Volume XXVI, Number 5 Monday, April 8, 2019

Specialized Information Publishers Foundation
EDITORIAL EXCELLENCE AWARD WINNER

From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE BUSINESS INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs / COOs / CFOs / PATHOLOGISTs

Restricted information, see page 3

COMMENTARY & OPINION by...

R. Lewis Dark
Founder & Publisher

What Have We Done for You Lately?

OUR EDITOR-IN-CHIEF JUST FINISHED the daunting task of confirming 125 speakers for more than 80 sessions for our 24th annual *Executive War College on Lab and Pathology Management*. It is our biggest conference ever! These facts are significant to you for an important reason.

The planning phase for an *Executive War College* requires requires hundreds of phone calls with lab vendors, lab consultants, pathologists, and clinical lab executives. These phone calls are concentrated in a 90-day period and produce two outcomes.

First, they allow THE DARK REPORT to identify innovative lab organizations, pathologists, and lab administrators who are willing to share their successes and lessons learned at our conference, which will be in New Orleans on April 30-May 1. Second, each of these phone calls produces valuable intelligence on the latest developments in the market for clinical laboratory testing and anatomic pathology services. This benefits you as a client and regular reader of THE DARK REPORT because this knowledge—and our strategic understanding of these developments—is presented in the intelligence briefings we publish.

What you'll read in this issue of THE DARK REPORT demonstrates the value of the intelligence network cultivated by our Editor-In-Chief. The lead story is about the clinical lab industry's first revenue-producing use of an aerial drone to move medical laboratory specimens from a physicians' office to the **WakeMed Health** laboratory in Wake Forest, N.C. *(See pages 3-5.)*

Our interview with the WakeMed pathologist coordinating this project with federal and state agencies, **UPS**, and **Matternick**, the drone manufacturer, gives you an insider's understanding of this innovative use of the latest drone technology.

Equally important is the story that follows about the new NCCI guidelines that were announced late in 2019. Made "without notice or stakeholder input," these guidelines are recognized to be disruptive to how labs code and bill, causing nine national lab industry organizations to send a letter to Medicare officials requesting that the new guidelines be withdrawn.

These examples of timely information demonstrate that when the staff here at THE DARK REPORT ask themselves the question, "What have we done for you lately?" they can answer in the affirmative! TDR

WakeMed Uses Drone to Deliver Patient Specimens

In a first for clinical labs, North Carolina system uses a quadcopter to deliver patients' samples

CEO SUMMARY: For two years, clinical lab professionals at WakeMed Health and Hospitals have tested the use of aerial drones to transport patient specimens from a physicians' office satellite lab/draw station to the WakeMed Medical Center's central lab. Late last month, they completed the first successful revenue-generating commercial transport of lab supplies by drone in the United States. The satellite lab now sends urine, blood, and other patient specimens for routine testing to the main lab.

LAST WEEK, the clinical laboratory at **WakeMed Health and Hospitals** in Raleigh, N.C., used a quadcopter drone to fly patients' specimens a distance of 1,377 feet from a medical complex of physicians' offices to the health system's clinical lab!

The shipping of specimens followed more than two years and more than 100 test flights. During one test on March 26, the staff of WakeMed's clinical lab worked with teams from **UPS**, the **Federal Aviation Administration** and the **North Carolina Department of Transportation** to conduct the first revenue-generating flight of an aerial drone to send supplies from the **Raleigh Medical Park** to the lab at the **Raleigh Medical Center** and back.

This test was one of the last test flights to transport specimens potentially containing bloodborne pathogens and to collect temperature stability data before going live with patients' specimens. "We completed more than 100 test flights to ensure the drones can operate on an every-hour-on-the-hour pick-up schedule and we're satisfied in that regard," said Michael H. Weinstein, MD, PhD, Director of WakeMed's Pathology Laboratories.

In addition to working with the FAA and the state DOT to secure the requisite approvals to use drones for specimen transport, the staff at WakeMed worked with delivery company UPS and **Matternet**, a company in Menlo Park, Calif., that manufactured the drone.

Following the successful completion of the test on March 26, the physicians and clinical lab staff took another step forward last week by using the unmanned autonomous aerial drone to transport patients' clinical laboratory specimens over the same distance from physicians'

THE DARK REPORT Intelligence Briefings for Laboratory CEOs, COOs, CFOs, and Pathologists are sent 17 times per year by The Dark Group, Inc., 21806 Briarcliff Drive, Spicewood, Texas, 78669, Voice 1.800.560.6363, Fax 512.264.0969. (ISSN 1097-2919.)

R. Lewis Dark, Founder & Publisher. Robert L. Michel, Editor.

SUBSCRIPTION TO THE DARK REPORT INTELLIGENCE SERVICE, which includes THE DARK REPORT plus timely briefings and private teleconferences, is $15.27 per week in the US, $15.27 per week in Canada, $16.05 per week elsewhere (billed semi-annually).

offices at Raleigh Medical Park to the lab at WakeMed's hospital in Raleigh.

"My part in this project is to explore the evolving capabilities and to determine if using drones can either be commercially advantageous or provide advantages in patient care that cannot be obtained in any other way," Weinstein said in an interview with THE DARK REPORT.

As most clinical labs do, WakeMed uses couriers in cars and trucks to transport patients' specimens. But over the next two years, WakeMed will test how many deliveries drones can make. "We expect to have drones running on a regular schedule from the medical campus to the main hospital laboratory," he said.

As Richard Stradling reported for the *Raleigh News and Observer* on March 27, "A white drone with four rotors appeared over the roof of WakeMed's main hospital on Tuesday morning and landed outside the front doors carrying a small brown box with a UPS logo on the side." For this unmanned test flight, the drone carried the supplies on a programmed route. Now, that white drone will make regular trips on that same route.

Doctor Was Formerly a Pilot

For this project, Weinstein worked closely with Stuart Ginn, MD, an ear, nose, and throat surgeon at WakeMed and Medical Director for **WakeMed Innovations**. Ginn is an important member of the team because he previously worked as a pilot and flight instructor before becoming a surgeon.

WakeMed and UPS used Matternet's M2 four-rotor quadcopter, which runs on a lithium-ion battery and can carry a five-pound payload as far as 12.5 miles before the batteries must be recharged. Like all aerial drones, the M2 vehicles are limited by regulation because they can fly only in a line-of-sight fashion, meaning they cannot be out of view of the operator.

"This flight was the first of its kind in the United States because it was a revenue-generating flight of an unmanned drone," said Ginn. "This is one of the first of several steps we're taking in this project. Right now, we're approaching the use of drones to deliver medical laboratory specimens very cautiously while we consider what drone flights can do for our patients and for the health system."

Drones Moving Specimens

At least one other clinical laboratory has tested using drones to deliver supplies or specimens. Two years ago, researchers from **Johns Hopkins** published an article in the *American Journal of Clinical Pathology* based on the results of a test to deliver chemistry and hematology samples. Since 2016, UPS has worked with the government of Rwanda in East Africa to use drones to deliver blood to transfusion facilities on demand.

WakeMed's is the first routine flight for revenue in the US. "We're standing on the shoulders of those other projects," Ginn said of Johns Hopkins and UPS.

As of March 26, the use of the drone had passed more than 100 such tests. "Right now, we're in this first level of development in which we're aiming to prove that drones can work both from the point of view of specimen integrity—meaning specimens don't get too hot or too cold and they don't get smashed up," said Weinstein. "Also, we need to be concerned about the safety of the community because, for example, there's a road that the drone passes over as it goes from the medical complex to the hospital labs."

A crashed drone carrying patient samples could create a biohazard on a public street. "We need to be careful about what types of specimens we're putting into the drones," Weinstein said. "Therefore, we won't transport specimens such as biopsies that can't be replaced, or cerebrospinal fluid that would be very difficult to replace. Those things will not go in the drone, at least for the near-to-intermediate term.

"While we would hate to lose any patient specimen, the plan during this pilot is to transport things like blood or urine where the patient can return and we

Goal Is to Explore Use of Aerial Drones To Save Money, Cut Lab Turnaround Times

AMONG THE BENEFITS OF USING A QUADCOPTER AERIAL DRONE to transport patient specimens from physicians' offices to a lab is that they can take off and land vertically and then fly horizontally, said Stuart Ginn, MD, a surgeon at WakeMed and Medical Director of WakeMed Innovations, a team of professionals who develop and implement ideas for improving care. Before becoming an ear, nose, and throat surgeon, Ginn was an airline pilot and flight instructor.

An aerial drone flying at 40 miles per hour could reduce the time for delivery from physicians' offices at Raleigh Medical Park to the hospital lab from about 30 minutes by courier to just over three minutes by aerial drone, according to UPS. Also, a drone would not be subject to delays that traffic can cause for couriers in cars or trucks.

Once specimens are loaded onto the drone at the physicians' office park, the quadcopter would fly on a preprogrammed route to a fixed landing site near the hospital's central lab. A remote pilot would monitor the drone's flight.

In the future, aerial drones may be used to improve lab turnaround time because they could get patient specimens to the lab more quickly than it might take a courier in a car, said Michael Weinstein, MD, PhD, Director of WakeMed Pathology Laboratories. And unmanned drones may be less expensive to operate, he added.

For now, improving daily TAT is not a significant goal for the drone program, he said, but drones could be used to speed the delivery of time-sensitive specimens. "Currently, we plan to use the drone to transport blood and urine primarily for routine laboratory testing," he commented.

Given that the distance from the medical park to the hospital is less than 1,400 feet, WakeMed's lab administrators considered installing a pneumatic tube system. "It was decided the capital investment to put a pneumatic tube under the road exceeded the value of just continuing to run couriers," Weinstein explained. "But getting the drone to function optimally would be almost like having a pneumatic tube system.

"In the medical park, we have phlebotomists who collect specimens and could carry them to the drone and send the drone to the landing spot right next to the hospital where they will get transported to the core laboratory," he said. "There, those samples will go into our large automated laboratory that handles almost two million tests yearly."

can recollect that sample," he explained. "It's not desirable, of course, to have a patient return to give another sample, and we don't take it lightly that we are transporting patient specimens."

Ginn agreed, "This system has been thoroughly and carefully vetted to absolutely minimize the risk to everyone involved. I say that from an operational standpoint and from my background in aviation. Everyone's role in this project has been all about risk mitigation, and, the FAA's role has been to ensure safety. That's what they do."

Over the next 24 months or more, WakeMed and UPS plan to expand the use of drone deliveries.

"The scope of the project over the next two years or so is to expand this transport network to include basically our larger facilities," Weinstein said. "We would anticipate that at the end of two years, we will be collecting clinical laboratory specimens from at least two of our three hospitals." **TDR**

—Joseph Burns

Contact Michael H. Weinstein, MD, PhD, at 919-350-8260.

Nine Lab Groups Say New NCCI Policy Is Inconsistent

➤Changes issued in December appear to create conflicts with earlier guidance from CMS, the AMA

➤➤CEO SUMMARY: By its name alone, the National Correct Coding Initiative (NCCI) Policy Manual implies that it will be accurate and consistent with other coding initiatives. But nine groups representing various clinical laboratories say NCCI guidelines that the federal Centers for Medicare and Medicaid Services issued in December and implemented on Jan. 1 are inconsistent with guidance NCCI issued previously and inconsistent with guidance from the American Medical Association.

"HIGHLY DISRUPTIVE" IS HOW NINE NATIONAL ORGANIZATIONS representing clinical laboratories and pathologists describe the new federal government guidelines for the coding of and payment for some clinical laboratory and pathology tests. This level of disruption is so severe that the lab industry groups have asked federal officials to withdraw the new guidelines..

Late last year, the federal **Centers for Medicare and Medicaid Services** (CMS) issued guidelines to the Pathology and Laboratory Services section of the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services. Because the changes also were made in the Policy Manual for Medicaid Services, the revisions affect payment made to labs for both Medicare and Medicaid beneficiaries.

➤Request for Comment

CMS did not reply to a request for comment from The DARK REPORT.

The new guidelines seem to have had the effect of making CMS' so-called correct coding initiative anything but correct, according to W. Stephen Black-Schaffer, MD, a pathologist at **Massachusetts General Hospital** and the Associate Chief, Education and Training, at MGH. He's also an Associate Professor of Pathology at the **Harvard Medical School**.

At issue are changes CMS issued in Dec. 12 and that went into effect on Jan. 1, less than three weeks later.

➤Letter from Lab Groups

In a letter to CMS Administrator Seema Verma, nine organizations representing clinical laboratories and pathologists complained that the changes were made "without notice or stakeholder input." What's more, the changes will be highly disruptive to coding and payment for clinical lab and pathology testing, the groups said.

For these reasons, the changes should be withdrawn, and CMS should work with clinical lab directors and pathologists to revise the guidelines, said the letter dated March 17.

The guidelines issued in December are problematic for two reasons. First, labs may not know how to bill for the tests involved, Black-Schaffer said, and

second, when CMS changes the NCCI Policy Manual, it does not routinely seek input from labs, as it does for formal rule-making.

"Any evaluation of these policies should reflect the current standard of care in test ordering and performance and include an opportunity for stakeholders to review and provide comment on draft policies prior to their finalization and implementation," the letter said.

Nine Lab Associations

The groups signing the letter were:

- **AdvaMedDx**;
- **American Association for Clinical Chemistry**;
- **American Clinical Laboratory Association**;
- **American Society for Microbiology**;
- **Association for Molecular Pathology**;
- **Coalition for 21st Century Medicine**;
- **College of American Pathologists (CAP)**;
- **Physician Fee Schedule Pathology Payment Coalition**; and,
- **Point of Care Testing Association**.

As a representative of CAP, Black-Schaffer was unaware if Verma had responded to the letter as of the last week of March.

Many Laboratory Tests

The guidelines affect "laboratory procedures," an ill-defined term that could apply to a large number of molecular and genetic tests that involve multiple steps, producing multiple results. Many such tests are done using next-generation sequencing. As its name implies, NGS automates multiple sequencing steps, Black-Schaffer added, resulting in multiple potentially reportable results.

"It's probably too early to tell for sure what's happening as to whether laboratories are getting paid or if they know how to bill for these tests," Black-Schaffer told THE DARK REPORT. "That's because it's up to the various Medicare Administrative Contractors (MACs) to implement these new rules.

What Do Guidelines Mean?

"To do that, the MACs must figure out what the guidelines mean first," he continued. "Then, on the other side, laboratory service providers must figure out what they mean as well."

The edits could create significant problems for providers of Medicare and Medicaid pathology services for two reasons: They're inconsistent with the previous NCCI policy manual instructions and they're inconsistent with the general coding guidance from the AMA, Black-Schaffer said.

Inconsistent coding instructions are a nightmare for any lab seeking to bill for such tests and hoping to get paid quickly and in full because any test billed incorrectly can be rejected. Or, if the test claim is paid and an auditor later determines the lab should not have been paid, the laboratory must repay that amount or Medicare or Medicaid can demand repayment.

"Anytime there's an inconsistency in coding instructions for lab tests, there's a possibility that a lab will get its coding wrong," added Black-Schaffer. "This means either it gets paid when it shouldn't, or, the laboratory might not get paid when it should."

How to bill and whether clinical laboratories and anatomic pathology groups will get paid are the most significant problems with the NCCI guidelines this year, he explained. But how and when CMS makes changes to the coding guidelines often creates problems, he added.

"The NCCI manual comes out every year, and when it does, we will sometimes get asked a question about a particular issue," Black-Schaffer commented. "At other times—as in this instance—federal officials basically say, 'Here is the NCCI manual for the coming year,' and we have to comply with it.

"The changes this year were inconsistent with earlier guidance and those changes were issued shortly before they were implemented," he continued. "Thus, laboratories found out less than three weeks before the changes went into effect. Labs also had no opportunity to ask questions.

"Lab billing staff have questions about when these reportable results are supposed to be grouped together or split apart," he added. "Then, if a lab follows the NCCI manual, it may not be following the correct coding guidance from earlier NCCI guidelines or the guidance from AMA.

"Aren't all those sources of guidance supposed to be consistent with one another?" he asked. "That lack of consistency is a problem for billing departments because they try to code correctly and the last thing they want is to have problems in their billing departments."

Questions about Guidelines

Asked which tests are affected by the new guidelines, Black-Shaffer said that depends on many factors. "The answer really depends on what is meant when we use the term 'laboratory procedure' to describe a test," he said. "Typically NGS testing produces many reportable results that are relevant to the patient's condition. So in that sense, the new guidelines potentially could be applied quite broadly.

"It means that for general purpose laboratories, the rate of molecular testing that produces many reportable results may be a small fraction of their overall testing volume," he explained.

"However, there are a number of molecular pathology laboratories for which this is what they do for almost every test," noted Black. "These molecular and genetic testing laboratories are not going to want to wait for guidance because they want to get paid. Yet, they don't know how to bill in a compliant fashion. Neither of those alternatives is very attractive."

CMS said that on Feb. 1, the NCCI Medicare and Medicaid Program Contract was awarded to a new contractor, **Capitol Bridge LLC**. Capitol Bridge will instruct other MACs about how to implement the NCCI guidelines, Black-Schaffer explained.

Opportunity to Work Together

Black-Schaffer made a point of saying that he was not critical of Capitol Bridge. In fact, he added, given that Capitol Bridge was recently named to the NCCI contract, the laboratory industry and CMS have an opportunity to work together and with representatives of Capitol Bridge to implement the changes.

"By necessity, clinical labs and CMS need a formalized process for review and input for changes to the NCCI policy manual," he commented.

"If you think about it, the name NCCI means its goal is to do correct coding. And how could anybody be against that?" Black asked. "The problem is that if there is not a process involving all stakeholders, it isn't necessarily going to be correct coding.

"In this instance, the process produced demonstrably incorrect coding advice because this year's changes are inconsistent with earlier coding advice," he added. "It's unclear what CMS was hoping to accomplish with these changes.

Hopes for Two Outcomes

"The nine lab associations that sent the letter to CMS hope there are two positive outcomes," noted Black. "First, that this specific set of instructions in the NCCI policy manual be rescinded and revised to whatever the real intent was with these changes.

"Second, that the problems we've seen this year—and the fact that we have a new contractor—will lead to a better and more formalized process that will work reliably in the future," he concluded. TDR

—Joseph Burns

Contact W. Stephen Black-Schaffer, MD, at 617-724-1463.

For Clinical Laboratory and Pathology Billing, Latest NCCI Coding Guidance Raises Questions

IN A LETTER TO THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, nine clinical laboratory associations complained about changes CMS made to the National Correct Coding Initiative (NCCI) Policy Manual.

The letter sent March 17 had an example of a problem that affects payment for some lab tests for Medicare and Medicaid beneficiaries. An instruction in the NCCI policy manual states that if a lab procedure produces multiple reportable test results, labs should use only a single HCPCS or CPT code for the procedure, the letter said. "If there is no HCPCS/CPT code that describes the procedure, the laboratory shall report a miscellaneous or unlisted procedure code with a single unit of service," the CMS guidance says.

Which Code to Use?

That guidance alone raises difficult questions. For example, does it mean each lab producing multiple reportable test results would choose a code to apply to such results? If so, would different labs choose different codes in such situations? If different labs use different codes, how would Medicare contractors or any Medicaid managed care plan know which lab test is involved?

In the letter, the nine groups said, "This instruction is overbroad and unclear. It is unclear what constitutes 'a laboratory procedure' per the new manual revisions. Many laboratory tests are performed in batches or using multiplex processes that produce multiple, different, clinically significant reportable test results."

What's more, the letter said, if each batch or multiplex process is treated as a single procedure, tests ordered for different patients but processed in a batch could constitute a single procedure.

"Additionally, if each test performed using a multiplex process is considered a single procedure, many procedures that currently are reported with test-specific codes would need to be reported using miscellaneous or unlisted procedure codes," the letter added.

Doing so would create five significant problems, the nine groups explained. These changes would:

- Violate AMA guidance to use the most specific CPT codes;
- Make it difficult for Medicare claims processors to determine which tests were performed;
- Put a heavy claims processing burden on Medicare Administrative Contractors (MACs) and state Medicaid programs;
- Cause substantial delays in payment for laboratories; and,
- Limit the data CMS needs to set rates under the Protecting Access to Medicare Act (PAMA).

"All the signatories to this letter are concerned that these NCCI guidelines are an impediment to the normal processes that laboratories use when billing for these tests," said W. Stephen Black-Schaffer, MD, a pathologist at Massachusetts General Hospital and an Associate Professor of Pathology at the Harvard Medical School.

CEO SUMMARY: Many anatomic pathology groups are watching their revenue decline and margins shrink on the same or greater case volume. These trends make it imperative to have a deeper understanding of the operational and financial variables that contribute to stability in the group's finances and pathologist compensation. One expert on the financial complexity of anatomic pathology operations provided insights into how these groups can analyze their coding, billing, and collections operations and improve expense management.

Anatomic pathologists may be missing key performance indicators

AP Groups Can Protect Revenue, Pathologist Compensation

PART ONE OF A SERIES

It's been said that if you don't know what your business spends and what it generates in revenue, then those numbers are likely much worse than you think.

For Al Sirmon, co-founder of **Pathology Practice Advisors** (PPA) in Columbia, S.C., that warning is particularly significant for pathology groups. In over two decades as a practice consultant, he's seen pathology groups that don't have accurate numbers on their revenue and expenses. Consequently, they assume their finances are much rosier than the reality of their group's situation.

Since co-founding this consultancy in 2016 with Chappy Manning, RN, CPC, CPMA, Sirmon has learned that many AP groups—when attempting to manage their practices to optimal levels of revenue and pathologist compensation—fail to use the best key performance indicators (KPIs) that can be developed from every group's billing reports and financial statements.

Stated differently, many pathology groups have not regularly updated their coding/billing/collection and financial reporting systems in ways that allow them to do two things. One, to extract accurate, detailed information that allows them to better manage revenue and reduce costs. Two, to access this information in real time, so as to intervene more effectively.

Most physician groups, anatomic pathology (AP) practices, and other healthcare providers get their advice from practice management consultants and certified public accountants. In an interview with The Dark Report, Sirmon said these advisers are well versed in the basics of accounting, taxes, and business management.

Yet, noted Sirmon, these advisors often don't fully understand the unusual characteristics of the anatomic pathology profession and how to help pathology groups boost productivity, revenue, and partner compensation.

"Management consultants and CPAs are knowledgeable about the problems and idiosyncrasies inherent in the standard medical practice's billing, collections, and accounts receivable activities," stated Sirmon. "By contrast, AP groups with their own histology labs are not like most other physician groups.

Histology Lab Activities

"Pathology groups with these histology labs are more akin to small manufacturing companies," he observed. "That's why AP practice advisers need to understand the process involved in preparing slides for review."

Sirmon can make these observations about practice management consultants and CPAs because he practiced as a CPA for many years. He no longer retains his CPA license, however, because he does not practice accounting in his current role.

Since 2016, Pathology Practice Advisors has performed reviews of the coding compliance and billing performance of more than two dozen AP groups nationwide. Sirmon and Manning typically find these groups using procedures that were successful in earlier, simpler times.

Revenue Left on the Table

"Many pathology groups leave substantial sums on the table," observed Sirmon. "Further, pathologists in these groups are often unaware of the need to update their coding compliance and billing practices in response to more complex claim-submission requirements from all payers. Today, pathologists must document claims thoroughly in order to respond to tougher audits.

"The demands of practicing medicine and managing an independent AP group leave few pathologists with the time or tools to evaluate and optimize financial performance effectively," Sirmon explained. "All too often, neither the practice nor the billing company are reviewing the monthly billing reports and financial statements. That's why problems and opportunities go undiscovered and revenue is lost. That is a direct reason why pathologist compensation is less than it might otherwise be."

As revenues decline and expenses rise, every AP group needs to understand the many, various elements that go into analyzing the revenue and expenses of their businesses. Therefore, when working with

pathology groups, Sirmon and Manning do a deep dive into financial and performance records in the following ways:

- First, they review the CPT and ICD-10 coding;
- Second, they analyze the revenue cycle in detail, including all charges, contract adjustments, collections, refunds, bad debt, and receivables;
- Third, they compute key performance indicators and benchmarks to evaluate billing performance; and,
- Fourth, they review the expense side of the income statement.

In these reviews, Sirmon and Manning gather data needed to match the AP group's fixed and variable costs to its various sources of revenue. "This level of analysis reveals how certain health plans may not pay enough to cover the costs of a particular pathology service—meaning that service operates at loss for that pathology group," commented Sirmon.

Payment Less Than Lab Cost

For example, one insurer may not pay enough for the technical component of immunohistochemistry stains, Sirmon noted. "The only way to know that fact is to analyze what each payer pays for each component of such work, then determine what your group's costs are to produce these stains," he said. "If a pathology practice does not do such an analysis, then it may never learn that it's losing money on that work for that health plan.

"The traditional role of consultants like myself and others is to monitor a practice's billing, and that's certainly important," he added. "During our analysis of an anatomic pathology group's operations, we review both the revenue and expense sides of the profit-and-loss statement. That includes a comparison of revenue and expenses.

"We begin with the practice's accounting program and look at income minus expenses to get the practice's net income," continued Sirmon. "Unfortunately, many pathology practices use the general ledger chart of accounts that comes with their accounting program. The P&L may have only two sections, income and expenses.

"We prefer to use a classified P&L that has the following sections: income; cost of sales (technical component); gross profit; selling, general and administrative expenses; income before physician expenses; physician expense; and net income," he added.

"Another important factor is that many practices have income from both hospital patients and outreach patients," Sirmon explained. "For outreach patients, a pathology group may bill globally and either make or buy the technical component. Therefore, if the group compares only the hospital-based revenue to the outreach revenue, it would have misleading numbers because a portion of outreach revenue is used to pay for the technical cost.

"Also, the pathology practice may have other sales and marketing expenses for the outreach business [that are not incurred for inpatient cases]," he added. "That's why it's much more meaningful to compare the income-before-physician-expenses of the group's hospital patients to the income-before-physician-expenses of the group's outreach patients.

Understanding Audits

"After reviewing the pathology group's billing and collections reports, we typically perform an audit by pulling a random sample of cases," Sirmon explained. "This gives us additional information about the practice's billing. It also gives us some assurance that its billing reports accurately reflect how the practice performed.

"We pull the random sample from the various accession logs that the practice uses," he said. "We want to pull the sample from these logs to test that all cases get recorded in the system. A pathology group cannot collect if the case never gets into the billing system in the first place!

Using the Right Financial Metrics to Analyze Pathology Collections, Revenue Performance

TO FILE A CLAIM with the federal Centers for Medicare and Medicaid Services, clinical laboratories and anatomic pathology practices use the CMS 1500 health insurance claim form.

Al Sirmon, founder of Pathology Practice Advisors, explained that this form has some 30 places for practices to include data on each claim, such as the diagnosis code, the referring physician, the pathologist involved, the CPT code, location, and place of service. In addition, the explanation of benefits from each payer provides useful data as well. "Using data from these two forms allows pathologists to identify trends in a practice, along with financial problems the practice needs to address," he said.

Pathology Example A: Financial Analysis*

Gross Charges		$ 7,522
Less Contract Adjustments		$ 1,586
Net Charges		$ 5,936
Gross Collections		
Primary	85%	$ 4,273
Secondary	6%	$ 320
Patient	8%	$ 416
Less Refunds	0%	$ 0
Net Collections	100%	$ 5,008
Bad Debts		$ 385
Still in Accounts Receivable		$ 543

*($s in thousands)

Pathology Example B: Analysis of Pathology Cases

Cases	*50*
Units	*111*
Units per Case	*2.22*
Average Charge	
Per Case	*$ 150.44*
Per Unit	*$ 67.77*
Average Collection	
Per Case	*$ 100.17*
Per Unit	*$ 45.12*

Example A above shows the net collection percentage at 84.4%, which is below the goal of 90%. **Example B** above shows the data for several key performance variables of a real pathology practice. "To develop these data points for a real anatomic pathology group, we created a pivot table by taking all payments from each hospital and totaling those payments by CPT code, place of service, location, pathologist, referring physician, and other variables," explained Sirmon.

"By sorting the data in this way, we revealed that insurers for one hospital were rejecting some claims submitted by the hospital due to lack of appropriate patient demographic data," he said. "Getting more patient information helped turn denied claims into paid claims for this pathology group."

Pathology Example C: Key Performance Indicators

Example C at right shows how key performance indicators (KPIs) were calculated from the data presented in Examples A and B above.

Key performance Indicators	*Actual*	*Goal*
Net Collection %	*84.4%*	*90.0%*
Bad Debt %	*6.5%*	*10.0%*
Still in AR %	*9.1%*	*0.0%*

"For most pathology practices, these 100 cases give us a good sample," he added. "This is especially true if the sample is selected on a statistically random basis.

Documenting 100 Cases

"For each one of these reviews, we gather the following supporting documentation for those 100 cases," said Sirmon. "For each case, we look at the requisition, Pathology Dx Report, CMS 1500, explanation of benefits, and remittance advice.

"The first phase of the audit is to review the CPT coding by reading the Pathology Dx Report and comparing the actual codes and number of units that should have been charged to what was actually charged, he stated. "At this time, we also make sure proper modifiers, such as the 59 modifier, were used.

"The next phase of the audit deals with billing performance," explained Sirmon. "This includes four major areas: charge capture, payment posting, patient responsibility, and follow up. Under charge capture, we audit to confirm all accessions were properly recorded and entered into the billing system accurately and timely.

Patient Responsibility to Pay

"For payment posting, we ensure that payments, contract adjustments, and denials were entered accurately," he added. "The patient responsibility section is becoming more important as deductibles and co-insurance amounts rise.

"This section is important because we must verify the pathology practice has processes in place to collect these amounts from patients," he commented. "This includes review of data from patient statements, call centers, and patient portals. Under follow up, we look at whether amounts that were written off as bad debt—or those still in accounts receivable—had been adequately worked to collect the balance.

"At the conclusion of this phase, we can compute an error rate for the above procedures," he said.

Sirmon noted that the final phase of the audit summarizes the 100 cases to show the total revenue cycle, as follows:

- *Net charges*, which is gross charges minus contract adjustments; and,
- *Net collections, bad debt, and amounts still in accounts receivable,* which is calculated from gross collections minus refunds.

Key Performance Indicators

"From there, we can compute the following key performance indicators: net collection percentage, bad debt percentage, and amount still in accounts receivable," he said.

"We also compute other benchmarks," continued Sirmon. "These include gross collection percentage, average charge per case and per CPT, along with average collection per case and per CPT. Next, we compare these key performance indicators and benchmarks to the pathology group's year-end results from its billing and collection reports.

"These basic numbers are the foundation for helping a pathology group optimize operations and revenue," noted Sirmon. "The good news is that—given the analytical software tools available today—it's possible for any anatomic pathology group to look even deeper under the hood to understand what's happening financially at a granular level." TDR

—Joseph Burns

Contact Al Sirmon at 843-319-0605 or al@pathologypracticeadvisors.com; Chappy Manning at 803-553-8717 or chappy@pathologypracticeadvisors.com.

Al Sirmon to Speak in New Orleans at Executive War College

Sirmon will discuss five power analytics that anatomic pathology groups can use to boost revenue. Visit ***www.executivewarcollege.com*** to register.

Facing Price Cuts and Less Revenue, Some Pathology Groups Do Deep Financial Analysis

REGULAR REDUCTIONS IN THE PRICES health insurers pay for anatomic pathology services means less revenue for pathology groups. In turn, that means less compensation for pathologists in these practices.

For pathology groups that want to anticipate and stay ahead of these payer cutbacks, more detailed and regular analysis of their billing/coding/collections activities becomes essential. However, one hurdle is that many pathology groups have billing software and business practices that date back years. By contrast, today payers are more demanding of documentation and ready to conduct rigorous audits. These expose a pathology group to risk of more denials and large recoupment demands from a payer audit.

Deep Financial Analysis

"This is why some of our pathology clients ask us to go deeper than most advisers in our assessment of their operations, their revenue, and the net margins they have to distribute to partners," stated Al Sirmon, founder of **Pathology Practice Advisors**. "We can do data mining for pathology practices that want a more sophisticated assessment of their operations and finances," he said.

"When I talk about doing a deep dive into a pathology group's numbers, I get almost evangelical about how pathologists should look at the data they have and use that data to start asking questions about what's happening in their groups," he said.

"For example, in just this past year, we found three different pathology practices that had to refund money because they were billing a particular place of service incorrectly," he recalled. "Although they had to refund that money, they were thankful that these problems were identified and rectified before too many months went by. If the problem had gone undetected much longer, they would have had to pay even more than they did."

For a deep dive into a group's financials, Sirmon and Manning will produce income and expense reports by:

- CPT code;
- Location (meaning work done in one hospital versus the same work done in another hospital, physician's office, or ambulatory surgical center);
- Pathologist;
- Payer; and,
- Place of service (whether the work was done for a hospital inpatient, a hospital outpatient, in a physician's office, ASC, or in an independent lab).

"These numbers provide a more thorough understanding of costs versus revenue," noted Sirmon. "Using these numbers, it is possible for us to go even deeper in our financial analysis by picking any combination of these numbers and comparing the different values. For example, we can review CPT codes and revenue by payer and place of service by location.

"Another analysis involves reviewing revenue and expenses by CPT code and place of service or revenue and expenses by payer and pathologist," he said. "This level of data helps the practice to understand its strengths and weaknesses.

"Take the case of a pathology group that does not get paid enough by one payer for a certain CPT code to cover its expenses for that work," he added. "The practice administrator can then meet with the payer and use these numbers to show why its payment is insufficient to cover the group's costs. We also can help the group show how that payer's current payment is lower than what the pathology group gets from other payers for that same work."

Reacting to PAMA Cuts, Lab Works with Payers

➤Two-prong strategy with private health insurers helps Health Network Laboratories avoid more cuts

➤➤CEO SUMMARY: Before Medicare's lab test price cuts went into effect last year, Health Network Laboratories began discussions with private health insurers and nursing home clients about the possibility of renegotiating their contracts. In these discussions, HNL promoted the value it delivers to health insurers in terms of fast turnaround times, lab-test utilization management, and data that health insurers and nursing homes can use to manage patient care effectively.

One worry keeping many clinical laboratory directors awake at night is whether health insurers will follow Medicare's lead by cutting the prices they pay for clinical laboratory tests, which Medicare began doing last year.

Under the **Protecting Access to Medicare Act of 2014**, the federal **Centers for Medicare and Medicaid Services** (CMS) cut what it pays labs for 1,300 lab tests by 10% last year and 10% again this year. Next year, another 10% cut is scheduled. The next three years of cuts will begin in 2021, but those cuts may be even deeper. From 2021 through 2023, CMS can slash what it pays for lab tests by 15% per year.

In conversations with his private payers, Dean Hoppes, MBA, the Chief Financial and Administrative Officer for **Health Network Laboratories** (HNL) in Allentown, Pa., learned that payers are aware of the cuts Medicare has made and plans to make. He's also found that many payers are willing to work with HNL to ease the financial effects—to some extent, he said.

To mitigate the significant financial impact of CMS' cuts in lab test payments, HNL implemented a two-pronged strategy. The first prong of the strategy is to work even closer with its health plans to explain the value the lab delivers, particularly in terms of helping insurers to improve patient care.

The second prong involves reaching out to its nursing home clients to establish new contracting arrangements. These agreements are crafted to recognize how Medicare price cuts alter the economics of providing lab testing services to the nursing home's Medicare and Medicaid patients.

➤Regional Laboratory

HNL is the exclusive lab provider for the **Lehigh Valley Health Network** (LVHN), which is one of the largest health systems in Pennsylvania. Based in Allentown, LVHN has nine hospitals, numerous community health centers, lab, imaging, and urgent care facilities, more than 1,340 primary care and specialty physicians, pharmacies, and home health services.

About 60% of HNL's revenue comes from LVHN and the balance is generated from the lab's outreach program. The lab has contracts with all major health insurers, including national companies such as

Aetna and **UnitedHealthcare**, and regional insurers such as **Highmark**, **Capital Blue Cross**, and **Independence Blue Cross**.

"All our payers are aware of PAMA," Hoppes explained. "But I think they're aware of it for the wrong reason. The payers are watching to see how labs react to these Medicare cuts, and they're considering whether they should enact similar price cuts.

"Private health insurers commonly used a percentage of Medicare fees when setting lab test prices for their contracts with us," he commented. "Therefore, they see PAMA as an opportunity to further reduce what they pay for lab tests.

"That's a development that is unwelcome across the entire clinical laboratory industry," noted Hoppes. "If that happens, we say internally that it will put us in a 'death spiral.'" To avoid falling into this spiral, HNL took two actions. First, it implemented the previously mentioned two-prong strategy of renegotiating contracts with private payers and nursing homes. Second, it embarked on a program of process improvement to realize continuous cost improvement.

"To drive continuous cost improvement, our lab is becoming more efficient and effective at what we do every day," Hoppes said. "We felt the effects of the 10% reduction from Medicare last year and need to prepare for the second round of price cuts this year. As a result, our laboratory has seen a reduction in the non-LVHN-related revenue, which is our outreach revenue.

"To date, our total revenue has declined by more than 2% due to the CMS cuts," he added. "However, we have increased our operating margin performance by driving out more costs through operating efficiencies and automation in our lab, without impacting our employees. We've been able to accommodate volume growth with limited increases in staff.

"Medicare is a large payer of ours and represents about 35% of our lab's total payer mix," he said. "HNL has a handful of small health plans that are tied to the current Medicare fee schedule. We knew we needed to speak with them when the deep PAMA cuts in Medicare lab test payments were announced.

"So, we renegotiated existing payer contracts with the goal of shifting the payment basis away from a fixed percentage of the Medicare fee schedule," stated Hoppes. "Originally we wanted to move to a contract price schedule that is fixed and based on the Medicare schedule of lab test prices that Medicare used in 2017.

Separate Fee Schedule

"But we quickly determined that the best solution was to simply create a separate fee schedule that is not linked to Medicare in any way," he continued. "Several payers accepted that solution. Other payers did not, and instead agreed to use the fixed Medicare lab test fee schedule based on rates paid in 2017, which was one year before the PAMA reductions.

"Not all payers accepted HNL's proposal to use the 2017 fee schedule, but a significant number of the larger payers did agree," added Hoppes. "We still are progressing in conversations to move all of the payers to a fixed fee schedule. We were successful in these negotiations because those payers agreed that it would not be fair to assume that their lab providers should take a 30% reduction from every payer over the next three years."

HNL's experience in these negotiations has insights for other labs seeking strategies to cope with the Medicare fee cuts. "Of course, our private payers wanted to follow CMS' lead and cut lab test payments by 10% each year for three years," he commented.

"That's why we took the time to help payers understand the problems the PAMA lab test price cuts would cause," noted Hoppes. "At the same time, we also showed the payers ways that our lab could help them improve patient care.

"It certainly helped payer negotiations that Health Network Laboratories is well

known in the region, and it's owned by three not-for-profit health systems," explained Hoppes. "That means our lab has a different mission and has different values than the large, for-profit publicly-traded labs. We have a vested interest in the communities that we serve.

"Another factor in our favor is that payers know the value of having data from our lab to support the continuum of care. HNL provides uniform test results from inpatient, outpatient, and outreach settings for individual patients," Hoppes commented. "Most payers today look at cost-per-patient encounter, rather than just the cost-per-lab test, as they did in the past.

Recognize Added Value

"This is why demonstrating how our clinical laboratory has a positive influence on the cost-per-patient encounter is an important part of these negotiations," he said. "In our conversations with payers, we emphasize that HNL encourages payers to recognize there is added value when comparing the cost-per-patient encounter to the cost-per-lab test.

"We explain that the cost of lab tests in hospitals is about 2% to 3% of the total cost of delivering care. That's a small portion of total costs," he stated. "But we all know that it drives 70% to 80% of the clinical decisions that doctors make for patients.

"Most payers are open to that argument, but when they're not, we bring in the fact that we're part of the LVHN network and remind them of the benefit of having a large health system such as LVHN on their side," Hoppes said. "We also emphasize to them that we have fast turnaround times and that we provide lab test utilization management for all LVHN providers."

HNL has been successful in winning concessions from most of its payers. Having said that, HNL recognizes that it is only into the second year of a six-year process in which Medicare will cut prices each year through 2023. "Because we are in the midst of the six-year process of price cuts coming under PAMA we need to continue these discussions with private health insurers," he concluded. TDR

—Joseph Burns

Contact Dean Hoppes at 484-425-8151 or dean.hoppes@healthnetworklabs.com.

HNL Lab Offers Nursing Homes Fixed Prices

LABS OFTEN SEE THE SEVEREST EFFECTS of the PAMA price cuts most frequently when serving nursing homes and long-term care facilities.

"When we saw that PAMA was coming, we went to all 100 of our nursing homes to explain that we needed to have a fixed-price contract," said Dean Hoppes, MBA, the CFO for Health Network Laboratories (HNL). "We said we could not tie our rates into 100% of Medicare, because if we did that we would have a 30% reduction in payment under PAMA after three years.

"We can't afford to provide lab services to these clients if we did that. They were amenable to our arguments," he noted. "Also, we worked with nursing homes to alter the services that we deliver to them. For example, instead of having a phlebotomist go there five days a week, we may send a phlebotomist there three days a week.

"Another strategy was an a-la-carte menu for nursing homes and LTC facilities," he explained. "We tell them if they want a phlebotomist there five days a week, there will be a fixed fee for that service. This fee helps both the nursing homes and HNL understand what services are important services and what frequency is truly required."

The PAMA price cuts have caused some labs in the region serving nursing homes to close. "When other labs left the nursing home business, that created opportunities for us, either fortunately or unfortunately," Hoppes added. "Last year we unexpectedly received calls requesting our service. Everyone benefits because we service those facilities with our existing phlebotomists and lab staff."

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

BeaconLBS announced a collaboration with **MagnaCare** of Garden City, N.Y., last month. The press release issued by the two companies stated that MagnaCare would use the "BeaconLBS Physician Decision Support (PDS) solution with its network of physician and laboratory providers." MagnaCare describes itself as a company serving "Taft-Hartley funds, TPAs, carriers, and worker's compensation and no-fault payers in the New York, New Jersey, and Connecticut tri-state area," Paul Conlin, President, BeaconLBS said, adding, "We look forward to working with MagnaCare's extensive network of providers and its members to improve the quality and affordability of advanced laboratory testing."

MORE ON: *BeaconLBS*

BeaconLBS is a wholly-owned subsidiary of **Laboratory Corporation of America**. It has been closely watched by many clinical lab executives and pathologists since its first contract with **UnitedHealthcare** for the insurer's commercial lives in Florida, announced in 2014. In the MagnaCare press release, BeaconLBS says it now serves eight million lives in all 50 states. It also said that "physicians who use the BeaconLBS PDS platform have improved test referrals to high quality labs by up to 28%, improved test selection quality by up to 61%, and lowered patient out-of-pocket costs by up to 59%."

MED TECH SHORTAGE ENDS OUTPATIENT LAB SERVICES

Concerns about the shortage of skilled medical technologists continue to be an issue in both the United States and Canada. In St. Marys, Ontario, Canada, the **Huron Perth Healthcare Alliance** announced it would close the community [outreach] laboratory services at **St. Marys Memorial Hospital**. The reason is recent lab staff retirements and a shortage of med techs in the province. Inpatient lab testing will continue at the hospital, but outpatients in St. Marys will need to visit independent lab companies for their clinical lab tests.

TRANSITIONS

- **Washington University School of Medicine** named Richard J. Cote, MD, as its new head of the Department of Pathology and Immunology, starting May 1. Cote was at the **University of Miami Miller School of Medicine** and has previously held positions at **USC/Norris Cancer Center**, **Cornell University Medical College**, and **Memorial Sloan-Kettering Cancer Center**.

That's all the insider intelligence for this report. Look for the next briefing on Monday, April 29, 2019.

SPECIAL SESSION

Many Blessings, Some Curses from an LIS That's Fully Integrated with the EHR

Raj C. Dash, MD
Vice-Chair, Pathology IT
Duke University Health System, Durham, NC

Our Lessons from Using Beaker and Epic to Support Clinical Collaborations and Contribute to Improved Patient Care

Many hospitals and health networks that use the EPIC electronic health record (EHR) system are deciding to implement EPIC's Beaker LIS, often because of the generous licensing terms that EPIC extends to the hospital. This case study of a major health system's adoption of Beaker provides a valuable opportunity to learn more about this laboratory information system.

You'll hear about this laboratory's multi-year journey to implement the full menu of functions offered by Beaker, along with how the lab adds the newest capabilities of the Beaker LIS as they become available. One interesting dimension to this case study is how the clinical lab leverages Beaker's integration with the EPIC EHR to advance patient care and support physicians and other clinicians in ways they find valuable.

Is the Beaker LIS being considered by your hospital administration? If it is, then this is a must-attend session for you and your lab team. Register today to guarantee your place!

It's Our 24th Anniversary!

24 YEARS

EXECUTIVE WAR COLLEGE

Conference On Laboratory & Pathology Management

April 30-May 1, 2019 • Sheraton Hotel • New Orleans

For updates and program details, visit www.executivewarcollege.com

UPCOMING...

- ***Part 2 of Steps Every Pathology Group Can Use to Increase Revenue, Protect Partner Compensation.***
- ***Converting Lab Test Orders to Collected Specimens: How Labs Use New Real-Time Digital Tools.***
- ***What's New and Effective with Lean, Six Sigma: Useful Ways to Increase Lab Staff Productivity.***