Getting paid: policies, pressures, and a power struggle

April 2022—*All things billing, revenue, income, and business-related were tossed around when representatives of four billing companies met online Feb. 14 with* CAP TODAY *publisher Bob McGonnagle. With them were Vachette Pathology founder Mick Raich and Al Lui, MD, of Innovative Pathology Medical Group, Torrance, Calif.*

The No Surprises Act, pathologist shortage, pharmacies, and SARS-CoV-2 testing post-pandemic were just some of what came up. Artificial intelligence too. "In the next two or three years, the payers are going to use AI to deny claims," Raich predicts. "They're going to know which claims are less likely to be appealed when they're billed."

And that will only make more difficult an already tough situation. In the past year, says Kyle Fetter of Xifin, "there's been an increase in the use of the CO-252 rejection/denial code." Chris Condon of APS Medical Billing agrees, saying the job of the carrier "is to figure out ways to not pay pathologists."

Here is more of what the roundtable participants had to say.

CAP TODAY's *guide to billing/accounts receivable/RCM systems begins here.*

Janet Chennault, what are you hearing from your clients about billing?
Janet Chennault, VP of Product Management, CGM SchuyLab, CompuGroup Medical: We have about 100 labs using our billing system, and many of them are in the Caribbean or Canada or other places around the world. We have not heard from even one of them about problems in billing for COVID. We've not had any requests to change a billing submission, a transmission, or some other sort of report. And this no news is big news. Many of these clients are doing complex billing, such as in the islands in the Caribbean where they do testing for cruise ships, which have people from all over the world on them. Yet we're not hearing anything from them. The billing for COVID has been an invisibly easy process for them.

Fetter

Kyle Fetter, what is top of mind for people in the current market and within normal laboratory work billing, outside of COVID, in surgical pathology and molecular testing?
Kyle Fetter, chief operating officer, Xifin: The larger national laboratories are acquiring more than they typically would. There was the Labcorp and Ascension announcement last week, and Sonic Healthcare acquiring ProPath, for example.

There are a lot of people who wouldn't typically be sitting on this much cash and are trying to figure out how to convert that cash by acquiring businesses outside of COVID. That's driving up the multiplier valuation of pathology groups and others because buying groups that are more heavily weighed toward surgical pathology procedures, cytogenetics, immunohistochemistry, et cetera, is a nice way to take COVID-related revenue and use it to leverage yourself into other types of businesses.

Your clients are upbeat because they have cash to expand their business, essentially.
Kyle Fetter (Xifin): They're also trying to figure out where the next source of revenue is going to come from. Acquisition is an easy place for them to focus.

Being acquired must look appealing, I'm assuming, when the big guys are on a buying binge.
Kyle Fetter (Xifin): Especially for those that don't do a lot of COVID testing, it is a good opportunity to get acquired.

Kurt Matthes, what are you hearing from clients?
Kurt Matthes, vice president, RCM service and reengineering, Telcor: Top of mind for laboratories we talk to are things that are impacting immediate operational needs, one of which is the No Surprises Act. It's still an in-progress perspective, trying to determine how to appropriately communicate and adapt operations so patients are billed according to the spirit and parameters of the No Surprises Act.

Also top of mind are the increasing requirements from payers around prior authorization and the need to operationalize that process and try to relieve the administrative burden, no matter where it lies.

Billing/Accounts receivable systems product guide

Dr. Lui

Al Lui, what is your perspective as a provider?
Alfred Lui, MD, president and medical director, Innovative Pathology Medical Group, Torrance, Calif.: With the disclaimer that I'm not in a situation where I'm involved in billing now, I think one of the things hitting pathologists is related to contracting, whether it is having contracts—being in network—or being noncontracted. The No Surprises Act plays into that. I think it's driving pathologists who might've otherwise been noncontracted to sign contracts with any payers they can.

Another item is billing for the professional component of clinical pathology to sustain pathologists' income. The ability to do that and get paid differs markedly from state to state.

One other thing that is not related to billing but to pathologists' attempt to keep their income stable is the recently developing shortage of pathologists. The shortage hasn't yet translated to increased fees for pathology services from payers. So pathologists are working harder to try to maintain the same level of income.

Tom Scheanwald, what are you seeing?
Tom Scheanwald, president and chief operating officer, APS Medical Billing: Professional component billing is still popular, but like billing for other services for pathology and lab, the professional component of clinical pathology is under fire, again. Cigna decided last spring to stop paying the professional component by July 2021. Then it rescinded its decision. And last fall it reintroduced the policy to stop reimbursement for the professional component. For years, Aetna's and United Healthcare's national policy was to not pay the professional component. That's still the case today.

Going back to laboratory, I think there's going to be a significant change in how COVID testing gets paid based on medical necessity, meaning there has to be a reason for the COVID test. A simple screening may come into play when we're outside the national emergency period where it may or may not be paid.

The pressure on payments and fee schedules at the laboratory level is incredible. Kurt mentioned prior authorization denials, but you have to look at all the other denials labs get en masse. They're trying to deal with all the different payer policies and processes out there.

A lot of labs are evaluating where they go from here. How do we get better production, not just out of our billing but out of our own lab operation? How do we better communicate with the referring physicians who are ordering these tests? There are a lot of communication and educational needs.

Zaborski

Matt Zaborski, would you like to add anything?
Matt Zaborski, VP of sales and marketing, APS Medical Billing: I manage a lot of groups that are in hunts for pathologists, and the increasing demand for fresh out of residency, fresh out of fellowship pathologists means higher and higher wages and ownership, without putting in the time to earn that ownership, from the perspective of the groups that are hiring.

Top of mind, too, is general lab staffing. They're spending so much time training and retraining staff, making sure processes aren't falling apart. And their pocketbooks continue to get hit and they have to worry about running a business that has a positive cash flow and meets income expectations while everything else is moving at once, including clinical lab cuts that haven't taken place because of the delays in the PAMA reporting but are still looming next year. And then same with the cuts on the physician fee schedule that were implemented at the end of the Trump administration. There's a lot of uncertainty about what revenue is going to look like while there's greater expectations with the workforce today.

Janet, do you hear some of this from your clients and their laboratories?
Janet Chennault (CompuGroup): What I mostly hear from laboratories that are doing large amounts of active billing, in general, is the result of a failure to philosophically differentiate between production billing and OCD-like meticulous handcrafting, which is to say that using any of the modern lab information systems that do billing, you should be able to do production billing of, say, 80 percent. If you have medical necessity screening turned on, and demographics are in good shape, et cetera, you should be able to do a high percentage of your billing automatically. So the problem I am seeing in clinical laboratories has nothing to do with COVID or reimbursement; it has to do with the philosophy of how you run a billing department.

Al Lui, can you comment on that? There is an excessive individual attention in billing, but for most people there's also worry about claims being rejected and kicked back, is there not?
Dr. Lui (Innovative Pathology): Yes, and I'm glad Janet mentioned that because in our experience it is this slight battle of philosophies—we talked about capturing every billing code. There used to be a mythology among pathologists that the only people who can do that accurately are pathologists. In our experience that's not true. If you have good coders who are backing up what the pathologists do, reviewing the reports, and making certain everything's documented—even, for example, having the appropriate controls noted for immunoperoxidase stains—it makes a difference of a few percent in terms of all the work you do, what might be referred to as nonautomatic billing.

For the billing in a clinical laboratory, most of that's going to be captured by the information systems. The anatomic pathology piece of it is highly individual. It's hard to get pathologists to focus on it. If you have someone with expertise following it and making sure you capture everything, the increased dollars are substantial.

Kyle, can you comment on well-designed automated billing in which everything is going through because it's being prepared properly versus the difficulty in some individual instances, not only in surgical pathology but also across molecular pathology?
Kyle Fetter (Xifin): The difficulty with the historical approach where every claim is touched is profound when you take into account a couple of things. One is the cuts in the fee schedule. The bigger one that gets implemented somewhat more insidiously on the payer side is coverage edits. What they do is start to request medical documentation at a much higher percentage, whether their published policies reflect it or not.

Over the past 12 to 13 months there's been an increase in use of the CO-252 rejection/denial code—request for

additional documentation—for pathology-related services, and not just for molecular pathology services. On some level you end up having a justified concern on the billing side that they have to produce this type of documentation, so they better review it before they release a claim. That's not truly an option for most groups; it's not efficient enough. You have to be able to automate not just the front-end process but also be efficient in how you code. From our perspective a huge focus is, How do you automate? How do you automate the attachment information? How do you automate if you have to do prior authorization?

Payers assume there's automation happening within pathology—perhaps an assumption that digital pathology will make everything faster and easier. It's another gap between perception and what's pragmatically going on in practices. Payers are assuming there are cost offsets within pathology groups, so they're cutting fee schedules. From that perspective, whether you're in a small pathology group or a large one, you must assume you have to automate everything you can so you have enough time to fight the denials on the other side.

Give us an example of what you do for some of your clients that helps with the automation and minimizing denials.
Kyle Fetter (Xifin): Most billing systems have the ability to consolidate codes based on payer requirements in a way that is still compliant. When you know you're going to get a request for additional documentation, we'll set it up so with a given payer, a certain document will get thrown up for review so people can run through their worklist quickly if they need to.

But if they don't need to for a given payer, because all they do is request documentation, we'll attach it in the X12 format automatically. Even if that reason code comes back, the system will reattach it automatically and send it back to the payer. Most of the bigger payers have formats for accepting that; with some of the smaller ones, you configure your systems to send it out via an electronic fax, for example. You can remove the need to touch those. You only want somebody to review a document if you know there's payer sensitivity, in which case you need a quick worklist review process.

Matthes

Kurt, I assume you're doing something similar on behalf of your clients?
Kurt Matthes (Telcor): We see laboratories embracing technology. The last thing anybody wants to do is throw bodies at their problems, especially when there are technological solutions that can bridge the gap. I understand Janet's comment about OCD billing; trying to tackle some of those things head-on is imperative for any billing service or vendor of billing software.

What Kyle described needs to be 100 percent integrated; billing services or vendors that provide billing software need to be doing all the heavy lifting on behalf of labs. Many labs don't have an in-office workforce, so if those activities have to take place, they're in a new paradigm with how they're deploying their teams, because most of them are remote and it doesn't look like that will change.

With the new paradigm comes opportunities. If you were struggling with labor and had attrition during the pandemic, this has opened the doors for you to hire people who aren't necessarily within your region. Labs can now hire people from across the country.

Chris Condon, we know in the pandemic there was a lot of slow pay regardless of the business you were in. That has to be an incentive for automated billing and following up, does it not?
Chris Condon, VP of client services, APS Medical Billing: Absolutely. You have to find those processes and be able to

automate on the front end.

For our large labs, we deal daily with some of the national coverage and local coverage determination denials. We have bad data coming over to us, and we're not getting it over on the front end. We can help automate and get clean claims out on the front end without having bodies on the back end working manually on denials.

Condon

Are you seeing with the carriers any innovation that is helping to meet you halfway in terms of clean claims and processing?
Chris Condon (APS Medical): No. Their job is to figure out ways to not pay pathologists. Kyle is right about the increasing use of CO-252 for additional documentation. They're trying any trick to make it more intensive for us to get our clients their money.

Janet, what's your impression of the situation where the incentives are not loaded in the same direction?
Janet Chennault (CompuGroup): The first thing that occurred to me is, are the CO-252 rejections targeted? Or are they being spewed out by some random, let's-not-pay-the-physician fountain? I would hate to think that sort of thing is still occurring.

Mick Raich, would you like to comment?
Mick Raich, president of revenue cycle management consulting and founder, Vachette Pathology: I see it as a tech war, and it's going to the artificial intelligence side. We see some billers developing unique AI processes, natural text processing where they can read texts and local coverage determinations. You see it with some companies that offer add-on billing services for the front end. They'll use AI to make sure the claim is going to be paid correctly. We see it on the back end with denials, and we know several companies that are developing that.

In the next two or three years, the payers are going to use AI to deny claims. They're going to know which claims are less likely to be appealed when they're billed. On the biller side, they have to figure out which claims are most likely to be paid when it's denied. And the winner of that tech war gets to keep the cash temporarily.

Tell us what's top of mind as you look at the world right now.
Mick Raich (Vachette): The biggest thing I see is the concept of the nine percent pay cuts coming for pathology. If the public health emergency goes away, that will reshuffle the deck and make things interesting for pathologists going forward. We're going to see an interesting power struggle because there are 700 open pathology jobs. Does this create leverage whereby pathologists can ask for more and get more? Are we going to see the Medicare Part A turnaround?

On the laboratory side, it's going to be the evolution of COVID and how we continue to bill that. They're not going to pay for five asympto-matic COVID tests a month. We will have to come to a realization of what's realistic, and every payer will have their own way of denying that.

Would you care to predict who is going to win this power struggle between the shortage of pathologists and the livelihood of being a pathologist?
Mick Raich (Vachette): You're going to see it shift back to the pathologists having leverage. No longer will you see a health system hold a pathology group hostage, because pathologists will be able to say there are 700 open jobs and we'll go work somewhere else. We don't have to take this pay cut in our Part A; we don't have to deal with that.

It will be interesting to see how Labcorp deals with the Ascension pathologists. There are a lot of them, and that could be an interesting workforce going forward.

Janet, what's on your mind as you look at the world now?
Janet Chennault (CompuGroup): COVID will not be the last disease we have to deal with in this fashion, because it is an aspect of nature that somewhere someone has something, and they will probably fly. So we need to strongly endorse having labs in airports, because we need to start having the necessary infrastructure. We need to have the government be able to point to the labs in the airports and say, "Start testing for this. We'll figure out the payments later. The government will cover it for now."

Kyle, in the long term, does this not argue for either greater consolidation under a few providers, or even more governmentalization of laboratories? Public health laboratories tend to be underfunded and understaffed. How would you see this emerging, if you were advising an entrepreneurial lab or pathology group?
Kyle Fetter (Xifin): The government taking over or centralizing the laboratory effort in a case like this doesn't seem to be overly realistic because we struggled with that in California—they claimed there was going to be this great California lab.

What you saw with COVID was a powerful way to do things. The government decided on a price point and within fairly short order there were a ton of companies performing high-quality testing and it was available pretty rapidly. The biggest issue was how many pieces of equipment were available for labs to buy to run the tests. The CLIA process, the local coverage determinations, were fantastic.

You don't want to have lean or underfunded laboratories that don't have the equipment or the capability to respond quickly when there's a public health crisis.

Having laboratories everywhere with high-quality testing capabilities, with laboratory professionals who know what they're doing, who can figure out a new variant or a new type of disease state quickly and provide test results quickly, is critical. Whether they're independent or part of a consolidated laboratory network is less important.

Al, you've seen many ups and downs over the years. Your thoughts?
Dr. Lui (Innovative Pathology): I think the shortage of pathologists is going to drive more pathologists toward an employment model rather than a partnership model. If there's a shortage of pathologists and they demand increasingly higher wages and there's downward pressure on payment per unit, the only way you can shift that to make up for it is to be employed by a health system that can take some of the funds from other areas and shift it to pathologists, because they'll need to in order to get pathologists to work.

To the comment about high-quality labs springing up during COVID, I would also say there were low-quality labs that popped up. The list of labs that the CMS asked to cease and desist was about 150 long, and some of them were because they were functioning without a CLIA certificate. They were being run by entrepreneurs who saw an opportunity because the difference between what the government was paying and the cost of the test was substantial. Some were naive enough to not even realize they needed a CLIA certificate.

Kurt, give us your impression about what you've just heard.
Kurt Matthes (Telcor): As we enter an endemic phase, COVID testing will become more like testing for influenza. Downward pressure for reimbursement is going to be a fact of life as it has been for all the other services laboratories provide. The $100 reimbursement is not going to last long. It will go down, and you're going to have laboratories offer COVID testing like they do influenza testing, at a relatively inexpensive price. And if there's another pandemic, it will be rinse and repeat.

Raich

Mick, I'm going to change the subject and ask you to put your consultant hat on. In the next few years as we see next-generation sequencing and liquid biopsy increasingly become the diagnostic modalities of choice, what will that do for the billing and reimbursement for cancer diagnostics?
Mick Raich (Vachette): You'll see a battle again between great medicine and getting paid for great medicine, and that's the frustration. The insurers will look at this testing and figure out the most economical way to pay or not pay for it.

The beauty of the capitalist system is we're going to continue to come up with great tests and new ways to look at and do things. We will drive the pricing down and continue to drive diagnostic testing to be more accurate. But there will be a tipping point when the payers say, yes, this is a great test, it does provide great results, but we're not going to pay you $3,000 for it; we'll pay $300. We're already seeing some of that in the molecular world—you see a 27-page denial you have to fill out, and you have to go to the second and third levels, and billers are even changing their pricing to accommodate these denials on bigger, high-dollar tests.

And we're seeing more preauthorization on that. You're no longer going to be able to order a $1,500 genetic test and expect it to get paid without preauthorization.

When you go to a cancer center, it's my experience and impression that a lot of expensive testing is performed and somehow the center is able to offer it. Things like the 360-gene panel or the liquid biopsy, which seem to be where most of academic medicine in cancer care is pointing, seem to be altering the way this field works—not now or in five years but maybe in a decade. Al, can you comment on the idea that there could be a paradigm shift in the mix?
Dr. Lui (Innovative Pathology): I think it's true. The way it works now, though, is the academic centers developing these huge panels are relatively unconcerned about whether they're going to get paid for them, because it's so hard. I don't know if we'll get to where you get paid only for something that actually makes a difference. Three-hundred-sixty genes now don't make a difference. Maybe it will become a little more like toxicology, where it's only the drugs of interest that would be paid for, as opposed to everything.

Final comments?
Kurt Matthes (Telcor): More will be revealed in the upcoming year, especially around things like the No Surprises Act. PAMA is not too far off. Downward pressure is a reality. We'll continue to see payers challenge reimbursement, and the laboratories that remain nimble and able to respond quickly in collaboration with their vendors will continue to be successful.

Kyle Fetter (Xifin): Innovation and continuing to move deeper into molecular pathology has to be a focal point for everyone. This is a time to focus on population health, expand your capability and throughput, and look at those increased reimbursement-type procedures.

Mick Raich (Vachette): On the billing side, the pathology group side, or the laboratory side, it's going to be a simple rule of business: The one who is most effective and works hardest will win.

Scheanwald

Tom Scheanwald (APS Medical): We have to be involved at the state and national levels and in efforts that change our pay. We have to get more involved with Congress and in the legislative process in every area.

There's the situation, for example, with the Merit-based Incentive Payment System. It's become so difficult to work effectively around that programming—to get a bonus—that it's become a big burden to a lot of groups.

From a revenue cycle management side, we have to make sure we are taking care of our house. We have to bill and document for everything we do and make sure we get paid at the rates we should.

Dr. Lui (Innovative Pathology): The pharmacies sprang up as the closest thing we have to a public health system, in terms of giving vaccines. They're able to communicate with each other. For example, you can't go to a pharmacy to get your medications filled in large quantities and then go to one down the street and have that repeated because they know nationally what prescriptions you've filled. So the pharmacy has popped up as a substitute, maybe a poor substitute, for the public health system. That's been recognized by the pharmacy chains that are beginning to purchase and put in primary care practices and laboratories. Installing clinical laboratories in pharmacies is not a completely new concept, since this was one of the major ambitions of Theranos.

Pharmacies and telemedicine will play a bigger role in primary care. In this environment and in this new kind of system, pathologists and laboratories would do well to think about whether there are roles for them.