Ten Best Financial Accomplishments
Ten Worst Mistakes
I've Seen in the Pathology and Laboratory Business
(since 1982)

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Ten Best Financial Accomplishments
My Top Ten List

#10 Annual Practice Retreat

#9 Regional Cooperation on a GYN Cytology laboratory

#8 Performance Incentives resulting in a Part A bonus

#7 Implementation of "ABC Practice Plan"

#6 Global Billing using contract rates for GI labs

#5 Contingency Arrangements

#4 Eighteen Proposals to get the best deal from Aetna

#3 Paying TCR based only on direct costs

#2 Implementation of PCCP billing

#1 Elimination of Medicare Prevailing Data

#10 Annual Practice Retreat

- The most successful practices commit to a formal annual retreat. This is most effective on a Saturday at an off-site location.

- The use of a **Facilitator** is essential to achieving objective feedback to diverse input.

  Pathology groups select an attorney or MD with a significant amount of pathology management experience.

- The end product is a ***Road Map*** for the next year along with long term goals and objectives.
  "Long term" used to be 5 years. In today's rapidly changing environment, this is now 2-3 years.
  - ✓ Goals and Objectives must align the practice with those of the hospital/department. These need to be presented to Hospital Administration.
  - ✓ It is also important that practice management (employees or contractors) provide consistent priorities.
  - ✓ Finally, a capital spending program needs to be prepared.

- **These practices have multiple cost centers with partners making $600,000+**

#9 Regional Cooperation for 20+ years on free standing Cytology Lab in Connecticut (PLS)

- A group of five pathology practices and six hospitals agreed to establish a cooperative GYN cytology laboratory, known as ***Pathology and Laboratory Services, LLC.***
- The lab director (COO) purchased a membership unit for $20k. The consultant was given the title of CEO with two paid membership units (**bartering consulting services** for a value of $40k)
- At its peak, PLS handled 150,000 Paps.
- The Lab achieved significant economy of scale, including purchasing supplies at a reduced rate compared to individual hospitals.
- Hospitals benefited from a “cost plus” arrangement. They billed the patients and third parties. Pathologists billed ($40-$50) for abnormal smears.
- When ***Women’s Health of Connecticut*** (a large OB-GYN group) established their own histo and cyto lab, PLS was no longer viable.

#8 Performance Incentives Resulting in a Part A Bonus

- There has been a modest trend to include **performance incentives** in Part A contracts.
- The first efforts are usually in the range of $50,000 with Part A contracts of $400-$500K.
- They include 5-10 elements paying $2,500-$10,000 each.
- When Part A support is much lower than documented effort, X $150/hour, such as 50-60%, the incentive program could be as high as $150,000 for community practices with 10-12 members.
- To the extent that both parties recognize the hospital is unable to pay more Part A, unless they achieve future savings, the **Performance Incentive** is in addition to the current Part A.
- For those groups who have been able to negotiate a better arrangement for **send out testing** and **blood products** it is not unreasonable to be paid 50% of the savings in year one and 10%+ over a trailing period (2-5 years).
- **The average group with a $50,000 incentive package generates $35-$45K and must submit new incentives each year.**

#7 Implementation of ABC Practice Plan

- Senior partners are typically paid equally → X. The only exception is the President/Chair who may receive → 110-115% X

- Many groups use the concept of **Partner Drawing Accounts** to provide flexibility for a full range of benefits, including health, life and disability, travel and CME. While the practice policy may be two weeks and $5,000 for CME for an employed pathologist, a partner can spend $15,000 "on their dime."

- Practices need to address bad behavior of individual partners who were not equally contributing to the Part A and Part B workload. They implemented ***"ABC Practice Plans."***

Part A activities had to be carefully documented through time studies and daily diaries.

Part B is best measured by work units (88305 = .75) not by charges or cash receipts.

Part C (citizenship) reflects the contribution to practice reputation and waterfall activities.

- Base compensation was set at $250,000 for all partners ($275K for the Chief) and the ABC Practice Plan generated another $250,000 for those making an equal contribution. Partners earning $100-$150K quickly realized that other employment was their best option.

  A 12-person group received two resignations within three years.

#6 Global billing using contract rates for GI labs

The worst arrangements involve the GI's paying a fee for pathology professional services as a percentage of Medicare rates. This is often 50% or $18-$20 per CPT code.

When billing for pathology services, hospital based physician contracts are usually better than those available to GI groups.

It is important that arrangements for government payers (Medicare and Medicaid) require the GI's to bill the technical component. Ideally, the pathology group bills their professional services.

For all other payers, it is possible for the pathologists to globally bill and reimburse the GI lab at an attractive technical fee. For the GI group, this eliminates bad debt and billing costs. It assures their cash flow 30 days after the month of service.

The pathologists should use a placeholder equal to full Medicare rates. After paying the Medicare PC, TCR and billing/other practice expenses, there is still a technical profit.

Practice 1: 5,700 CPT codes = $120,000

Practice 2: 6,000 CPT codes = $150,000

#5 Contingency Arrangements

A. Pathology groups are reluctant to pay for feasibility studies and support the implementation of new programs or complex negotiations. (with hospitals or third parties)

B. Senior members of a practice were reluctant to spend current resources with a decrease in the bottom line. They had no guarantee that this would lead to financial gain.

C. A solution was found by employing consultants who were willing to offer a contingency arrangement. **There would be no cost unless an improvement was achieved.**

D. They agreed to 100% of any improvement. However, to make this acceptable, it was spread over three years.

E. The two options were:

50% - 25% - 25% (of any improvement)

1/3 - 1/3 - 1/3 (the option they selected)

As a result, many practices achieved significant improvements by selecting a contingency arrangement.

#5 Contingency Arrangements

Part A support

A four person group was able to increase Part A from $300,000 to **$500,000**.

Annual time studies were required.

After review with the Department Administrator, they were presented to the CFO.

In addition, the Part A payment was annually adjusted by a cost of living factor applied to hospital administrative personnel. (not a CPI)

The Pathology Group paid their consultant $66,666 per year for three years.

(time charges to prepare a Fact Book and support the negotiations over a six month period amounted to $100,000+) **There is no magic bullet to a successful negotiation.**

#5 Contingency Arrangements

Negotiating Third Party Reimbursement

Pathology groups agreed to pay for third party negotiations.

Example 1 – Their Blue Cross contract did not recognize global billing for referred patients. Reimbursement was $80 for 88305-26. The group paid the hospital $25 to provide the technical component plus a billing cost of 8%.

Their net was ($80 – 8% = $6.40) = **$73.60** prior to technical costs.

After one year of negotiations, their consultant convinced Blue Cross to recognize RVU's for global units.

The new payment was $160 less a new billing rate of 6%.

Net = **$150.40 (an increase of $76.80)**

The contingency fee was based on the improvement X 1/3 = $25.60 paid over three years.

#5 Contingency Arrangements

Example 2 – A third party wanted to change the basis of their payments to recognize the drop in Medicare reimbursement for the 88305-TC.

The payer proposed that the current payment of using prior Medicare X 120% ($115 X 120%) = $138 be reduced to current Medicare of $80 X 120% or $96.

Three months later the Pathology group agreed to a fee of current Medicare = $80 X 150% or $120. This was an improvement of $24.

While this was still a reduction of $18, it was $24 more than the payer's proposal which was applied to all groups in the state.

The practice paid a fee of $24 X 2,000 units = $48,000 at 50% = $24,000

The consultant's time to negotiate this deal was minimal.

It is important to recognize not only the results, but the time and effort spent by the consultant.

#4 Eighteen proposals to get the best deal from Aetna

A. Great results from third party negotiations can often take considerable effort.

B. Most third parties employ a strategy of wearing down the provider. As a result, many practices settle on a new deal after only 3-4 proposals.

C. An example of the most successful negotiation began in June of 2008 and ended in March of 2009 (a total of 10 months).

D. The practice had not approached Aetna for an adjustment in reimbursement for more than 8 years.

E. Aetna would not recognize a cumulative COLA. They told the practice that it was their responsibility to be proactive each contract renewal.

F. The pathology group relied on their billing company to arrange for routine adjustments. When a **Billing Audit** was finally performed, the pathologists realized the billing company was not handling this function.

#4 Eighteen proposals to get the best deal from Aetna

G. As required by the contract, the practice sent Aetna a letter of nonrenewal **6 months in advance.**

H. During the back and forth process, a total of three different Aetna representatives were involved. The first two left the company with minimal documentation of the process. The last one was a senior manager.

I. After requesting a series of three (one month) extensions, the senior manager wrote to the hospital indicating that "*a non par pathology group was unacceptable*".

J. The pathologists and their consultant met with the VP of Managed Care and laid out their case for inadequate reimbursement (80% of current Medicare rates). The VP agreed to waive the contractual provision that "the pathologists needed to participate with all payers" and gave the group 3 months to bill as non par.

K. Standing firm, and after eighteen practice proposals, a final settlement was agreed. The new contract provided $1,500,000 more over a five year period and adjusted the first year payment by 50%.

Of the total consulting fee, the practice paid $5,000 and their billing company paid an additional $20,000.

#3 Paying TCR based only on direct costs

- Many pathology practices purchase technical services from hospitals for referred patients and bill globally.

- The overriding concept is for them to pay "***Fair Market Value***."

- Some groups were able to negotiate a portion of the lab's direct cost and have continued that arrangement.

  Other groups, who more recently implemented global billing for referred patients, were required to reimburse the hospital using reimbursement for outpatient services with annual adjustments. This amount is in the $45 - $55 range.

- The group paying only direct cost of $20 was able to achieve maximum technical profit:

Receipts = 13,000 CPT codes x $131 =	$1,700,000 (**after the Medicare 52% TC hit**)
The technical component is 56%	$952,000
Less TCR 13,000 x $20	260,000
Less billing and management	86,000
Net Technical Profit	**$606,000**

#2 Implementation of PCCP billing

- Pathologists in many states billed the **p**rofessional **c**omponent of **c**linical **p**athology.
- This was not an acceptable practice in CT. It took the guidance of Robert Babkowski, MD (Chair at Stamford Hospital) to initiate this program. However, other pathology groups, with significant Part A support, were reluctant to negotiate this arrangement.
  - **The 4-person Stamford group was only receiving $200K for Part A (= cost report).**
  - **Many other 4-person groups received between $500-$600K for Part A.**
- Subsequent contract cycles (three years) indicated higher Part A with a 3% COLA and additional Part A hours. As a result, groups approached administration with PCCP as an add-on to current Part A levels.
- On the advice of their consultant, most practices set up a new LLC and selected **"non-par"** while their AP was always **"par."**
- Groups agreed to limit billing only to payers who accepted this arrangement.
  No patients were billed.
- **The most successful group achieved incremental income of $150K per month.**

#1 Elimination of Medicare Prevailing Data

A. At the inception of separate billing in CT, Medicare Prevailings were in place. They were based on the experience of Dermatopathologists of $35 for 88305-26.

B. Working as the Reimbursement Consultant to the CT Society of Pathologists, we researched the regulatory requirements to establish "prevailing data." We then petitioned the regional office in Boston and they agreed to abandon historical data.

C. Over the next year, three new private practice groups submitted charges which were subsequently used to establish new prevailings. Using an FOIA request, they obtained the Medicare data from Florida, Texas and California for the **90th percentile** to establish their fees.

D. The new 88305-26 Medicare prevailing was $150 +.

E. Annual benefit for ten practices was $5,000,000 per year

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My Top Ten List

#10 Failure to include performance measures in a billing contract

#9 Contingency Arrangements: When to say "YES"?

#8 Failure to address Part A support on a regular basis

#7 A hospital owned group assuming job security

#6 Adjustment to PCCP fees

#5 Departure of a Senior Partner

#4 Merging with another group

#3 Poor succession planning and losing contracts

#2 Getting rid of a Partner

#1 Failure to include modifiers when billing PC services

#10 Failure to include performance measures in a billing contract

The group had a three year contract with an outside billing company with 18 months remaining.

There were constant problems including turn over in the staff assigned to their account.
Results were less than ideal.

When they conducted a **Billing Audit**:	Top Grade
Months in AR were 1.8 (Ideal= **1.2**)	A=1.0
Accounts over 90 days by date of service were 30% (**20%**)	A=15%
Collection liquidation was 35% (**20%)**	A=15%
Processing on a current basis was 45% (**65%)**	A=75%

Their billing fee was low and the response from the service bureau was "*we can't do better for the fee we are being paid"*

Performance measures (in green above) allowing the practice to terminate the contract were implemented and the professional component billing fee was raised from 7 to 7.5%.
The biller met the new standards.

#9 Contingency Arrangements: When to say "YES"?

A twelve person hospital group on salary was negotiating a transition to separate billing.

The hospital VP encouraged them to move forward forming a new entity and work out the details of governance, financial arrangements, the hospital contract, etc.

The consultant, attorney and accountant, handling all aspects of the project, offer to provide their services under a contingency fee:

If the group was successful, the advisors would charge 200% of hourly rates

If the group did not move forward, the advisors would charge nothing

The group rejected this offer. The practice was going to be approved since they had VP support.

While the Pathologists were working out the details and reaching agreement on Part A support, the hospital President was negotiating with the Radiologists. This went poorly.

Three months before the transition date, the President instructed the VP to cease talking to the Pathologists and to prepare an incentive plan for hard work. The VP objected and was fired.

The eight Pathology "partners" obtained a bank loan and paid over $175,000 in fees

(this was reduced from $225K in charges)

#8 Failure to address Part A support on a regular basis

Pathology groups avoid routine discussions with administration on Part A support.

Without an annual review, Part A does not adjust for the increase in lab administrative requirements and the need for a COLA.

The typical contract has a three-year term. This is the only time the parties talk about the Part A payment.

If time studies are not a routine requirement, they are avoided by many pathology practices. They should be used to document activities and justify stable or increased payment.

Since most hospitals are reducing cost, the Part A is a prime target of cuts.
Their strategy is “DEATH AND TAXES”

Hospital consultants are also comfortable suggesting major reductions in Part A, especially when they are compensated as a % of the hospital savings.

One group was cut by **50% or $500,000** when a for profit assumed control.

#7 A hospital owned group assuming job security

The ultimate security blanket is considered to be a hospital salary arrangement. However, this is not without problems.

A 5 person group with a hospital salary of $450,000 (Chief at $525,000) assumed that they would be protected.

Their hospital faced a significant budget shortfall.

When one of the Pathologists decided to accept a position elsewhere, the hospital announced the open position would not be filled.

While the 2015 volume was down by 5%, administration used this as one argument not to fill the position. In addition, they learned that workload was 80% of those in private groups.

The group never prepared time studies nor addressed their productivity. Their appeal is being delayed as other "more pressing matters" are being addressed by the hospital.

#6 Adjustment to PCCP fees

- Practices were receiving income of between $.75 - $5+ from those payers who recognized PCCP billing.
- Their average fee was $10-$15 per unit and there was no interest in increasing this charge because of the high fee and low reimbursement.
- The Pathology group did not want to pursue generating data from their billing company ("they are too busy", "we have too many other things to worry about", "let's table that"
- After finally getting the OK, a detailed line item analysis discovered that higher fees would lead to higher reimbursement **if the practice elected non-par status**.
- This was followed by an adjustment in the average fee to $22-$25.
- One group of 5 Pathologists was able to increase monthly results by $15,000 per month/ $180K annual.
- This opportunity was brought to their attention two years prior. The income loss was **$360,000** for the time this was not addressed.

#5 Departure of a Senior Partner

- On more than one occasion a senior partner has left the practice with many unnecessary problems and often bad feelings. The worst case is when this is the Chief or President of the practice.

- Relationships that have been friendly and positive become unpleasant at the time of retirement or departure for another opportunity. (like family problems when someone dies)

- The blame often rests with both parties. The individual leaving doesn't take the time to document what they feel is due in at least three major areas:

  - **Time benefits** that have been accrued and not taken. They want a final payment
    - Many groups provide a base salary amounting to half of compensation and the rest in bonus payments. The person leaving considers both x days due. The practice might only want to recognize base or they feel that time not taken is not due.

  - **Value of the practice** changes in the operation might be poorly spelled out in the documents. There may also be an issue of the need for timely payment. This should be addressed when the individual announces the departure. **There is a need for a *Departing Partner Checklist* completed within 30 days of the announcement**

  - **Fringe benefit transition**

#4 Merging with another group

Two groups discussed the possibility of a merger after there was a change in the leadership of one group.

One group (six) had heavily relied on their advisors to run the practice. The other group (four) did most of their own management and financial services.

During informal discussions the larger group learned they were spending $50,000 more per Pathologist for a full range of services. However, they preferred not to be "hands on" and add management functions to their busy clinical schedule.

After a one year debate about practice management issues with neither group wanting to change their style and the smaller group not wanting to increase their cost, an agreement was signed and data was compared.

Merging resulted in the smaller group improving contract payments	$400,000
Less the smaller group incurs additional costs	$100,000
Billing rates for the larger group would achieve EOS	$75,000
PCCP income for the larger group would prevail	$200,000
GI group agreed to Pathologist billing globally (over the $25 paid)	$250,000
Less implementation $75,000 spread over three years	$25,000
Net	$800,000
For 12 months improvements were not achieved	**$800,000**

#3 Poor succession planning and losing contracts

A number of groups have done a poor job preparing for the future. Rather than designating a successor to the President (the VP) or to the Chief of the Department they fail to address this reality.

Senior partners that are neither interested or well suited for the leadership roles need to recruit an individual for these positions.

Pathology groups find it cheaper to hire new members from training and pay them $200-$225K with 2-3 employment years and 2 or more steps to parity. However, until they are partners the Part C practice duties are not assigned and they don't learn the skills needed to be appointed as Chair/President.

Over the past 10 years, 3 groups have lost their exclusive contracts for the following reasons:

- ✓ Two senior members (over 70) with great relationships but no new ideas + a change in hospital administration looking for fresh thinking
- ✓ Chief's retirement and group successor was unacceptable to administration
- ✓ Successor whose personality made them unsuitable then the hospital bid the contract

#2 Getting rid of a Partner

When groups seek to terminate a partner, they usually speak to their regular lawyer.

Since they did not retain a specialized labor attorney, their preparation was not complete. Further, the blanket of secrecy imposed by their attorney limited constructive input from other advisors and practice management.

Partners were terminated with a conviction that there was sufficient documentation.

Subsequently, it was clear that more detailed justification was required.

The terminated partner had an indication that their demise was at hand and used their time to address clinical errors made by their colleagues.

They also contacted experts in labor law to prepare their response.

In two cases, the courts required mediation and looked favorably on the dismissed individuals rather than the successful practice.

Judgement #1: $1,200,000
Judgement #2: $600,000

#1 Failure to include modifiers when billing PC services

A Pathology group received 75% of gross charges and paid billing of only 5%.
The state norm was 30-35% collection and 8% billing cost.

They agreed to a **Billing Audit** on the following condition:

The audit would not be charged if their results were as advertised

If problems were discovered, the practice would pay the quoted fee of $8,000

The audit found that three years prior they changed to a billing company without Pathology experience. Their fee was reduced along with a remarkable increase in collections.

65% of the practice was hospital-based professional component and 35% was global referred.
TC was bought from the hospital. Practice fees for PC and global were set at the same amount.

The new billing company didn't understand the difference between PC only and global billing.
They billed everything as global and collected accordingly.

The practice attorney directed the re-payment to all payers but not to patients. A total of **$500,000** was returned to payers requiring a bank loan. Some payers also considered terminating their contract but none followed through with this threat.