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Ambulatory Surgery Centers

Recouping costs on out-of-network

As if collecting payments from Medicare, Medicaid, and private insurers wasn't complex enough, ambulatory surgery centers (ASCs) face the added obstacle of being considered out-of-network by payers in many circumstances. Out-of-network typically means an ASC does not have a participation agreement with the payer or managed care organization or is otherwise not part of the panel of participating providers.

The need for careful attention to coding and documentation requirements is a given. But there are also strategies for maximizing payments and avoiding delays. For example, laws are strict about balance billing of patients when payers deny or reduce claims, and they vary by state.

Know the law

ASCs that know the laws and communicate payment limits well ahead of time have the best chance of recouping some or all of their costs for providing care.

Michigan attorney Andrew Wachler says he began to specialize in ASC issues after successfully challenging his state's Blue Cross Blue Shield organization for denying claims for surgery performed by physician-owned ASCs.

"When can we balance bill?"

At the ASC Association conference in May 2009 in Nashville, Tennessee, Wachler told ASC administrators and staff there are no easy answers to questions such as, "When can I balance bill?" for unpaid claims.

"If you're looking for black and white," he said, "it's very difficult to answer. These are state-by-state determinations."

General guidelines

Nevertheless, there are some general rules. An ASC that provides emergency service for a patient in the Medicare Advantage plan will be paid in full, Wachler noted. Commercial plans may resist paying if the ASC is out-of-network, but "there are ways you can challenge them," he said.

With changing federal regulations and 50 sets of state regulations, ASCs, especially those with multiple facilities in different states, need to stay on their toes. However, he said there are trends and principles they should be aware of.

Don't neglect the ABN

A provider must let the patient know if it is likely that a procedure will not be covered. For example, the treatment could be considered custodial care or not reasonable and necessary.

Effective March 1, 2009, the form for the advance beneficiary notice (ABN) has been modified. Wachler noted that the rules state that providers who do not provide such notice that the services will not be covered will be financially responsible for the cost.

The exception is emergency care, when the ABN should not be given. The rules for ABNs can be found in the *Medicare Claims Processing Manual*, CMS-Pub. 100-04, Chapter 30, Section 50.

A delicate balance

When an ASC is considered an out-of-network provider, reimbursement may be reduced. Whether the ASC can then bill the patient for the difference depends on both state law and the type of insurance.

While Medicare prohibits balance billing of its beneficiaries, commercial insurers often allow it

for emergency care, depending on state law. In Maryland and Florida, a provider may not balance bill for covered services, but this can be modified under private contract provisions. In California, while balance billing is also prohibited, private insurers must pay "the reasonable and customary value of the health care services rendered."

No such restriction on balance billing exists in Texas, where payments are based on negotiated agreements.

The copayment quandary

To lessen the effect of higher out-of-network copayments, ASCs may offer to waive the extra amount. Such an offer places the ASC on better competitive footing, Wachler noted. "But ask yourself, is it unfair inducement under state law?"

Not understanding state rules can have serious consequences. Under the Health Insurance Portability and Accountability Act (HIPAA), a "false claims" provision could be interpreted to impose potential criminal penalties for seeking reimbursement for charges that reflect a copay that was not collected, even for private insurance claims.

"A pattern of waiving copays," Wachler explained, "could be interpreted to mean you are claiming to charge more than you really are. For example, let's assume you charge $100 and the insurance company pays 80%, then the patient owes a 20% copay. If you waive that, the insurance company may claim it only owes 80% of the $80 you are actually charging."

That would reduce the insurer's liability to 64% of the total cost.

In a Michigan case that Wachler argued, the insurance company termed the copay waiver a "kickback."

"I think the key issue in all of these cases is whether you're making a false statement; ie, not making a full disclosure," he said.

To avoid exposure, one solution is to notify insurers of the ASC's billing practices, such as discounting or waiving a patient's share. "However," he added, "such notification will often not be favorably received by the insurers, who may then ask you to cease and desist such practices."

Under Medicare, it is not permissible to waive a copay unless the provider can demonstrate it would be a hardship to the patient. "There is very little leeway," Wachler said. ❖

—Paula DeJohn

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