Billing practices, problems—we ask the experts

April 2020—*Billing and collecting for pathology and laboratory services is "tough and getting tougher." That's the view of consultant Al Sirmon of Pathology Practice Advisors, Pawleys Island, SC. "In what other industry," he asks, "do you rely on a third party to decide how much and when you're going to get paid for a service you provide to someone else?" On the bright side, he says: "We have better tools now."*

Sirmon and others spoke with CAP TODAY publisher Bob McGonnagle in February about the problem of leaving money on the table, comparison shopping for solutions, and more. The others are Bob Dowd of NovoPath, Kwami Edwards of Telcor, Tom Scheanwald and Matt Zaborski of APS Medical Billing, and Kyle Fetter of Xifin (who joined the others about midway). Here is what they said.

CAP TODAY's product comparison guide to billing/AR/RCM software

Bob Dowd, in our roundtable on billing three years ago, you made important points about the need for billing to withstand scrutiny in order not to be denied. You mentioned that we had to work hard at optimizing the money we receive given the declining reimbursement, and the importance of using analytics in the software and in the services to make this as efficient and painless as possible for all staff. Three years later, are those all still things that you know we need to have in our billing approaches?

Dowd

Bob Dowd, vice president of strategic accounts, NovoPath: Yes, they are, and what we've done is further enhanced that service in our software for our clients and future clients to help them not only be able to bill first time without errors but also assist them with coding corrections and preventing double billing and missed billing opportunities. We've built in safeguards for that, so once the billing is done, we'll know we've optimized it, knowing what the government and payer regulations are. We've also built in the ability to do multiple entity global split billing, not just to TC/PC between clients.

We've done a lot of the standard things—patient payment plans and posting credit card transactions—but we've especially drilled down on the reporting capabilities. We've added a summary-of-activity report for a bird's-eye view of the financial health of each lab. Have you gone past time where you would've seen reimbursement? It'll flag the cases for you. Have you not optimized your payments so that you should've received $100 but you received $50? There are reports for that.

We're not trying to be billing for everything and everybody. We focus on anatomic pathology billing and coding, so our software gives our clients the ability to do all that. It's their system, per se, our software, and with our software support we combine with the clients, allowing them to optimize their billing and reimbursement themselves, with assistance from us.

Al Sirmon, what is your perspective on this need to withstand scrutiny, optimize the money that's

received, and make it all as efficient as possible?

Al Sirmon, co-founder, Pathology Practice Advisors: I'm in a different situation than the others on this roundtable because I'm a consultant. I don't run the billing company. I can tell you after running a billing company for 25 years it's much easier to be a consultant than it is to run a billing company.

I have clients say, "I've got a billing problem," and I say, "Well, you've got to realize billing is a problem." In what other industry do you rely on a third party to decide how much and when you're going to get paid for a service you provide to someone else? So it is tough and it's getting tougher because of the things you said about reimbursement. The problems of late are the denials; you have to have a way to manage your denials. The other is patient responsibility. It's creeping up more and more; it used to be it was just the 20 percent coinsurance fees but now we're seeing annual deductibles for the commercial payers getting to be so high that so much of that has shifted over to patient responsibility. It's a tough business to be in.

Kwami Edwards, in our roundtable three years ago Deb Larson [Telcor EVP] was with us and she made the point that many people were leaving a considerable amount of money on the table because of the lack of an efficient billing software or efficient billing service. Are a lot of people still leaving money on the table?

Kwami Edwards, chief customer officer, Telcor: Yes, definitely. We continue to see this at laboratories we deal with for the first time. When you look at the opportunities to improve collections and the money being left on the table, some of it comes down to doing the basics effectively and with regularity. Getting something as simple as patient demographic data from the upstream systems on a consistent basis, knowing the payers, consistently verifying insurance up front—those basics are key to critical activities needing to happen from a billing perspective. There is also the opportunity, once you have the patient demographic information and the insurance information, to leverage tools and automation—some kind of rules engine to verify data and ensure claims are as clean as possible. You also need the insight to identify what tomorrow's problems might be and adjust your workforce.

We also see a lot of effort on the back end. Many labs struggle with identifying the right tools as well as the right process to ensure time spent following up on claims and appeals is effective. When looking at the opportunities to collect more, much comes down to doing the basics effectively, organizing workflow efficiently, and reengineering processes all to ensure clean claims go out the door the first time.

Tom Scheanwald, would you like to comment on what you have heard?

Tom Scheanwald, president and chief operating officer, APS Medical Billing: In providing billing audits, in terms of leaving money on the table, it is a problem that still exists today, surprisingly so. The coding piece for tests still remains problematic, and I'm surprised at how many practices don't routinely audit their coding and because of that dramatically under code. The other thing we see is practices not getting paid according to the contracted rates agreed to with the insurance companies, and that type of pattern can go on for years with significant losses of revenue.

Al Sirmon brought up self-pay collections. We have become a bank. Each practice today has to learn how to manage and maximize self-pay collections without alienating the patient, but it's a problem today because many—and I'm still surprised at the amount of practices—just adjust and write off self-pay, and you can't afford to do that anymore.

It's so important today, too, that pathologists, laboratorians, take an active role in their state and national organizations. It's necessary that we remain vigilant on all fronts to the attacks we're getting from payers, state legislators, laws that are being passed—the surprise billing legislation, for example, and how some of the language is being crafted. We have issues with payers in states that have significantly reduced fee schedules overnight. Some payers have implemented their own medically unlikely edits and correct coding initiative edits. New Jersey is a recent example; a major payer in that state put in MUEs that severely limited 88305s being paid to four units for all cases except prostates and GI, and the state pathology society there was active in getting that reversed.

Matt Zaborski, when someone calls and is interested in exploring a new billing entity like APS, what are the first couple of questions they ask? Are they concerned they're leaving money on the table?

Matt Zaborski, assistant vice president of sales and marketing, APS Medical Billing: They almost always are concerned they're leaving money on the table, but usually it's more of a service question that leads to how much money they're leaving behind. A pathology group of 12 to 20 anatomic pathologists that has a little more infrastructure to manage their business—not just the physicians and their biller but also a CEO, a CFO, or a few others who are finding problems before their biller—gets tired of identifying issues and says, "Our biller's great at responding to the issues, but we would prefer their finding the issues and reporting them to us, not vice versa."

Bob Dowd, I'm at many trade shows in the field and I'm struck at how often I'm told people are constantly shopping for billing solutions, for the clinical laboratory and for pathology. We know that consolidation of practices leads to some of it. We know we're fighting kind of an arms race against denials, against declining reimbursement, et cetera, but is my perception correct that there's a lot of comparison shopping going on by people responsible for the financial health of labs and pathology practices?

Bob Dowd (NovoPath): Yes, I would say you're correct and for the reasons you just heard all of us talk about. What tools can they get to sharpen what they're trying to do? In some cases they may be using a service. They may be using software they've had for a long time and it didn't cost them money but it is costing them money now because they're not seeing a reimbursement. So what can they do to increase their reimbursement without a significant increase in cost?

What are my options? Is it something I can do in-house using the knowledge we have? A lot of times people have expert coders who can do it. Can the system help them do the coding and get it out? That's forcing people to look around. As reimbursements get squeezed, they ask: How can we improve that margin by having the most optimal system or software?

Kwami Edwards, the same question: Is this perception right? A lot of people are continually looking?

Kwami Edwards (Telcor): Yes, definitely. Many times organizations are looking for a system or a service that is scalable. As they grow, as their business model changes, can they continue forward without the desire to grow being a hurdle? Can they absorb changes but still gain productivity, improve their collections? Organizations are looking for a solution that can do multiple things.

We talked about coding but there's also the idea of integration with front-end systems. Can your billing solution support multiple tax IDs, as we see more and more of that? And direct billing is important—you don't want to use spreadsheets because you need effective follow-up. We see a lot of shopping around and there's always the age-old question: Do you manage your billing in-house or outsource it? It comes down to what the need is and what sort of predicament each laboratory is in.

Al Sirmon, a market state like this is perfect for consultants. Would you agree? And I'm interested in this question of outsourcing. We all know that the workforce in labs and pathology practices is getting older and there is a shortage. Are people telling you their coders are retiring and they're having trouble getting that level of expertise in-house and they're looking for the service outsource solution?

Al Sirmon (Pathology Practice Advisors): Yes, it's a good market for consultants. And unfortunately sometimes when people think about taking billing in-house, they underestimate what it takes. They think about having someone sitting at a keyboard and keying the charges in, and everyone on this call knows there is so much more to it, whether finding someone who can code correctly, credentialing, or analyzing the reports. If anyone does think about bringing it in-house they need to look at that closely because it requires a lot. Some people do it and do it well, but it's quite an undertaking.

Sometimes, too, the lead question when they start shopping billing companies is price, and often what we see is one price can be very different. It's sometimes not an apples-to-apples comparison. Some billing companies include credentialing, some include coding, some include postage and statements, and some don't. You just can't use that straight percent price they give you.

Tom and Matt, are you getting a lot of calls from people looking for better or different solutions, or do they just want to be reassured they're billing optimally, regardless of whether they're doing it in-house or outsourcing it?

Zaborski

Matt Zaborski (APS Medical Billing): I'm working now on audits for three pathology groups just to validate charge capture, denial trends, and revenue cycle optimization with various billing situations. Some insource, some outsource. It just depends. There's always a concern about optimizing, but when it comes to, say, the idea of insourcing billing, as Al said, it's the comprehensive services and processes that need to be implemented—the credentialing, charge capture, contract management, payment validation, denial management, et cetera. But there also must be checks and balances in place, so an insourced model must consider how complex and flexible your system needs to be to put those checks and balances in place, not just to track every accession but to have ways to account for the charges that should've been billed within the accession as well as amendments and addendums. Regarding denials, sometimes you can't make heads or tails of what the carrier's remitting to you and it takes a lot of research and work off your back end to make improvements on the front end to help ensure efficient billing.

Tom Scheanwald (APS Medical Billing): Usually there's a trend downward in terms of payments, collections, month after month, year after year, and with no explanation as to why, so the inquiries we get sometimes are related just to the service itself and they don't have anyone they can talk to about this to get an understanding of why what they're seeing is happening with the practice financially. Often, too, it can be customer service—patients who call in to try to get their claims filed correctly and get them paid. There are a lot of patient complaints coming from groups that are shopping. So sometimes it's not just about the money but about public relations.

There's an increasing appetite among pathologists to become employees of health systems as opposed to working in private practice, and I think we'd all agree we're seeing that play out across the country. Does anyone disagree with that?

Tom Scheanwald (APS Medical Billing): We're taking some from employment salaried situations to private practice.

How does that usually work?

Tom Scheanwald (APS Medical Billing): The hospitals sometimes lead the charge because they no longer can afford to pay the competitive rates required for pathology and they approach the pathologists and ask them, as they did years ago, to form a private practice and they would contract with them. We don't see that much of a trend. We see more trends toward the smaller pathology practices merging with the larger pathology practice that is in private practice and performing their own billing or hiring a billing company.

We have a couple of big systems right now that are looking to take their billing out, and the contract would be with the hospital system.

What is your impression of that?

Tom Scheanwald (APS Medical Billing): It is the same age-old problem of letting the hospital bill for pathology. It does not work well. The hospitals are recognizing that, and they very much need to turn that around and get some money in the door because they're measuring it. They're watching it.

Matt Zaborski (APS Medical Billing): When it costs the hospital's billing arm the same to collect on a $150 or a $200 pathology claim as it costs for a surgery claim, priorities get shifted and they end up losing money in one area, and it's going to be those smaller bills.

That's been a long-time truth—that you don't want the hospital billing for your pathology practice. But you're indicating that now some of the hospitals are recognizing they're not the best entities to be performing these functions. Is that correct?

Al Sirmon (Pathology Practice Advisors): I haven't seen much of that. Many times the hospitals I've seen don't know what they don't know.

A couple of weeks ago I asked a group I was talking to: How many pathology practices does your hospital billing department bill for? It's one. Well, when you've seen one, you've seen one. There's so many things they're not used to and overlooking, like not using the 59-modifier when you have flow and IHC combined.

Bob Dowd (NovoPath): We have seen quite a few mergers of groups, and what it comes down to is you have multiple groups all of which had some sort of billing arrangement in the past. As they've merged and become a larger group, the expectations are they're going to do better as a new group in terms of their revenue expectations. So now the pressure is on—what are we going to do for billing and how are we going to optimize it? They have to meet the expectations of the board, or whatever they've set up as part of the merger, to make those revenue numbers. How are they going to optimize it? Usually people have a strong opinion on how they've been doing it, so that then becomes an opportunity for all of us in the billing space to get involved.

I'm assuming there are well-executed combinations and some that are less well executed. Al, are most people worried about this billing on the back end after they've already hashed out the merger of the practices?

Al Sirmon (Pathology Practice Advisors): In my experience, billing is not one of the big issues considered up front. Usually they're trying to merge for other reasons. Many times it's because the hospital is pushing them to do so. As the hospital systems merge, they expect their underlying practices to merge. That's what I've seen the most.

Billing should be front and center if they're contemplating a new arrangement of practices. Matt, don't you agree?

Matt Zaborski (APS Medical Billing): Yes, you're buying someone out of their practice or giving them value of the overall based off of numbers. I don't know why you would not include the billing performance as part of that, and it's at the core of what it is outside of, say, your part A stipend. A poorly performing billing arrangement for the group being absorbed can lead to a drastic undervaluation.

What's the status of professional component billing in pathology? Tom, where do you see that in 2020?

Scheanwald

Tom Scheanwald (APS Medical Billing): It's still a viable revenue source for many practices that take advantage of

it, and many are interested in doing so. Where it's going to be in 10 or 20 years is up to us. We have to embrace it as a revenue source and we have to begin working with payers who don't recognize or pay for that service. So often people are okay with walking away from it as a revenue source, and as things get tighter, we're going to have to make sure our clients are billing for everything they can.

Matt Zaborski (APS Medical Billing): The surprise bill laws are making a dramatic impact, but that's state by state, so it'll be interesting to see how the federal government handles it versus each state, because a lot of the states' language will say "on Medicare-covered services." A professional component of clinical pathology doesn't fall under a Medicare-covered service, so it creates its own gray area. Going back to what Tom said earlier on being active in state and national organizations, engagement with these organizations is imperative to help protect revenues from payer and legislative actions.

Kyle Fetter, three years ago we talked about the need to be able to withstand increasing scrutiny of billing, to make sure bills are clean, to optimize the money that will come into practices, and the importance of analytics. Are those still things you worry about on behalf of clients?

Fetter

Kyle Fetter, executive vice president and general manager of diagnostic services, Xifin: Yes, absolutely. We have a combination of products here in terms of technology and services, so to us there's been a patient engagement theme going on for some time wherein it was necessary to be able to provide patients certain information commercially up front regardless of regulatory requirements. From a business standpoint, billing has been problematic for a while in that patients get bills they typically don't understand, they didn't know were coming, or that maybe were not fully disclosed to them, and it manifests itself in a lot of ways. So there's been a business need for patient engagement for a long time, and technology tools that support that have been critical, things that tell patients what they can expect to have to pay. This is particularly so in pathology, where there is more reflex testing and things like that, so it's not simply about an ordered test. And then there's the issue that we run into of tightening up commercial guidelines on what will be paid and when, which for a lot of our customers has resulted in an increased need for appeals.

I'd like to hear more about how a pathology practice optimizes its patient engagement so the patient is not left surprised or angry and calling their local representatives. What are some of the things you've seen that have been working on behalf of the client?

Kyle Fetter (Xifin): It depends on the nature of the workflow for the pathology group. For us, patient engagement becomes a tool around being able to take the information that comes in from a payer during an eligibility check, marry that up with the potential services ordered, and in that eligibility check you have key benefits information. You take that benefits information and marry it up with the potential outcome of that order in terms of contract rates by procedure, and provide a disclosed estimated responsibility based on that order with the correct language around it that says other things may be ordered. From an electronic standpoint, if you can get that information to the ordering physician and the patient as early in the process as possible, it's great. A lot of these orders move around on paper, though, and that inherently has some issues.

We've noticed with some of our much more expensive service practices, they may be reaching out to the patient up front and sending an email notification to that patient that then gives the patient the ability to authenticate from a HIPAA standpoint. Then it's a notification that a service is about to be performed and to understand your estimated benefits, please click this link, and then you have to authenticate for security reasons.

You've offered us an important approach to preapprovals and clean claims and so on. Al, can you comment on how to manage the patient a little better in a pathology practice?

Al Sirmon (Pathology Practice Advisors): We engage the patient in three ways. The most important one and the one we've dealt with the most is having a good call center. When that patient gets a statement and has a question about it, there has to be a call center where they can get their question answered promptly.

The second is the patient statement, which is the first way we contact the patient. We tell our clients it's a good idea to sit down and look at their statements and if they can understand them, then maybe the patient can understand them. Many times we hear complaints about the EOBs the insurance companies send out. Many people can't understand them because of the way they're worded. It's the same with our patient statements.

The third is the patient portals where patients can see their accounts and even make payments or a payment plan. We didn't see much of that in pathology in the past. We're starting to see it now.

Kwami, would you like to comment on that, not only from a pathology point of view but also from a clinical laboratory billing point of view?

Edwards

Kwami Edwards (Telcor): You do have to have a good apparatus that is structured around the patient. The communication to let the patient know in advance who you are as a laboratory or as an organization and that they may receive a bill is important. It helps the patient to better prioritize that bill when they receive it. It's also important to understand and leverage tools, the various systems out there, to make sure claims are routed to the right jurisdiction, that they are going to the right place with the least amount of involvement from the practice. And it is about a multipronged approach. Being able to deliver statements with various options to pay, recognizing and identifying patients who may qualify as charity or indigent populations, and having a good process around adjustments for that and having portals as well. The best thing we can do is provide a straightforward and streamlined way for patients to understand what's happening. And when they do have questions, make it easy for them to get the information they need.

Bob Dowd (NovoPath): We've worked with some of our multiple entity clients to distribute information to their patients up front that says, "Yes, you're going to be receiving a statement from us but you may also receive a statement from the ABC Pathology Group, which is our partner, and this entity may do this component of your test." So there is no surprise.

Kyle, we're hearing a lot about the burden of preapprovals for testing and the panels that are getting ever narrower and more difficult to enter into. What are you seeing at Xifin with regard to both of these?

Kyle Fetter (Xifin): The issue related to the rollout of laboratory benefit management programs where payers have made an investment in these groups to potentially put utilization controls in front of a lot of testing, from a medical standpoint, has always been that this is critical testing, required within a timely manner in many cases. Delays around things like prior authorizations have been a big problem for laboratories and pathology groups for a long time because at the time an order is received there's a timeliness to it, and generally the one who's ordering it isn't going to do the prior authorization for you. This is a problem that only technology and a business focus from pathology groups and diagnostic companies in general can resolve, and it's two parts.

One, there's an inherent benefit to the pathology group or lab of parts of the prior authorization process, which is that you receive certain medical and clinical information about the patient that if you were receiving an order alone you would not get. So it's okay from a procedural standpoint and technologically to take additional pieces of information from the ordering physician that are ultimately going to be required, things that would typically come off a medical record, to get a prior authorization. It's a nice reason for pathologists and other diagnostic providers to get information clinically on the front end. To make it not a burden for ordering physicians, though, it has to be easy to do.

If there's a requirement that UnitedHealthcare, for example, is driving, make sure you're providing them electronically with a way to fill out quickly the UnitedHealthcare prior authorization form. You need to know up front, then, if this service for this payer requires a prior authorization, and only in that case are you going to put that burden on the ordering physician to do it. That requires technology.

Taking that a step further, you have to then be able to provide that information succinctly to a payer, and what unfortunately happens is even when you put prior authorization numbers in the correct locations on the claims, often you run into issues with the payer where they'll kick it back and say they didn't get the prior authorization number for various reasons, and so you have to be able to handle that from a technology standpoint.

The last piece is that a lot of providers over time have had a prior authorization requirement put in place and then lobbied and/or worked and appealed with the payer to get them to remove the requirement because it is a burden to the ordering process. It slows testing for patients and often it's critical and time-sensitive testing. Providers have had success in getting payers to remove those requirements for time-sensitive testing.

Would anyone else like to comment on preapprovals and preauthorizations? Al, do you see a rising tide of this among the people you consult for?

Al Sirmon (Pathology Practice Advisors): Some but not yet as much as you might think, but I deal strictly with anatomic pathology.

Matt Zaborski (APS Medical Billing): The prior authorization conundrum does tend to lie more on the clinical laboratory side than the anatomic side. Some medical groups capitate certain populations' testing to Quest or LabCorp if they're outpatients, not inpatients. Seema Verma [administrator for the Centers for Medicare and Medicaid Services] indicated on February 11 that this year Medicare as a whole is going to be taking a look at prior authorization, so I would expect some changes to it, at least at the Medicare level, and then you tend to have other payers follow suit.

And there's hope in that? Or is it going to be a great problem?

Matt Zaborski (APS Medical Billing): The claimed goal is to reduce waste and provide administrative simplification. I would expect the process to utilize more online tools and be technology ready.

Any final comments from the group?

Bob Dowd (NovoPath): Your readers should know we're doing everything we can as far as the billing process and the front end where you're doing pre-eligibility, verifying demographics, and so on. We're also doing everything we can software-wise to build in regulations, coding nuances, proper coding, highlighting errors, things like that so when that bill is ready to go out, it has received all the scrutiny needed to minimize reimbursement problems.

We've also done a lot to do automatic appeals where you have the ability to edit your appeal letter, and since everything's digitized, you can combine reports, slides, anything you'd like to do with that appeal. So we're making it easier for people to have efficient billing.

Matt Zaborski (APS Medical Billing): Whether groups are going to bill internally or externally in an outsource model or move from one outsource model to the other, they should focus on picking a partner with whom they can see growth in the relationship, clear communication, and honesty. Those are the people who are going to go over the

issues on a regular basis and put that effort into the relationship.

Kwami Edwards (Telcor): I agree with everything that's been said. Every organization has to find a partner that makes sense for them, can evolve with them, and can develop a great tool and also guide them with a process so they can continue to be more profitable. Collecting more is great, but you don't want to spend more on staff and infrastructure to get there. It means having assistance and guidance from a partner who is going to evolve their thinking and technology—one who will listen and help you get there—and a lot of groups are trying to do that.

Simply switching out the tool you're using isn't the solution. You need to have something that is going to serve you not just for the next year but for the next five or 10 years and be scalable.

Sirmon

Al Sirmon (Pathology Practice Advisors): We've all talked about how billing is getting tougher, but on the bright side we have better tools now—you can almost use the term data mining. Even for a small pathology practice, there's a wealth of information located in their billing system, and now we have the ability to go in there and drill down and extract that, put it out on Excel or a pivot table and you can learn a lot about your practice. We've just got to convince our groups they need to take the time to do that, and with the average group being so small, they need someone to support them in doing it.

Kyle Fetter (Xifin): For many of us that do development in services in this space, we're trying to figure out how to help our customers—pathology groups or other types of diagnostic providers—provide a good experience for their ordering physicians and patients. It's a combination of many things.

If prior authorization requirements are kicking up, whether it's immunohistochemistry or more cytopathology work or things like that, then use it as a touchpoint for your ordering physicians. Whether it's through technology or through time to speak to them, people should leverage these requirements to get closer to their patients and their physicians. That's at the core of any development we're doing from a software or service perspective.