

# Billing vendors adopt and adapt to boost clients' revenue

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*May 2014—From federal requirements to voluntary standards to back-office activities and business tools, vendors of billing/AR/RCM systems share how they are helping their clients. Beginning on page 16 is [CAP TODAY's 2014 guide to lab billing/accounts receivable/revenue cycle management systems](#).*

## How are you helping laboratories and hospitals address the upcoming ICD-10 requirements and other coding standards?

**Bill Taylor, chief marketing officer, Xifin:** Our product was designed from the very beginning to support ICD-10, in that it already has the longer fields for diagnosis codes. We provide a Web portal to physicians that contains an app that assists them in choosing the right ICD-10 code. It uses natural language programming, which can essentially read a narrative diagnosis and possibly even an ICD-9 code and suggest, through a series of questions to the physician, the appropriate ICD-10 code.

**Deb Larson, executive vice president, Telcor:** We were fortunate that our product was always ICD-10 compliant, so we didn't have to do any big conversions. But our customers were getting nervous as to whether it would be universally accepted at the same time, and we thought we should try to help them on that front.

We've always had a diagnosis import, so we allow ICD-10s to be imported and also allow an import for the crosswalk between ICD-9s and 10s. But we added to the product, on a payer-specific basis, the ability to say, 'Are we going to allow 9s or 10s, and what's the effective date for that for each payer?' Then we have rules embedded, so if you got a 9 and it needed a 10, we try to automatically crosswalk it if we can. If we can't, we put it in our error work queue and it can be automatically faxed back to the provider to let them know that the diagnosis code they submitted was incompatible.

While there are a lot more ICD-10 codes than ICD-9s in the laboratory, many of the 9s can crosswalk automatically to a 10. If it's not a one-to-one match, we have to send it to a work queue. In that case, if we have one ICD-9 code that relates to, say, 20 ICD-10 codes, then at least we can narrow it down for the person looking at it and say, 'Here are some possible ICD-10 codes.' It gives them more information to work with if they're in a conversation with the doctor's office.

**Megan Schmidt, director of product strategy, Sunquest Information Systems:** Our products are ICD-10 capable, and many of them have been since 2010-2011. They can store and display ICD-10 codes and can handle 9 and 10 simultaneously during the transition process. Most of our lab clients are now on an ICD-10-compliant version.

We also support other coding standards, such as LOINC, SNOMED, and UCUM [Unified Code for Units of Measure]. These aren't billing codes, but I think LOINC is relevant to the billing/accounts receivable product because some of our payers want to receive LOINC codes with their claims. LOINC provides a lot of information about the test type, units of measure, even the methodology, and I think payers are using that in their analytics with regard to what they will pay for. Laboratories are looking at LOINC strategies from a meaningful use perspective and a general interoperability perspective, and payers are beginning to ask for this information as well.

**Jim Schroeder, senior product manager, Infor:** Our software is ICD-10 ready, and we have features and functionality in the software to prepare clients when they start coding in ICD-10. Using our software, a provider could begin coding in ICD-10 now. We, and our clients, are anticipating that payers may start accepting ICD-10 at different times. Our software will know when a payer becomes effective with its ICD-10 capability and will automatically bill using the ICD-10 or the ICD-9 value, based on the payer's readiness to accept.

## How will your billing/AR/RCM system handle the shift from fee-for-service-based reimbursement to other forms, such as capitated or value-based reimbursement for ACO and CCO contracts under the Affordable Care Act?

**Schmidt (Sunquest):** The fee-for-service reimbursement model helped create the perception that lab work is a commodity to be shipped out. But in financial models like ACOs [accountable care organizations], regionally delivered laboratory work can affect the overall episode of care; in population management, it's clearly an advantage. We feel that a single laboratory providing the vast majority of community testing needs, inpatient and outpatient, is an ideal situation in an ACO model. So the billing system needs to support bundled reimbursement for inpatient work but also be able to manage bringing in work from outpatient care inside and outside the network. Our product has the ability to handle multiple payment schedules and fee types in client lists. We're able to individualize pricing for clients to match their contracts. For example, if you negotiate that a particular test is going to be a high-volume test, you'd like to offer the client a discount on that particular line item but then provide list prices for the remainder.

We're not going to see everything go to value-based reimbursement immediately, although more and more of the community is going to be covered by an ACO model or other type of network. You need to be flexible and still meet your clients' needs and negotiate sales to bring that work into your network laboratory.

**Ellie Vahman, vice president of sales and marketing, SCC Soft Computer:** With the advent of value-based reimbursement, the key is to provide the elements that determine or represent value and quality and make these accessible and decipherable. Finding these elements may require reaching across various systems. Our business intelligence tool, SoftBI, will ultimately provide the ability to combine the data from various clinical systems to help clients determine costs and quality of care, both of which directly affect contracts for ACOs and CCOs [coordinated care organizations].

**Carrie Scott, director of sales, Cortex Medical Management Systems:** Since the Cortex medical billing system is patient based, not claim based, we can provide one patient account that has multiple services/charges, each with its own tax identification number. The billing program then determines and sends out the proper bill—claim, secondary claim, patient or client bill—to that payer. Multiple payments and corresponding adjustments can also be posted to the individual services/charges. This design should work well for traditional and value-based reimbursement.

**Larson (Telcor):** Our full revenue cycle management product has, for a long time, allowed capitated pricing with exceptions. In addition, we allow covered lives billing, quantity-based discounting—different features that encourage that model. For example, some tests would be capitated, meaning they'll be covered at, say, \$5 per month for covered lives. But there are always exceptions—more esoteric tests, molecular tests, services that are more high cost, which may not be included in that capitated pricing. You have to be able to handle all the exceptions and still be able to say, 'For our own insurance, for our organization, we're only going to bill this much per month per covered life.'

Because our analytics are real-time, online, and very user-selectable, clients can monitor their data to figure out how laboratory usage is improving. We also have several customers who use warehouses to combine lab testing data and billing data to do disease-state management: Here's how to optimally test for this disease—how much does it cost to do that? I think people are going to look for more of that type of data to determine if the laboratory is providing the value they need.

**Taylor (Xifin):** The key for labs in this environment is their ability to provide their payer, or whoever's managing the risk, with the level of information that can prove the value of the diagnostic. For example, if you perform a test on a patient that makes a downstream surgery unnecessary, that demonstrates the value of the diagnostic. So laboratories need to provide information systems that are clinical decision-support systems that help physicians order the appropriate diagnostic test and then interpret the result such that the patient gets the right evidence-based therapy. They may also need to provide a patient registry for the physician so the physician can track the

outcome of the patient.

We're providing a technology platform that enables this kind of clinical decision support as an app on our physician portal. We've also assisted a few clients in negotiating a different relationship with payers based on this type of clinical decision support. These are the kinds of offerings that are required for laboratories to participate in new coordinated care models, like ACOs.

### **How does your billing/AR/RCM system assist with claims scrubbing and eligibility checking or other activities that drive efficiency in the billing process?**

**Janet Chennault, vice president and co-founder, Schuyler House:** When clients set up billing in SchuyLab, the bill types fall into three major categories: third-party billing, direct invoices to the physician, and patient billing. Since SchuyLab billing is integrated in the lab information system, you bring the claims into the billing module, and as they come across, SchuyLab checks the requirements field for patient demographics. If you have all the requirements, the claim is set to ready status. If you're missing a requirement, then it comes over set to open status, meaning the claim exists but something needs to be scrubbed. If you manually try to set an open claim to ready, the prompt line will indicate what's missing. Then you fix that and send it to ready.

The crosswalk between the diagnosis code and the CPT code is a module known as medical necessity. Medical necessity checking can be run when the test is ordered, via our Internet module, SchuyNet; or when a claim is entered by an accessions, as the blood arrives in the lab; or in the billing module, when you're trying to set claims to ready.

Another way to increase the efficiency of billing is in remittance capturing. Instead of three people manually entering explanation of benefits information, you get a file from Medicare or Medicaid or Blue Cross and download it. In 30 seconds, it posts hundreds of payments. SchuyLab accepts these 835 transmissions into billing results in line-item annotations of payment status. This enables the laboratory to submit remaining costs to other payers.

**Schroeder (Infor):** The built-in scrubbing capabilities of our software allow it to edit claims as it receives data. If it detects issues that would cause a claim to be unbillable, it drops that claim into an account representative's work queue to be corrected before it goes out to bill. There are rules within the software that let you assign work queues on a very minute level of detail so that it's easy to split up work based on who is most capable of dealing with specific issues, payers, or types of patients. The end result is that you can monitor the types of deficiencies that come up and, using our analytical tool, go back and determine whether training is required for the people submitting the orders and registering patients or if rules could be built into the software that could correct for and accommodate those deficiencies.

**Taylor (Xifin):** The best place to ensure you have a clean claim is in the physician office. The Xifin technology platform uses Web services so that our claim edits can be extended to the physician office in a couple of ways. One is on our physician portal. In addition, we have partnerships with CPOE [computerized physician order entry] vendors where they use our edits in their product. In both cases, when a claim is ordered, all of the edits are performed in real time, and if there are errors, there's an indication right on the portal to the person making the lab order that information is missing or incorrect. For example, the system may tell the physician office that there's a medical necessity edit and an advance beneficiary notice is required; it's difficult for labs to go back and get ABNs. And if there is an error on the claim, we can also automate the error processing on the physician portal, so the physician office will get a notice on the portal that this claim requires a higher specificity of the diagnosis code, missing demographics, or something like that. It's far more efficient and productive for the errors to be corrected before the order gets to the lab.

**Vahman (SCC):** We try to ensure a clean claim before it hits the back office by determining medical necessity at the time of order entry. Using the SoftCompliance medical necessity checking system, each test is checked against the most current LCD/NCD [local coverage determination/national coverage determination] rules to determine whether the test is eligible for Medicare reimbursement. Our SoftA/R invoicing module processes each order

against a series of defined rules and edit checks. For example, an order-consolidation feature provides the ability to meet the requirement for one claim per day. This feature evaluates all tests for a given date of service and merges them into a single claim. The module can also determine the appropriate price based on defined fee schedules that offer numerous levels of pricing definition. All of this is offered as an automated process requiring little to no user intervention.

**Larson (Telcor):** Claims scrubbing and eligibility checking are important, but if your system is archaic and doesn't handle patient portals, credit cards, automated payment posting, automation of the back-end processes for handling appeals and secondary claims submissions, you still have way too many employees. Nobody can afford that any more, not with all the cuts in reimbursement.

We are highly automated in payment posting—not only 835 remittance, but also payments from banks, credit cards, and online patient portal payments with credit cards. We have rules that handle adjustments automatically, as well as next steps in the process. This automation not only promotes efficiency, it significantly improves net collected revenue.

Labs have to get into a re-engineering mindset on their back office, just as they did on the lab testing side of their business. We tell our customers that installing the software is one thing. But it's really during the year after it's installed that you keep implementing more and more automation and re-engineering, because you can't change everything overnight. It's a process; it's a continuous quality improvement initiative.

### **What is your company doing to support laboratory management's need for financial transparency, business intelligence, and analytics?**

**Taylor (Xifin):** The Xifin system is a financial package. We close our clients at the end of every month and balance to the penny. The financials are GAAP [generally accepted accounting principles] and Sarbanes-Oxley compliant and can be directly exported into the lab's general ledger. Without financial integrity, a business intelligence environment on top of crappy data gets you nice pictures of crappy data. The integrity of the data is what's really important.

We create for our clients a cloud-based data warehouse with a world-class business intelligence tool on top of it that performs reporting, dashboards, and business analytics. Our clients can then perform higher-level analytics that help them determine profitability by customer and test. In addition, we offer mobile reporting, where analytics performed in the data warehouse are presented on an iPad or smartphone. This enables sales staff within the lab, before they visit a client, to see the client's volume, test mix, payer mix, and error rate on the client's requisitions. The back office used to do this task for the sales force via a phone call, and now the sales force can self-serve through that feature.

**Larson (Telcor):** We've invested a lot in decision support and key performance indicators throughout our application. If you want to keep the ship on the straight and narrow, and you want to be continuously monitoring your re-engineering efforts, then you need to be looking at your key performance indicators on a daily and weekly basis. How many things do I have in error? What's my productivity in getting those corrected? What's the productivity of my sales staff? How many dollars did I post? How many payments have come in?

Our product lets clients pick the fields they want to monitor in business intelligence, and then they can set up the system to have that information e-mailed to them daily, weekly, or monthly. In the reference lab market segment or outreach business, if you don't have specific information at your fingertips, you're at a real disadvantage. It's one thing to know that your business is profitable, but if you have business lines, you might want to know which CPT codes are profitable, or which doctors. Also, if you want to expand your line of business—say you were primarily a clinical lab but you want to enter the toxicology market or the molecular market—you need to do some modeling and determine if that investment is going to add to your bottom line.

**Chennault (Schuyler House):** We provide lots of reports—some of them canned, some that can be created on an

ad hoc basis—that can help you analyze what you’re doing right and wrong. An important question a lab might ask is: ‘Shall I bring this test in-house? Am I doing enough homocysteines that it’s actually worthwhile to me to get a new instrument or add a new reagent to an existing instrument?’ We can help a client make that determination.

We provide aging reports so the client can see who is and is not paying on time. If somebody isn’t paying on time, and given the overhead of billing this physician five times before he pays, I’m going to renegotiate his fee schedule. We designed these reports for private labs, as most of our lab clients are privately owned, but we do have some government labs, and they need the same capability.□

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*Interviews conducted and edited by writer Jan Bowers.*