WHITEPAPER

Revenue Cycle Management for Ambulatory Surgery Centers

Where ASC Billing Differs, and What It Costs When Those Differences Are Missed

An ASC is not a small hospital and not a large physician practice. It is reimbursed under its own methodology, carries implant and supply costs that are frequently unrecovered, and depends on a scheduling process that determines financial outcomes before the case begins.

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1. Executive Summary

Ambulatory surgery centres sit between two models and are billed correctly by neither. Staff who came from hospital billing apply methodology that does not fit. Staff who came from physician practice billing treat the facility claim as though it were a professional claim.

The financial consequences concentrate in a few specific places: cases scheduled without confirmed coverage for the exact procedure performed, implants and high cost supplies not recovered, and procedures paid under a rate structure nobody verified against the contract.

The core finding

ASC financial performance is largely determined **before the patient arrives**. Once a case is performed without verified coverage, confirmed authorisation for the specific procedure, or a contract position on the implant, the revenue outcome is already set.

Back end collection work cannot recover what pre-certification did not secure.

2. How ASC Reimbursement Differs

Dimension	Physician practice	ASC facility
What is billed	Professional service	Facility service, separate from the professional claim
Payment basis	Fee schedule per service	Grouped payment methodology, frequently packaged
Covered procedures	Broad	Defined lists. A procedure may not be payable in this setting
Packaging	Limited	Extensive. Many items are included in the procedure payment
Implants	Rarely applicable	Significant cost. Recovery depends entirely on contract terms
Multiple procedures	Modifier driven	Reduction rules apply, often steeply
Site of service	Usually fixed	Determines whether the case is payable at all

The third and fourth rows cause the most avoidable loss. A procedure performed in the ASC that the payer does not recognise as payable in that setting will not be paid, regardless of clinical appropriateness. And an item assumed to be separately billable that is in fact packaged into the procedure payment is a cost absorbed silently.

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Before the case
Where ASC financial outcomes are decided

Packaging
What is separately payable is contract specific

Implants
Frequently the largest unrecovered cost

3. The ASC Revenue Cycle End to End

Stage	Critical ASC specific requirement
Case scheduling	Confirm the procedure is payable in an ASC setting for this payer
Pre-certification	Authorisation for the specific CPT codes planned, not the general procedure
Benefit verification	Facility benefits specifically, which differ from professional benefits
Financial clearance	Patient responsibility on facility and professional components separately
Implant planning	Contract position on the implant confirmed before the case
Case documentation	Operative detail supporting every code billed, including implants used
Coding	Facility coding, with correct application of multiple procedure rules
Claim submission	Facility claim, correctly separated from the professional claim
Payment verification	Payment compared against the contracted rate, including carve outs
Denial management	ASC specific denial reasons, which differ from professional denials

4. Scheduling and Pre-Certification, Where Outcomes Are Decided

More ASC revenue is lost at scheduling than anywhere else in the cycle, because the errors made there cannot be corrected afterwards.

- **Confirm the procedure is payable in an ASC setting for that specific payer.** Coverage in a hospital outpatient setting does not imply coverage in an ASC.
- **Authorise the specific codes planned.** Authorisation for a general procedure does not cover additional codes billed when the case turns out to be more extensive.
- **Plan for intraoperative change.** Where a case may extend beyond the authorised procedure, establish in advance how that will be handled with the payer.
- **Verify facility benefits separately.** A patient may have professional coverage and different facility benefits, including a separate deductible.

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- **Confirm implant coverage before the case.** Not after, when the implant has been used and the cost is committed.
- **Check authorisation validity dates and unit counts**, since rescheduled cases routinely fall outside the approved window.

The most expensive ASC scheduling failure

A case performed under authorisation obtained for a different or narrower procedure than the one actually performed.

The facility has incurred the full cost of the case, including staff, supplies and any implant, and holds an authorisation that does not cover what was billed. The appeal position is weak and the write off is often total.

Find Out Where Your ASC Is Losing Revenue

Our free RCM audit reviews your pre-certification process, implant recovery, contract compliance and denial profile, and identifies the specific gaps costing you revenue.

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5. Implants, Supplies and Carve Outs

High cost implants are among the largest sources of unrecovered cost in ASCs, and the losses are usually structural rather than accidental.

- **Know the contract position for each implant category before the case.** Some contracts carve out implants for separate reimbursement, some package them into the procedure payment, and some set a threshold above which separate payment applies.
- **Where implants are packaged, the procedure rate must cover the cost.** If it does not, the case loses money every time it is performed, and that is a contract negotiation issue rather than a billing one.
- **Document invoice cost, manufacturer, model and serial or lot number** in the record, since carve out claims routinely require invoice substantiation.
- **Submit the required documentation with the claim**, not in response to a request, which adds weeks.
- **Track implant recovery as its own metric.** Implant cost incurred against implant revenue recovered, by payer, is a figure most ASCs do not produce and should.

A calculation worth running this quarter

Total implant cost incurred in the last twelve months, against total implant revenue recovered, segmented by payer.

ASCs running this for the first time frequently find one or two payers where implant heavy cases are structurally unprofitable. That is actionable at the next contract renewal, and invisible without the calculation.

6. Coding for Facility Billing

Facility coding is not professional coding applied to a facility claim. The differences produce specific and recurring errors.

- **Multiple procedure reduction rules** apply to facility claims and are frequently steep. Sequencing procedures correctly affects total payment.
- **Packaging determines what is separately billable.** Coding items that are packaged produces denials and, repeated, invites payer scrutiny.
- **Modifier conventions differ** between facility and professional claims for the same procedure.
- **Bilateral and multiple site procedures** follow facility specific rules.
- **Cancelled and discontinued procedures** have defined coding requirements that determine whether anything is payable.
- **The operative report must support every code billed**, including implants and any additional procedures performed.

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7. Multi-Specialty Case Mix

Most ASCs host several specialties, and each brings its own coding conventions, payer policies and authorisation requirements. A business office built around the dominant specialty will underperform on the others.

Approach	Outcome
One coder handling all specialties	Accuracy falls on lower volume specialties. Denials concentrate there
Coders assigned by specialty with cross coverage	Accuracy maintained. Requires enough volume per specialty
External partner with specialty depth	Accuracy without the volume requirement. Common for smaller ASCs

Report every core metric by specialty as well as in aggregate. An ASC whose overall denial rate looks acceptable can contain one specialty performing far below the rest, and the aggregate conceals it.

8. Out of Network and Patient Responsibility

ASCs carry higher patient responsibility than most settings, because facility deductibles and coinsurance apply on top of the professional component, and patients frequently do not anticipate receiving two bills.

- **Establish facility patient responsibility before the case**, separately from the professional portion.
- **Explain the two bill structure in advance.** A patient who understands they will receive a facility bill and a physician bill disputes far less than one who does not.
- **Provide a written estimate** where the procedure and coverage allow it.
- **Arrange payment plans before the case** on larger balances rather than after the statement.
- **Understand your obligations on patient cost transparency and surprise billing protections**, which apply to facility settings and carry notice and consent requirements. Confirm your position with counsel.

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9. Denials Specific to ASCs

Denial	Usual cause	Prevention
Procedure not payable in this setting	Site of service not verified at scheduling	Confirm ASC payability per payer before booking
Authorisation does not match procedure	Case extended beyond authorised codes	Authorise the range planned. Establish an intraoperative process
Implant not separately payable	Contract position not confirmed	Check carve out terms before the case
Item packaged into procedure payment	Packaging rules not applied in coding	Facility coding review before submission
Multiple procedure reduction applied unexpectedly	Sequencing or expectation error	Model expected payment before the case
Facility benefits exhausted	Facility benefits not verified separately	Verify facility benefits, not professional only
Documentation does not support codes billed	Operative report lacks required detail	Documentation standards for the codes performed

Six of those seven are prevented at or before scheduling. That distribution is the argument for concentrating ASC revenue cycle effort at the front of the process.

10. What to Measure

Metric	Why it matters in an ASC	Cadence
Net revenue per case, by specialty	The core measure of facility performance	Monthly
Implant cost recovered against incurred, by payer	Frequently the largest hidden loss	Monthly
Cases performed without confirmed authorisation	The most expensive preventable failure	Weekly
Payment variance against contracted rate	Underpayments arrive looking like payments	Monthly
Denial rate by reason and payer	Where the process is failing	Monthly
Days in A/R	Collection velocity	Monthly
Patient responsibility collected before service	Determines collectability	Monthly

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Metric	Why it matters in an ASC	Cadence
Case cancellation rate and cause	Financial clearance failures show up here	Monthly

The verification most ASCs do not perform

Comparing each payment received against the contracted rate for that procedure, including any implant carve out.

Underpayments arrive as payments. The claim is marked resolved and leaves the active queue. Without systematic comparison against the contract, nothing flags it, and the loss compounds quietly across every case.

11. Self Assessment

Scheduling and pre-certification

- ☐ We confirm the procedure is payable in an ASC setting for that payer before booking
- ☐ Authorisation covers the specific codes planned, not a general procedure description
- ☐ Facility benefits are verified separately from professional benefits
- ☐ Authorisation validity dates and unit counts are checked on rescheduled cases
- ☐ A process exists for cases that extend beyond the authorised procedure

Implants and supplies

- ☐ The contract position on each implant category is known before the case
- ☐ Invoice cost, manufacturer and serial or lot number are documented
- ☐ Carve out documentation is submitted with the claim, not on request
- ☐ Implant cost recovered against incurred is tracked by payer

Coding and contract

- ☐ Facility coding is performed by people who code facility claims regularly
- ☐ Multiple procedure reduction is modelled before the case where it matters
- ☐ Every payment is compared against the contracted rate
- ☐ Every core metric is reported by specialty as well as in aggregate

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Patient financial

- ☐ Facility patient responsibility is established before the case
- ☐ Patients are told in advance they will receive two separate bills
- ☐ Written estimates are provided where coverage allows
- ☐ Our position on surprise billing notice and consent requirements has been confirmed with counsel

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12. Frequently Asked Questions

How is ASC billing different from physician practice billing?

The ASC submits a facility claim separate from the physician's professional claim, and it is reimbursed under a grouped methodology rather than a straightforward fee schedule. Many items are packaged into the procedure payment rather than separately billable, multiple procedure reduction rules apply, and a procedure may not be payable in an ASC setting at all for a given payer. Staff who have only billed professional claims routinely miss these distinctions.

Why are implants such a common source of loss?

Because whether an implant is separately reimbursable depends entirely on contract terms, and those terms vary by payer. Some contracts carve implants out for separate payment, some package them into the procedure rate, and some apply a cost threshold. Where an implant is packaged and the procedure rate does not cover its cost, the facility loses money on every such case. That is a contract problem, and it stays invisible until implant cost recovered against incurred is measured by payer.

What is the most expensive preventable failure in an ASC?

A case performed under authorisation that does not cover the procedure actually billed. The facility has already incurred staff time, supplies and often an implant, and holds an authorisation for something narrower than what was performed. The appeal position is weak and the write off is frequently total. Authorising the range of codes that may be required, and establishing a process for intraoperative extension, prevents most of these.

Should a multi-specialty ASC use specialty specific coders?

Where volume supports it, yes. Coding accuracy comes from repeated exposure to a specialty's codes, modifier conventions and payer policies. A single coder covering six specialties will be less accurate in the lower volume ones, and denials concentrate there. Smaller ASCs that cannot justify dedicated coders per specialty frequently use an external partner with specialty depth, which achieves the same accuracy without the volume requirement.

How do we know whether we are being paid correctly?

By comparing each payment received against the contracted rate for that procedure, including any implant carve out, and investigating variances above a set threshold. Underpayments arrive looking like payments, so the claim is marked resolved and leaves the active queue. Without systematic contract to payment comparison there is no mechanism to detect that a payment was insufficient, and the loss compounds across every case.

13. How StafGo Health Helps

StafGo Health is a USA physician-owned revenue cycle management company supporting ambulatory surgery centres, multi-specialty groups and provider organisations nationwide. ASC billing requires facility

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specific knowledge that general medical billing does not supply.

- **Pre-certification and benefit verification.** Facility benefits, ASC payability confirmation and code specific authorisation, handled before the case is booked.
- **Facility coding.** Coders who work ASC claims regularly, with correct application of packaging and multiple procedure rules.
- **Implant and carve out management.** Contract position confirmed before the case, documentation prepared with the claim, recovery tracked by payer.
- **Contract to payment verification.** Every payment compared against contracted rates, with variances identified and disputed.
- **Denial management.** ASC specific denial reasons, worked with root cause analysis rather than case by case rework.
- **Reporting by specialty.** Net revenue per case, implant recovery and denial performance segmented rather than aggregated.

Get a Clear View of Your ASC's Financial Performance

In 30 minutes we will review your pre-certification process, implant recovery and contract compliance, and show you where revenue is being lost.

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