Billing, business, win, lose: roundtable dives in

April 2021—*A look at laboratories post-pandemic was at the heart of a revenue- and billing-focused roundtable led by* CAP TODAY *publisher Bob McGonnagle on Feb. 10.*

With McGonnagle were Mick Raich, Vachette Pathology; Bob Dowd, NovoPath; Kwami Edwards, Telcor; Kyle Fetter, Xifin; and Tom Scheanwald and Matt Zaborski, APS Medical Billing. They talked about pathology groups investing strategically and for long-term efficiencies, a return to consolidation, and what residents and new-in-practice pathologists should know. "Specialize, and be the tip of the spear," Raich advises. Their full conversation follows.

The CAP TODAY *guide to billing/accounts receivable/revenue cycle management systems begins here.*

Kyle Fetter, we know how COVID-19 has affected laboratories clinically. Tell us what financial impact it has had, the billing dilemmas, and what COVID has meant for this segment you're all part of.
Kyle Fetter, chief operating officer, Xifin: When COVID kicked in last year, the drop-off in pathology specimens processed through us was 40 to 60 percent, and that was the initial dip for many of our pathology groups large and small. Many ramped back up slowly to a normal state. In some cases, backlogs were received at later points that created volume fluctuations in the summer. Many were in the 90 to 95 percent range in quarter four. Eventually some of the pathology groups with molecular instrumentation were doing almost as much COVID testing from a revenue perspective as they were doing pathology work. It became a huge part of all of the clinical laboratory business in general.

For the labs that are regional dominant, testing across the board rose by 100 percent, so COVID is making up the majority of their volume. For most laboratories we work with, what they had to do in terms of capital expenditure to get that volume was not cheap. They invested heavily with the knowledge that it would go away and they'd probably be left with an asset that was not depreciated at that point.

Bob Dowd, is this more or less in sync with your experience at NovoPath?
Bob Dowd, VP of strategic accounts development, NovoPath: Yes, that is exactly right. The AP work volume dropped and molecular work increased, and our position was aligned perfectly to take that additional data and marry it up with results to go with the billing information.

A lot of our clients took advantage of our capabilities with whole slide imaging, working remotely. We've taken it to the next level.

Matt Zaborski, we have had a volume rebound, but did we completely straighten out the dip in income that spanned three or four months, including not only anatomic pathology volume but also some of the other routine laboratory tests, which fell off the map a little?
Matt Zaborski, assistant VP of sales and marketing, APS Medical Billing: The dip we saw depended on the area. In Chicago, for example, we saw as much as an 80 percent reduction in anatomic pathology, but 40 to 80 percent was where most of our clients fell on the AP side. Most clients have returned to near normal, but I would venture to say most clients have not received full monthly volumes or ramped back up to their prior levels, and I don't think most got any sort of catch-up, in essence. It's not like we had double or triple AP volumes in July, August, and September to make up for lower volumes in March through May.

Clients that bill a professional component of clinical pathology mitigated the losses. This includes clients that were previously not billing for certain hospital locations but started to work with their hospital administration to clear the way to start billing that revenue that was otherwise being left on the table.

Raich

Mick, you have a wide-ranging view of this slice of life. What are your comments about COVID as it relates to the volumes and revenues being replaced, and some of the extraordinary COVID payments that were out there and what effect they may have as they winnow their way through in the next few months?

Mick Raich, founder, Vachette Pathology: The big question here will be when does the COVID payment change. We saw our pathology groups go up and down, and most are close to normal again. Lab clients went from billing 100 COVID tests a week to 1,000 COVID tests a week. A lot of them are at 5,000 COVID tests a week and still struggling to handle some of the gray areas in the billing world—whether you can bill screening tests or a collection fee. There is still ambiguity on how those things are paid.

The other big question is, at what point does Medicare say, "We're going to lower the fee for this"? I am looking at July Medicare recommendations; will they come out and lower the high-volume tests to $35 versus $75, with the extra incentive for turnaround now, so you get an extra $25? Will they take that away? At what point do you stop following the money? Does this no longer become profitable, and do we see these tests drop off?

On the other side of that coin is the possibility that a COVID test might be required for domestic travel. If that happens, we will have a lab at an airport, and if so, we would still be ordering 100 million tests or more a year.

Kwami Edwards, what additional comments do you have on COVID?

Kwami Edwards, chief customer officer, Telcor: Labs that were doing 2,000 requisitions a day and then went to, say, 15,000 because they took on a large portion of COVID testing in their region had their ability to absorb that volume pressure tested. Even if they've made the investment, it is getting all the necessary information related to those patients, dealing with uninsured patients, having good processes, and so much more. It has changed the landscape and the question is, at what point does that volume dissipate?

We've seen a lot of new players set up COVID testing labs virtually overnight, and I would expect to see them begin to fold their tents as soon as the reimbursement hits the more typical laboratory reimbursement level. Would you agree?

Kyle Fetter (Xifin): That's right. They'll fold their tent voluntarily or someone else will chase them out of business, and there are a lot of regulatory things that we think people are looking at now, particularly the OIG. Some of the labs that popped up out of nowhere may not survive that. We saw that in toxicology several years ago, and we don't see a reason why we will not see that here.

Dowd

Bob Dowd, once we get back to normalcy, and I realize that's a squishy concept in an ever-evolving story, do you see long-term consequences for laboratories and their financial health that might arise out of the effects of COVID?

Bob Dowd (NovoPath): Yes, I do. There were a lot of shortcuts given to allow all these other labs to pop up. The inspections, the diligence, may not have been there. Long term, as some of those labs fall out, people have tried to

get more efficient on the front end.

Labs that qualified for the Payroll Protection Program and kept people employed might have had people doing other things to keep the staff so they did not have to go back out and recruit accessioners all over again. They positioned themselves well as they started picking up additional specimens and getting the molecular machines online to do COVID testing.

So long term, yes, we will find that efficiencies and processes that we have had to use in this emergency will be expanded. We'll see a lot of front-end automation, a lot of things that we're doing in the artificial intelligence space with structured input, with structured output, and working with people on that to try to reduce that handling. The investment for us on the AI machine learning piece will help all clients streamline, so you will see a lot of it. The work environment for all industries is changing.

Tom Scheanwald, you have seen the ups and downs in the lab business for a long time. Do you have a comment about what some of the long-term effects of COVID might be on the business?
Tom Scheanwald, president and chief operating officer, APS Medical Billing: Long term, we will see more clarification by payers on what they will pay for COVID testing. Right now, anyone involved in that can see that 100 percent of the insurance companies are not paying for COVID testing for one reason or another. The payers will, once we get through this period, establish medical necessity guidelines, as they do for other lab tests, and those will be followed in terms of their payment. And, as Mick said, a lot depends on the government and what it requires for COVID testing just to travel in this country. That will define things as well.

Some of the new legislation on surprise billing will better define for the labs clearer billing guidelines. Some of the laws will require a quick turnaround time from the time a test is run or service is provided and when it is billed to the insurance company or patient. And then once a claim has been filed to the insurance company, strict turnaround times are being proposed for insurers to adjudicate the claim. So a lot of things are going to change how the industry operates and we'll see things pick up faster.

Mick Raich, what do you make of this line of discussion? Do you have your crystal ball ready?
Mick Raich (Vachette): The labs that will do best at this are the ones that follow the business model of Nucor Steel. Nucor Steel is a classic business model where in downtimes, they don't lay people off. They retrench, they find a way to make a little profit, they save up money. Then during the uptimes they make two or three times margins. We're going to see the same thing here.

Some labs will save all their COVID money, and their marketing, sales, service, and product will be five times better than those of some of the other people who take the money and run. And that is going to determine three or four years from now who is left in this marketplace and who isn't.

That's a nice segue to another topic I want to raise, and maybe the introduction there is the news about UnitedHealth acquiring Change Healthcare. That is to say, this is a question of ever-increasing consolidations, in part to answer those very pressures. Kyle Fetter, what do you make of the announcement, and do you see one effect here being increasing consolidation and even integration of many different functions?
Kyle Fetter (Xifin): There is a lot of consolidation in general in many health care IT areas. UnitedHealthcare through Optum for many years has been becoming a health care IT company. It has been a focus for them. When the Affordable Care Act was passed, the writing seemed to be on the wall for some commercial insurance carriers—they felt they needed to become more IT oriented and diversify their product portfolios. UnitedHealthcare via Optum has done that more than anyone.

It's an interesting move to get into a business so heavily focused on clearinghouse, and some of the different things they're focused on that make up the majority of their business, because Optum already has a fairly large clearinghouse business as well. So they're trying to consolidate, and in general, to pick something up like that at that size for the multiple they picked it up is not unheard of in a market like this.

Whether it's a surprise or not, the bigger problem you get with some of these larger companies is service deficits and things like that. They're conglomerates. How do those things work in terms of engagement, in markets like pathology and complex clinical laboratories, specialty laboratories, and things like that? The historical answer has been not that well because it's not that big a part of their business.

There is going to be in many ways fantastic technical infrastructure left behind by the pandemic—interchanges, interoperability, ability to deliver patient information directly, ability to handle things from a payment perspective digitally. All of it will be left behind for the laboratory industry to better deliver care to physicians, so that's going to position diagnostic players who leverage technology and interconnectivity very well. Optum's acquisition of Change seemingly makes strategic sense, but Optum's focus has been on large, nonspecialized providers, not the groups we all cater to, like pathology and diagnostics.

Zaborski

Matt Zaborski, what are the thoughts of the groups that you and others on this call cater to as they look into the future? Are they worried about the need for increasing consolidation of lab providers, pathology providers?

Matt Zaborski (APS Medical): I don't hear our current client base concerned that they need to consolidate based off this. Most of those that have moved over from Change Healthcare in recent years indicated they were pretty happy they made the change before this happened. They don't feel it's in their best interest for a company that owns a large national insurer to be in charge of their revenue cycle also. I have leaned more toward Kyle's explanation—I think they're a little more interested in pinning down the clearinghouse industry to begin with and growing that model of business. I am not sure where it will lead for revenue cycle management.

Bob Dowd, would you like to comment on this line of thought?

Bob Dowd (NovoPath): Whenever we see the combinations of large outfits merging disparate systems, it's never seamless, so there will be issues. And United, as it gets bigger and as the big dog, starts to guide other things that are happening. It was one of the first companies to issue new coding for some of the molecular testing and some of the requirements around it and prior authorization. So they're going to be at the forefront of doing that. They're going to try to meld the industry somewhat.

In 2020 anything clients had in capital, any projects they were trying to do, were put on hold. They had no idea what was going to happen to their revenue stream; if they were going to upgrade or look at other systems, they stopped it. What we're thinking now and seeing already and probably will see for Q3, Q4 this year is that people will now invest that money this year that they already had approval for, to upgrade their systems to accommodate all the changes, to make things more efficient, to make specimen-tracking process improvements. It's like Mick said, they have COVID money and if they're able to stash some of it aside, it can help smooth out the operation and make it more efficient going forward. We're already hearing that.

United will be at the forefront of trying to move some of the testing. We're going to see the scrutiny over molecular tests like we did years ago when it started coming out. Everybody started doing molecular tests because on the fee schedule it looked good, and then Medicare and all the carriers said they weren't seeing clinical utilization changes and weren't going to pay for it. What we're hearing now is, COVID is an emergency, we're going to pay you, but if it comes down to a lab in every airport for a while, it's going to go down to $25.

So what are labs doing to reinvest to position themselves knowing that there is going to be more scrutiny on reimbursements? Making themselves more efficient is the answer.

Edwards

Certainly what Medicare giveth it can also taketh away—that's almost the entire history of Medicare in the laboratory business as we've all experienced it. Kwami Edwards, are you seeing from some of your clients this same interest in making important strategic investments in their operations, perhaps with some of the money realized from COVID testing?

Kwami Edwards (Telcor): First, one additional comment about Optum. It makes sense for them only from the standpoint of when you look at COVID, they didn't have the best integration in terms of getting patients registered, and using Change probably makes sense for them—so they can be more nimble and do what they need to do.

Labs that have seen an advantage from their COVID testing are already looking at other opportunities to get into other areas now that they can make that investment. If they're already doing the PCR testing, the question becomes what else can they do. Do they go into wound care? Do they do other things that are out there that, once the pandemic is over, are a more seamless transition?

So we have heard from labs that are making positioning changes for a life without COVID, potentially being able to do other tests by leveraging similar technology. They're trying to calculate where they are going to be able to get the reimbursement from a payer perspective if they move into these other areas.

Until COVID hit, clinical labs were staring in 2020 at further reductions in payments. They weren't feeling great about anatomic pathology reimbursement. They were looking at consolidations. Mick Raich, what do you make of this current environment as it may evolve?

Mick Raich (Vachette): You're right—it's a different ballgame. We've had several projects in which we were looking at merging pathology groups and they all came to a stop with COVID. We anticipate this fall those will probably move forward. And we'll probably see Medicare come out in July with its proposed fee schedule putting in the cuts that they reduced a little this year.

So things will crank back up by 2022, and I think we'll be looking at consolidation in pathology groups going forward and then we'll see further consolidation in the lab world. Strong regional labs will still be players. For other people, once their COVID volume goes away they won't have much to sell. It's like you said, it's not a pretty picture. I think we've seen the heyday of revenue for both labs and pathology within the last 10 years and we'll see it retrograde going forward.

Kyle Fetter, what's your reaction to that gloomy prediction?

Kyle Fetter (Xifin): If there was anything I was going to be optimistic about it is that maybe there's some regulatory understanding of what it's like to have an undercapitalized laboratory industry when a pandemic hits. We are going to be in an endemic world going forward, where specificity around infectious disease is critical, and if you put this infrastructure in place, private or public, there will be knowledge and hopefully enough message spreading through the major lobbying groups to say, do you want to be in the same situation where it takes longer to ramp up than it theoretically could because the industry is undercapitalized and not in a position to respond quickly enough? Everybody did everything they could to get the volume going, but it took longer than it would have if some of these cuts hadn't come earlier.

And it wasn't just about cuts; it's about coverage. UnitedHealthcare is trying to get people to put stuff into a lab test registry that in many cases will circumvent the CPT process. When we get out of this, we will need to understand how to continue to test for the SARS-CoV-2 variants within COVID ongoing, and to identify the difference between patients who have other infectious diseases versus COVID. We can only hope that will be well understood from a regulatory perspective going forward. You cut too much through coverage or rate cuts and you

are going to have a big problem.

There are other things that play against the industry—supplies, billing laws, and prior authorization, for which labs need the technological tools that ultimately ensure the right information is received up front and also tells patients what their out-of-pocket will be prior to testing. You have to be able to get that type of technology as early into the process as possible or you're going to have patients getting bills on the back end they didn't expect, and we've been dealing with that for years. But now there are more state and federal laws about having to disclose estimated out-of-pocket and such early on, especially if you're out of network. The growing number of prior authorizations is definitely not going to go away.

The only answer is that we have to, as an industry, get closer to patients and physicians early in the process of ordering. You do have the combination of the reimbursement requirements that are changing and the patient disclosure requirements that are changing, but hopefully a greater understanding that while some bad players may get flushed out of COVID, a lot of people had to invest a lot and take a lot of risk to get themselves into a position to be able to service the needs of the pandemic, and we don't want to put ourselves in a situation again where we're behind the eight ball on that.

Scheanwald

All of you work a lot with pathologists, and we know two things. One is that the pathology workforce is aging to some degree. Certainly we have an aging workforce in the lab overall and that's leading to some of the labor shortage. We also know pathology is one of the few areas, if not the only area, that's constantly infusing new blood through new graduates from fellowships and residency programs.

Let's spend a few minutes giving new pathologists who are entering the workforce some advice. Tom Scheanwald and Matt Zaborski, what would you want to say to a new pathologist going into the workplace for the first time? Something they need to know that they didn't learn in fellowship or residency.

Tom Scheanwald (APS Medical): A critical piece, and it always has been, is to learn the business of pathology. Learn how it works, how important it is that they do their part in the revenue cycle, how their services are paid for. No time is spent in medical school teaching that, and not that it has to be a long course, but they need to become a student of the business.

They also need to operate and become more adept in working with hospital administration. Pathologists provide a great many services to physicians and the health care community, and we need to be able to advertise that more. It's only to our advantage to be able to get out there and fully explain what everyone does and the benefit they bring to the community.

Matt Zaborski (APS Medical): For pathology groups to survive, first and foremost they have to hang on to their hospital contracts, and more groups out there are looking to take those contracts off their hands. So it's important for groups, and for the individual physician coming out of residency, to understand what value they're adding to the health system, tracking time they spend on tumor boards, time they spend in the clinical lab—anything they're doing that doesn't generate billable work. That money is often overlooked by administration when you sit down to negotiate a Part A stipend.

I work with radiology groups, too, and quite a few of them use apps to track their time, and when they sit down

with hospital administration, they let them know everything they do for free, in essence. It goes a long way to building that relationship when you have other groups that will come in from out of state and offer to provide clinical lab oversight for the AP volume and the ability to bill the professional component of clinical pathology and not ask for any Part A stipend.

Kwami Edwards, what one or two pieces of key advice would you give to the new pathologist entering the workplace?
Kwami Edwards (Telcor): I agree with the need to learn the business and understand how services are paid for, but also to know what are your costs and how you can leverage technology to collect on the services provided. And use everything at your disposal. As the executive of your pathology group, know what influence you can have so that you collect as much as humanly possible while not spending a lot to get it.

One of the things many were hoping might be a positive outcome of COVID was that hospital administrators would understand they have these entities called laboratories and highly trained, highly qualified physicians called pathologists to help them with exactly the kind of problem COVID is, and a lot of people in labs tell me it was the first time the administrators showed a genuine understanding of what they were doing in the laboratory.

Bob Dowd, do you think this recognition of the lab and pathology will last, and what is your advice for the new pathologist?
Bob Dowd (NovoPath): Yes, a lot of hospital administrators have gained respect for the laboratory as it was able to shift gears like it did and make up for revenue loss from normal AP work.

The administrators were mostly thinking, how am I going to keep my emergency services going? How am I going to accommodate all of the COVID patients? Then the lab starts to do all this. They take it over, they do it, it's a nice surprise, it's streamlined, it's done, there's money coming in. In a lot of cases that helped the lab administrators. A lot of them gained a new respect, and I think it will be long-standing.

New residents are a little surprised about the coding situation. How they dictate a case, what they do with the case, all that has ramifications on how that case is coded and billed. Some of them don't come in with a lot of that type of knowledge and how it's affecting the billing. A coding seminar for some of them would be a big help. They need to understand they're part of the process. It's an awareness that needs to be built.

Mick Raich, you've been an evangelist for this kind of activity and knowledge gain for pathologists. What would you want to convey to a new pathologist?
Mick Raich (Vachette): I do some speaking with different universities and I do virtual conferences on this, and there are two things I advise. Number one, subspecialize. Don't be a generalist. Take your time and effort, find something you'd be very good at and, like anything else, if you're unique and good at one thing, you're probably going to be more employable and do very well.

Number two, be the tip of the spear. Be out there with the new technology. Get into digital pathology. Work molecular. Don't be the person who comes in at 10:00 and leaves at 2:00 and doesn't pay his or her dues and doesn't understand the business or the technology that's going to change in the next 10 years. Digital pathology is going to be huge. So when I talk to residents I tell them to learn these things. This is going to be your cash cow as you go forward.

Fetter

Kyle Fetter, I began with you and I'm going to give you the last word. What is your view of what a new-in-practice pathologist needs to know?

Kyle Fetter (Xifin): Everything that the others have said makes perfect sense. Pathologists need to continue to think of themselves as people who have the ability to find out in-depth things about patients not based off of observation but from bioanalysis, and that's the future. There's no question on technology, and as the newer generations come in, some of the aversion to implementing technological platforms is likely to go away. All of the assumptions in the fee schedules are that the lab is automating everything, and that's why they're getting cut so much. Payers think overhead is going down. If they think the lab's throughput is going up because of automation, they're going to cut the existing reimbursement accordingly. They think technology is always moving ahead faster than rates are getting cut. That's a core assumption now of every commercial and federal payer.

You also have to position yourselves to be people who specialize in bioanalysis and understand more about looking at things at a cellular level than anyone else. Specialization will be a critical part of that—understanding all of the different disease states within each type of cancer, within different types of infectious diseases. That's critical. That is the way pathologists need to think of themselves—as the ones who don't necessarily see the patient but who understand things in terms of biomarkers that other people do not.