Risk, compliance, pay—a juggling act for labs

Karen Titus

August 2013—Theatergoers don't want to see theunderstudy. Passengers don't want to encounter a series of "flight delayed" messages on the departures board. And while it may not be every laboratory's worst nightmare, no pathologist wants to open a letter from a government agency or payer that starts out, "It has come to our attention," followed with words like "violation" and "false claim."

As an attorney who regularly represents clinical and anatomic labs, among other clients, Jane Pine Wood sees letters like that with some frequency. In fact, she said, she's starting to see more such missives as labs try to negotiate the intricacies of getting paid in a complex reimbursement world. Wood, a member of McDonald Hopkins LLC, Dennis, Mass., guided audience members through the payment maze in a session at *The Dark Report's* Executive War College this spring.

She started with the problem on everyone's mind, at least based on a show of hands: the difficulty of getting paid if you're out of network with a third-party payer. Wood said she gets at least one call a day from clients on how to deal with out-of-network status. "If the private payer has an exclusive or a preferred contractual arrangement with one or more other laboratories, we just can't get in-network," she said. So how should laboratories handle patients who owe large balances?

That's not the only difficult situation confronting labs. Even if labs aren't being deliberately excluded, some may be unable to contract with all the payers. Wood cited as an example a molecular lab that has clients across the country, where contracting with all the payers involved simply isn't feasible.

Wood

Wood had a simple answer for out-of-network labs, but made it clear it was an ideal. In this billing Shangri-La, labs would charge patients exactly what they owed for their out-of-network copayment, coinsurance, and deductible amount. "That's the best scenario," Wood said.

And then there's the real world, where Wood's clients work. "In many, many situations," she said, "they do not feel as though they can be competitive if they are billing patients the full out-of-network balance. How do you manage that and reduce your compliance risk?"

The goal isn't 100 percent compliance. Labs need to realize, however, that some risk remains whenever they reduce part of a patient's balance. When it comes to collecting balances, labs have a balancing act of their own.

When labs reduce patient balances to stay competitive, the risks increase. But labs can't afford to ignore market forces either. If patients are charged the full out-of-network balance, they're likely to complain to their physician, who may then call the lab and ask why. Or, a lab's marketing staff may hear, during a sales call, that competitors are offering physicians deals in which patients may never receive a lab bill—and then be asked to match that. Ditto for deals that cap total out-of-network payments for patients or limit patient bills to *X* amount of dollars.

Amid those pressures, it can be easy to lose sight of basic obligations. "From a legal standpoint," Wood reminded her audience, "remember that the patient is the one who owes you." Not the payer—the patient, although the two are intertwined. The third-party payer's obligation depends on what the patient owes, so as the lab adjusts that

amount, the amount the payer is responsible for will adjust accordingly, at least from a legal perspective.

Say a lab bills a test at $100. In-network, the payer amount is 80 percent; out of network, it drops to 60 percent. In the latter case, if the lab decides to bill the patient $20 (the in-network difference) or not at all, the lab's risk has just shot up. The third-party payer has a decent argument under federal and most state laws to say the lab has submitted a false claim, Wood said, "because on the day you submitted that claim, you already knew you weren't going to bill the patient the full $40, because you knew competitively that you couldn't."

In other words, said Wood, the payer can argue, "We believe you filed a false claim with us for $100 because you never intended to collect $100 from the patient." An increasing number of her firm's clients, she said, are receiving "very stern, very scary letters from third-party payers," making essentially that argument.

Payers are savvy, she said. Some are sending such letters to referring clinicians, drawing physicians' attention to the fact that they're sending testing to a lab that waives patient balances. Wood says the letters are carefully worded and usually ask whether the clinicians are aware the lab may be violating false claim laws. "Which means my clients are now getting frantic calls from the clinicians saying, 'You're violating federal law! We can't send work to you if you're filing false claims.'" It is, she said with understatement, a marketing nightmare.

State laws have their own peculiarities. Many have prohibited advance agreements to waive a portion of the patient balance; some states, including Florida and New York, say that when such agreements exist, payers must be told. Said Wood: "The New York Department of Health has sent nasty letters to some New York licensed laboratories saying, 'It has come to our attention you're waiving a portion of the patient balance. We view this as a violation of New York laboratory regulations,' which could even put the lab's New York license at risk."

Most of these problems hinge on that advance agreement, Wood said, so it's worth distinguishing such actions from those that happen after the fact—when, for example, a patient calls to complain about a bill. Once a lab makes a marketing statement that it will limit payments in some form, she said, it has put itself in potential violation of the law. It's even worse, she added, when a lab is a participating provider but still markets such agreements, even going so far as to agree not to bill patients for in-network balances. Doing so violates the payer contract.

Wood concedes it may be difficult to muzzle sales and marketing staff who make these promises. But labs can limit their exposure by scrubbing their Web sites and printed marketing materials to remove mentions of caps and representations of waivers. Wood gives that advice to her own clients, some of whom have received in the mail their own incriminating marketing material or screenshots of their Web site, stapled to threatening letters.

Better, she said, to use terms like "patient-friendly billing policies." Or, if the materials are aimed at patients, note that the lab is happy to work with patients to make the testing affordable. That can help labs stay competitive and moves troublesome advanced agreements to after-the-fact actions.

When patients do call to discuss billing, Wood urges labs to pay attention to the reasons for those calls. If a patient has lost his or her job, for example, then financial hardship comes into play. If labs reduce balances for such reasons, they have far less to worry about. Whether the payer is the government, private insurer, or patient, she's not losing sleep over a documented, bona fide financial hardship. "And I recognize that term has a lot of different meanings to different people," Wood said.

All labs should have financial hardship policies, she said, though the details can vary. Maybe you require documentation from patients; maybe you don't. Maybe you take the patient's word for it; maybe you rely on the clinician's word. But, she said, don't have a policy that tags every uninsured patient as a financial hardship case. Physicians are increasingly saying to labs that all their patients have financial hardships, she finds. "Unless it's a free clinic, I really don't buy it," she said.

When a patient calls to complain about a balance, that's a different matter, and it can go in a couple different directions.

If a patient recognizes that he or she owes significantly more on a copay than would have been owed if the work had gone to a large, national laboratory, it may be easy for the lab to rationalize (though Wood didn't suggest that this is 100 percent compliant) offering a so-called prompt payment discount—*if* the patient provides a credit card number or sends a check within the following week or two. In other words, payment within 90 days shouldn't trigger a "prompt payment" discount. She also prefers to avoid reductions that are below the in-network amount.

Deductibles are trickier to negotiate because they're intertwined with the payer. If the lab agrees to reduce what the patient owes on a high deductible without notifying the payer, the payer then has grounds to argue the lab engaged in collusive behavior with the patient to defraud the insurance company.

If labs do decide to reduce patient deductible amounts, Wood advises notifying the insurance company and perhaps resubmitting the claim. "Although I recognize it's a paperwork nightmare."

Not all of her clients are convinced. They ask her, Who cares about this? Will the payer ever find out? Will it really matter?

It does matter, says Wood. Payers do find out. And those who care—it may not be who you think—are driven folks.

She should know. When the situation has come up, "Many times I actually represent both labs," she said. "I'll have both of them calling me to complain about the other side, so I get to hear both sides of the story." The story boils down to competitiveness and sales reps who lose compensation because of sketchy marketing and billing techniques. Don't kid yourself, Wood said: Sales reps who lose compensation are motivated to "squeal on you."

"That's primarily where the complaints are coming from—sales and marketing people who are losing the work based upon a competitor's billing activities," she said.

Health savings accounts present their own enigmas. Oftentimes patients will want to negotiate after the third-party administrator has paid the bill. Wood is sympathetic: "These are their dollars." But even if you agree to reduce the amount, not all third-party administrators will take the HSA balance back from the lab once the bill has been paid, arguing that the books have been closed. That leaves the labs to return the money directly to the patient.

Again, labs need to steer clear of collusion. If you agree to reduce the amount, send a letter to the patient and copy the third-party administrator, letting everyone know that you've reduced the price and that you suggest the patient return the money to the HSA. That way the lab is on record that the HSA won't accept the balance. "Just a way to protect yourself there," Wood said.

Wood had no shortage of billing strategies to help labs, which she readily shared.

Labs can, for instance, notify payers in advance that they don't intend to bill patients the copay amounts or that they intend to cap the amount they bill patients.

It's not a sure bet. It's possible, she said, that some payers would respond by reducing the amount they pay the lab. (In fact, several of her clients explained their patient caps on their Web sites—and a large payer responded by saying it considered the entire charge, and therefore payment, to be reduced accordingly. With the attached printouts from the Web site, she said, echoing her earlier warning, it was "very difficult to argue against that one.")

But it's also possible that such a letter will get lost in a pile of paperwork. The lab at least has some documentation that it advised the payer. If you go this route, send the letter via certified mail, with return receipt requested. Wood says labs in New Jersey are starting to adopt this strategy, and so far payers have been quiescent.

What about billing strategies when you can't get in-network?

Sharing success stories from her clients—but acknowledging they won't work in every scenario—Wood offered the following guidance.

One option: Perhaps you know a lab or referring clinicians who are in-network. Would it be OK to sell or subcontract

the testing to the in-network lab, which would then bill for the work?

“Maybe,” said Wood, who concedes that clients despise answers that contain the phrase, “It depends.” But it’s worth parsing the details, she said.

First, does your state prohibit client billing or restrict selling of lab services? Many states won’t allow physicians to buy and rebill laboratory testing, and they vary on whether their laws limit clinical lab work or anatomic pathology; moreover, some limit only professional AP, others global AP. “Some are antimarkup, some are disclosure states.” State laws, she said, are a “mishmash.”

It’s not just the labs that are bound by these laws. Prospective purchasers might be constrained as well, depending on who the purchaser is. Most state restrictions exempt hospitals, Wood said. Many exempt other independent laboratories. But not all states do. And physicians often aren’t exempt. Prospective purchasers also need to consider state laws regarding Medicaid.

Payers matter, too. In the case of the Medicare Advantage Plan, default Medicare rules apply—and those rules don’t permit physicians to buy Medicare clinical lab testing and rebill it.

Look at your payer contractors as well. There’s a good chance that if you’re an in-network lab, your contract doesn’t allow you to subcontract work without the payer’s permission.

True, independent labs have purchased work from others and rebilled private payers for decades, “and with a few exceptions, no one’s cared.” But Wood has started to see these laissez-faire attitudes becoming less *laissez*, as evidenced by a trickle of, “It has come to our attention. . . .” letters now coming to her clients. The words “in violation of your contract” aren’t far behind. And nine times out of 10, she said, the contract in question does indeed prohibit this type of billing. Such cases are cropping up in Florida, New York, California, and New Jersey.

How are payers finding out? As with the discounted deductibles, disgruntled sales reps appear to be the ones sounding the alarm. And again, the billing laboratory risks having those dollars recouped. Labs need to be aware that if payers audit claims, it’s easy to determine, through the CLIA number on the report, if the testing was done elsewhere, she added.

If all these caveats sound petrifying, there’s a reason. Wood, being an attorney, doesn’t mind pointing out dire possibilities. But subcontracting arrangements aren’t forbidden. Just be aware of—and, of course, avoid—the aforementioned snares, she said.

Not bad advice overall. Labs need to compete and accept risk, but not to the point of acting foolishly. After all, no one wants to start getting scary letters in the mail.

Karen Titus is CAP TODAY contributing editor and co-managing editor.