiding them is important. First the facility director must establish what cases will be performed in the ASC and what specialties will participate if the ASC will be a multispecialty entity. It is critical that third party payors and the facility agree on those procedures. Most payors will have a list of supported CPT codes but all participating physicians should peruse such a list very carefully. If exceptions are to be made both parties should agree on a preauthorization mechanism for "off the list" procedures in advance of their being performed. In the case of procedures that are deemed medically necessary and must be performed at the time of surgery an agreement should be reached as to how they are handled. Many payor contracts have a "hold harmless" clause that exempts the plan member from being responsible for services the plan refuses to cover even if the plan goes bankrupt. Although there are varying state laws regarding this (and federal in the

case of Medicaid/Medicare) most plans will attempt to write a much more restrictive clause than required even to the point that procedures previously authorized can be denied after the fact and the ASC cannot bill the member. Fortunately most plans are willing to negotiate this clause. Another clause called “governing law” dictates which state’s law applies if there is a dispute between the plan and the provider. It is a good idea to change this to the state the ASC is located in or ask for binding arbitration. If this isn’t addressed in advance the facility may be forced to legally challenge improper payment in a distant state. If an ASC is audited, particularly by Medicare or Medicaid a new insurance product called “compliance insurance” can cover the legal expenses of providers in the case of an audit or sometimes even if criminal proceedings are started. Given the higher profile that an ASC has this can be prudent if the ASC accepts Medicare facility fees. Submission of bills and late payments by payors is another frequently overlooked area. Plans that allow electronic submission to be held till required document can be submitted either on paper or electronically will speed payment considerably. Adding interest to late payments another area that plans will sometimes agree to or this can even be required by the state.

Attracting Other Providers and Carriers to the Facility

The ASC that bills for facility fees can be very attractive for both surgeon and insurance carrier. By developing a cost profile the ASC can look towards expanding to other panels. In particular local employers can persuade the carrier to add your ASC to their panels when you can lower their costs. In the same way surgeons can lower their cost profile by taking their cases to a facility that costs third party payers less. The other elements that make a facility attractive to an insurance plan are patient satisfaction and safety. Since both are an integral part of AAAASF accreditation the prudent facility director can quantitatively demonstrate success in both areas. It is important that third party payors (in theory) serve their clients (your patients). One area of attracting surgeons to a facility must be addressed. The use of incentives that even have the appearance of a referral to a facility that the physician has a financial interest in brings in the possibility of Stark rules and Laws. Additionally, if there is a perceived financial benefit to the referral anti-kickback laws can come into effect. Physicians who are shareholders are less susceptible to these rules but non-owner physicians are not exempt either. It is critical to get sound legal advice on these matters. Unfortunately, there are no absolute safe harbors for Stark rules for participating physicians so the ASC facility director and shareholding physicians must have as complete an understanding of Stark as possible. It is also possible to “lease” space in the facility at fair market value and allow the surgeon to collect his own facility fee. These arrangements must be made very carefully and be able to withstand close legal scrutiny. However despite the pitfalls it can still be in the facilities’ interest to make such arrangements with other providers to enhance profile and better utilize existing personnel.