Pathology Practice Management

A Case-Based Guide

Lewis A. Hassell
Michael L. Talbert
Jane Pine Wood
Editors

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Editors
Lewis A. Hassell
Department of Pathology
University of Oklahoma Health
Sciences Center
Oklahoma City
Oklahoma
USA

Michael L. Talbert
Department of Pathology
University of Oklahoma Health
Sciences Center
Oklahoma City
Oklahoma
USA

Jane Pine Wood
McDonald Hopkins LLC
Dennis
Massachusetts
USA

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Preface

Most pathologists know almost nothing about practice management when they take their first regular positions. Despite many years of training, they risk financial stability, practice harmony, and professional satisfaction through trusting what may be categorized as a "gut feeling" about a practice opportunity. While some pathologists then learn through the "School of Hard Knocks," others gradually learn practice management through their early years in practice and progressively take control of their professional lives.

Practice management is a broad topic encompassing such diverse areas as billing and contracting, strategic planning, personnel and human resource issues, decision-making, and productivity. There are basic factual components, but the application of the principles of management is situation specific and best honed by experience. To increase the challenges, these factual aspects change as the health-care system changes and as the practice of pathology evolves.

Though highly trained specialist physicians, pathologists typically receive limited useful instruction and experience in practice management during residency and fellowship. Also, for most pathologists, the initial lure of medicine and pathology in particular was not arcane billing rules, the finer points of contracting, or a desire to address personnel issues. However, practice management issues are critical to day-to-day pathology practice, impacting quality, practice success, and professional satisfaction.

This book will provide relatively short didactic overviews of topics and concepts complemented by cases drawn from the experiences of the various authors. The cases are intended to illustrate approaches to common problems, provide a basis for discussion in a training environment or, for the more experienced leader, to stimulate thinking when faced with a particular practice management issue. We learned a lot from each other while assembling the didactics and cases for this book. We hope your experience is the same.

The authors have had a range of experiences as practicing pathologists, attorneys, practice managers, and consultants. We have also taught courses for the College of American Pathologists, United States and Canadian Academy of Pathology, American Society for Clinical Pathology, and American Pathology Foundation, along with other organizations, and feel blessed to have had the opportunities. But our best

experiences have come from those with whom we have worked and networked. Our friends and colleagues have been the best teachers and sounding boards. Our thanks to you all.

This publication is designed to provide general background information to readers regarding a wide range of business, legal, financial, and billing topics. The publication provides general information rather than specific business, legal, financial, or billing advice. Because it is necessary to apply business, legal, and accounting and billing rules and principles to specific facts, always consult your professional advisor before using the information in this publication as a basis for a specific action.

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Contributors

Dale W. Bratzler Health Administration and Policy, College of Public Health, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA

Krista Crews ProPath, Dallas, TX, USA

Kimball Fisher The Fisher Group, Portland, OR, USA

Lewis A. Hassell Department of Pathology, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA

Amelia B. Larsen McDonald Hopkins, LLC, Cleveland, OH, USA

Linda McLean Department of Pathology, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA

Dennis L. Padget APF Consulting Services, Inc., Laguna Beach, CA, USA
The Villages, FL, USA

Karim E. Sirgi LambdaX3 International, Denver, CO, USA

Michael L. Talbert Department of Pathology, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA

Jane Pine Wood McDonald Hopkins LLC, Dennis, MA, USA

Part I
Money and the Practice of Pathology

Chapter 1
Health-Care Finance and the Pathology Practice

Michael L. Talbert

Overview

Case: Evaluating an Employment Opportunity

Nine years of training. Four years of medical school, 4 years of anatomic pathology/clinical pathology (AP/CP) residency, and a year of fellowship. US$175,000 of debt. A husband and two young children. You will be the primary breadwinner, and it is time to select the private practice job you have dreamed about for the past several years. You have interviewed with two groups, and both are interested in hiring you. By coincidence, both groups have six pathologists covering two hospitals in midsized cities in the Southeast near your parents. What do you need to know about the groups before a decision? How could such similar practice situations vary? Since you plan to buy a house and put down roots, how do you assess which situation is the most stable? What questions should you ask?

Understanding the fundamentals of practice management can help you understand the merits and potential risks of a practice situation. We will return to a discussion of the above scenario in Chap. 24 at the end of this book.

Many pathologists are drawn to medicine and hopefully pathology by the wonderful complexity of the human body, its range of maladies, and the variety of responses to disease. The pathology practice environment is similarly complex in that no two practice settings are identical, and no two practice environments present the same range of opportunities, threats, and financial milieu. When just looking from the outside of a practice opportunity (such as when evaluating a potential new job), one cannot immediately determine how successful a particular practice might be nor what the future trajectory of that group might be. But with an understanding of the environment, the internal structure and culture of the organization, and the skills and resources of the individuals within the organization, one might be able to reasonably forecast the future in that setting.

M. L. Talbert (✉)
Department of Pathology, University of Oklahoma Health Sciences Center, 940 Stanton L. Young Blvd., BMSB 451, Oklahoma City, OK 73104, USA
e-mail: michael-talbert@ouhsc.edu

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Practice Structures

Case: Can I Be a Partner in This Practice?

Dr. Carol Smith, now a fellow in surgical pathology, waited while her call was put through to Dr. Al Wright, her former residency program director. After exchanging greetings, Dr. Smith cut to the chase: "I am looking at joining a local community practice, but they said they don't have partners. I'd like to someday own part of my practice; am I being offered a poor deal?"

Discussion: Opportunities for partnership depend on the structure of a practice. If a practice opportunity involves a freestanding legal entity, such as a professional corporation (independent private practice) or a freestanding laboratory, it is possible to own stock and be a partner. How one obtains such stock may be through a buy-in which can occur at a particular time or be structured over a period of time during which a non-partner works for reduced compensation, or through a combination of the above. For partnership in a practice, the time frame for consideration should be specified in the initial employment agreement with that practice. The advantages of being a partner are potentially threefold: (1) Particularly on matters of great importance, a partner has more say (shares can be voted) than a non-partner; (2) partners typically divide and distribute excess revenues over expenses as bonuses or dividends (depends on legal/tax structure) to avoid having the practice pay taxes on profits; (3) should the practice or laboratory be sold, a partner would be entitled to a portion of the proceeds reflecting his/her share ownership in the entity. As such, partnership opportunity and status can be of great importance.

A partnership opportunity is not available in the typical academic practice since the pathologist is usually an employee of the state, university, or practice plan. Similarly, no partnership opportunity would exist if a pathologist were directly employed by a hospital or large laboratory. Finally, non-partnership tracks exist within some independent private practices. In these cases, the pathologist may have a different workload or schedule, a different pay package, and certainly would not enjoy the advantages of an ownership share of the practice. Non-partnership tracks are often used for part-time pathologists or for pathologists who are not expected to have an extended period of employment.

To simplify things, it can be useful to think about practice structures as being one of four types but with endless variations: academic, independent private practice, employed private practice, and commercial laboratory. Characteristics of an academic practice include the combined missions of clinical service, teaching, and research with the classic example being a university-medical-school-based practice with the majority of faculty physicians operating within some form of practice plan. The faculty could be wrapped into a common organization with the hospital or could be distinct. In the academic scenario, the pathology department may be virtually indistinguishable from the larger organization(s) or may function as an independent business unit with its own income statement and reserves. Most pathology departments operate somewhere between these extremes.

Legal Aspects of Practice Structures

There are many different types of legal entities in which pathologists can practice, all of which are established and governed by state law. Most pathologists in private practice have professional corporations or professional associations, which are corporations that can be owned only by licensed professionals.

Some pathologists practice through general business corporations in states where the use of a professional corporation or association is not mandatory. These corporate entities select either C corporation status or S corporation status from a tax-reporting standpoint, with the distinction between the C and S status being how the entity is taxed. This selection is typically made in consultation with the corporation's accountant.

Increasingly, pathologists in private practice use limited liability companies (or professional limited liability companies, depending upon the state) because these entities provide greater flexibility from a governance and tax standpoint. Occasionally, pathologists have limited liability partnerships, but these are not common. The importance of a corporation, limited liability company, or limited liability partnership is the protection afforded the owners from a liability standpoint. Although a pathologist always retains liability for his or her own actions, an appropriately formed and maintained corporation, limited liability company, or limited liability partnership can shield the pathologist from liabilities of the practice entity as well as the acts or omissions of the other pathologists in the practice. In contrast, partners in a general partnership share liability on a personal level for all acts or omissions of the practice and its pathologists.

The independent private practice represents the classic example of a private practice. The pathologists band together typically in a professional corporation (but there are other structures such as partnerships and limited liability companies), and, among the owners, decision-making is based on an equal-shareholder/partner/member concept or percentage ownership of the various owners. Practices can vary in size and have varying numbers of nonowners on a track to ownership, and possibly even pathologists on a nonownership track. Shareholder/partner/member status is typically done through a buy-in, which may range from token to substantial and which also can take the form of reduced total compensation during a variable number of pre-ownership years. In the independent private practice model, pathology groups typically contract for medical director services with the hospitals or laboratories they serve.

In the employed private practice model, pathologists are employed by a larger entity, typically a hospital or multispecialty group, with a direct reporting relationship up the leadership chain of the larger organization. While this lacks the independence and ownership aspects of an independent practice and is usually a bit less lucrative, being employed by a larger entity can be more stable with a degree of insulation from the significant business risks inherent in independent private practice.

Commercial laboratories range from privately held freestanding laboratories to nationwide behemoths that handle massive numbers of specimens and trade on the New York Stock Exchange. Commercial laboratories may serve the full range of AP/CP testing or may limit themselves to one or a few specialty areas. In these settings, the pathologist may be a salaried employee with productivity targets and

limited say or responsibility in the business of the practice, may be independently contracted by the laboratory, or may be part of a group that is contracted by the laboratory.

Practice sizes may vary as well from solo practitioners to groups or departments of 50 or more pathologists. With increasing practice size typically comes greater specialization of pathologists and enhanced ability to capitalize (invest in) improvements in the practice. Larger practices usually can afford and often require more sophisticated management with a nonphysician practice administrator and more sophisticated human resources (HR) and legal support.

Thus, practice environments can be as variable as the practices themselves.

Key Concept
Pathology practice models and pathology practices differ in:
Mission
Size and scope
Funding model and incentives
Security offered
Culture
All should be considered in employment decisions.

Overall Financial Considerations

Case: How Do I Get Paid and for What?

Shortly after Dr. Carol Smith took a position with Good Health Hospital, the chief of pathology met with all five pathologists and told them, "Administration says we are operating in the red. If we can't raise revenues or cut expenses, they will need to take action like freezing hiring, denying raises or even cutting salaries by a small amount. What can we do to cut expenses?" By this time, Dr. Smith is having a hard time listening as her head spins with the thought of reduced income in the face of large school loans and a new mortgage. Need to raise revenues? Salary cuts? How can this happen in a country that spends the most per capita on health care?

Discussion: Understanding how pathologists are paid is absolutely key in this time of great change in health care. The following description will detail the various ways that pathologists are paid. Importantly, there are many things pathologists do that are not directly compensated or that may not be compensated at all. These include committee work, tumor boards, waiting for a frozen section, research support, and education. Each of these activities, though, are important for visibility, interaction with other members of the health-care team, and, ultimately, for maintaining a job or the contract to provide services. As health care slowly transitions towards payment for value and outcomes and away from fee-for-service where more services performed = more money, pathologists will increasingly need to show how they are adding value. For example, what value do pathologists add at tumor board? Do they change diagnoses previously made at other institutions? How often do they change or accelerate a patient's treatment based on their interactions at tumor board? Can this be quantitated? Other examples: (1) Can one quantitate the impact of a pathologist-initiated blood utilization program on decreasing immunosuppression, volume overload, and, perhaps most easily, total cost? (2) Can deploying a molecular viral identification test more quickly rule in or rule out viral meningitis and save hospital bed days? (3) Can pathologist-driven personalized medicine testing in colon cancer specimens lead to faster assignment to therapy, less testing when not needed, and better identification of those patients who may benefit from this workup? Can this effect be quantified? These are just a few examples of how pathologists can and do add value and how we will need to clearly demonstrate the value added in the future.

The US health-care system is not a system in the true sense of the word. It is a complicated, sometimes overlapping collection of various providers and payment schemes. Some areas, like the Veterans Administration, are better organized while others, such as individual practitioners and the uninsured population, are less so. Furthermore, as of this writing, there are truly monumental forces at work, some related to the Patient Protection and Affordable Care Act (aka Obamacare) and some driven by other forces.

The scope of the US health system is also debatable. Do we include public health and preventive care? What about health-related products such as Botox? A helpful way to understand how things work relative to practice management issues is to consider, in general, how money comes into a pathology practice. We can then consider changes that are occurring, with their attendant challenges and opportunities.

As we examine where money comes from in the health-care system, we can split pathologists' services into two general categories: (1) diagnostic work for individual patients such as surgical pathology and cytopathology and (2) medical direction such as quality assurance, designing protocols, hospital committee work, and laboratory direction. Diagnostic services for specific individual patients are described and billed using Current Procedural Terminology (CPT, see side bar, page 23) codes, a descriptive system maintained by the American Medical Association. For pathologists' purposes, CPT codes describe AP services and some CP services. For example, CPT code 88305 describes a diagnostic biopsy such as a typical gastrointestinal (GI) biopsy while 88342 describes an immunohistochemical stain. Payment is based on the CPT code submitted for a service and many pathology cases have multiple CPT codes reflecting multiple parts and additional studies such as histochemical or immunohistochemical stains. This is classic fee-for-service where payment is made for a specific service. A practice leader should have a strong working knowledge of the CPT-coding system. If not, there are seminars and online courses on coding in addition to any coding "experts" currently present in your practice.

Payment for Diagnostic Work for Individual Patients

Case: How Much Will I Be Paid for This Diagnosis?

Dr. Mike Taylor put the slide on the stage and quickly confirmed that the tissue was a section of gallbladder with a cross section of the cystic duct. He patiently examined the slide, confirming the typical changes of a chronic obstructive process while carefully excluding dysplasia or carcinoma. Seeing no other unusual features, he depressed the pedal of his digital dictation system and carefully said, "Diagnosis—Gallbladder: Chronic cholecystitis with cholelithiasis." He added billing codes and indicated there were no quality issues. Dr. Taylor then leaned back in his chair and thought aloud, "Wow, I just signed out my first case." Pausing a moment, he next thought, "I wonder how much money we'll collect?"

Discussion: How much a pathologist collects for a particular service varies depending on the service performed and for whom it is performed. In this section, we will discuss how a service is coded for billing purposes, which in turn determines the charge that is assigned; the actual payment is determined by the type or lack of health insurance coverage a patient has. If a patient has typical indemnity insurance, payment will usually be on a contractual basis and reflect a fee schedule set between the insurance company and the pathologist/practice. For patients with Medicaid, Medi-

care, Tricare, or Champus, the so-called federal payors, the rates are determined and not negotiable (but may vary between programs and geographic location). Patients with no coverage (so-called self-pay) may pay nothing, may pay the full charge, or may pay something in between, sometimes following a brief negotiation with the pathologist's billing office. Practically, most pathologists provide services without knowledge of a patient's health insurance coverage and accept that payments will vary. This is often the most practical approach given that a submitting healthcare provider will typically submit specimens reflecting a range of patient coverages.

For diagnostic work, there are four major payor categories: Medicare, Medicaid, insurance/managed care and other contracts, and the uninsured or self-pay. Medicare merits the greatest discussion because its payment scheme and rates often serve as a model for other payment sources.

Medicare is a federal government program overseen by the Centers for Medicare and Medicaid Services (CMS), which is part of the Department of Health and Human Services. Medicare covers persons 65 and older, persons under 65 with certain disabilities, and those of any age with end-stage renal disease or amyotrophic lateral sclerosis. Medicare has four parts: Part A, which covers hospital inpatients, skilled nursing, home health, and hospice; Part B, which covers physicians' services, outpatient hospital services, and medical equipment; Part C, Medicare Advantage or Medicare Managed Care; and Part D, Medicare prescription benefit. Much of Part A hospital inpatient payments are done using a prospective payment system where a single payment is made to the hospital based on the patient's underlying illness and comorbid conditions, the diagnostic-related group (DRG) payment. For Medicare Part B billing, which covers physician services for specific patients, payment is based on relative value units (RVUs) or the relative resources required to provide a particular service. The original RVU system values were derived from the Harvard Resource-Based Relative Value Scale study, but RVUs can change with time through the addition of new procedures or revaluing of existing RVUs. Once one knows the RVUs or resources assigned to a particular service, such as processing and diagnosis of a skin biopsy, then the payment from Medicare can be calculated by multiplying the RVUs by the current Medicare conversion factor (CF). The Medicare CF is typically set annually based on statute and congressional action. In concept, the payment system is fairly simple (RVU × CF = payment), but at any time, some aspects are under review or subject to political wrangling. Also, one can probably grasp that most all physicians would be impacted by changes in the CF, while predominately pathologists would be impacted by say, revaluing of RVUs for a frozen section.

Medicare Part B payment has additional complexities of importance to the pathologist. For many AP services, slides and reports must be made, forming the technical component (TC), in addition to the professional diagnostic work performed by the pathologist, the professional component (PC). The two, TC and PC, can be combined into a "Global Fee":

$$\text{Global Fee} = \text{Professional Component} + \text{Technical Component}$$

TC and PC may also be paid separately using a modifier (TC for Technical Component and −26 for Professional Component) appended to the CPT code. In the clinical laboratory, some services have a defined PC, such as: 86077 Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation, and written report.

RVUs are more complex than we have stated so far. In fact, the RVU for the PC is composed of three components: actual physician work, practice expense, and malpractice.

$$\begin{aligned}\text{RVU (PC)} = {} & \text{RVU (Physician Work)} + \text{RVU (PC Practice Expense)} \\ & + \text{RVU (Malpractice)}\end{aligned}$$

Similarly, TC RVUs are calculated by summing RVU subcomponents for TC practice expense and malpractice:

$$\text{RVU (TC)} = \text{RVU (TC Practice Expense)} + \text{RVU (Malpractice)}$$

So how might one calculate an individual payment for a service using RVUs? The CMS website provides a fee schedule search function that also yields RVU values (http://cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx).

The CF is also available on the CMS website and as of September 2015 is US $35.9335.

So we can calculate for the 2015 National Average Medicare Physician Fee Schedule:

- 88305 PC = [RVU (Work) + RVU (PC Practice Expense) + RVU (Malpractice)] × CF =[0.75 + 0.33 + 0.01] × US$35.9335 = US$39.1675 = $36.17
- 88305 TC = [RVU (TC Practice Expense) + RVU (Malpractice)] × CF = [0.94 + 0.01] × US$35.9335 = US$34.1368 = $34.14
- 88305 Global = US$39.1675 + US$34.1368 = US$73.3043 = US$73.30

There is yet another complexity before we actually collect a dime. Geographic Practice Cost Indices (GPCIs) are used to adjust individual RVU components to account for geographic variations in costs to provide services. For example, it is less expensive to run a practice in, say, Oklahoma City than many other places in the country. As such, PC RVUs in Oklahoma City are adjusted downward in 2015 for RVU (practice expense) and RVU (malpractice) by factors of 0.872 and 0.845, respectively.

For the PC

$$\begin{aligned}\text{RVU (PC)} = {} & \text{RVU (physician work) (GPCI)} \\ & + \text{RVU (PC practice expenses) (GPCI)} \\ & + \text{RVU (malpractice) (GPCI)}\end{aligned}$$

2015 Oklahoma Medicare Fee Schedule

$$88305\,\mathrm{PC} = [(0.75 \times 1.000) + (0.33 \times 0.872) + (0.01 \times 0.845)] \times \mathrm{US\$35.9335}$$
$$= \mathrm{US\$37.59}$$

(National Average 88305 PC = US$39.17)

So, if you provide Part B services, just submit the appropriate and complete CPT codes to Medicare with the proper documentation, and you can calculate the payment you can receive using data from the CMS.gov website.

Key Concept
CPT codes determine payment via linkage to RVUs for both technical and professional component work.

An additional point to be aware of is that Medicare adjusts payments to physicians through its Physician Quality Reporting System (PQRS) which entails specific reporting in select cases that, as a good lab, you are probably already doing coupled with specific codes to report that you did the right thing. We encourage you to look more closely at the PQRS process particularly if you have significant payments coming from Medicare. Initially, there were modest percentage increases in all of an individual's Medicare payments for correctly reporting an appropriate percentage and number of eligible cases. For 2014 and beyond, there are increasing penalties for nonparticipation/non-reporting. For 2015, there are eight measures for pathologists, the five original involving breast cancer resections, colorectal cancer resections, radical prostatectomy cases, biopsies with Barrett's esophagus, and cases with Her-2/Neu immunohistochemical stain reporting, and three new for 2015 measures involving lung cancer and melanoma reporting. Failure to report in 2014 resulted in a 2% penalty applied to *all* Medicare Part B payments to be made in 2016. Participation in 2015 PQRS will impact the 2017 PQRS adjustments and 2017 value-based modifier (CAP Today November 2014).

Medicaid is a joint federal and state program using basic federal benefits but with significant state-to-state variability. Individual state programs set their own payment rate structures that are CPT-code-based but which usually pay less than Medicare. Medicaid is subordinate to Medicare for patients who have both benefits.

Insurance and managed care cover a range of products and payors. Historically, indemnity insurance had limited or no utilization controls, less focus on preventative care, and higher patient premiums than for other types of insurance, corresponding to a higher degree of patient autonomy or choice, and hence utilization. The term managed care covers a range of products and payment systems but typically involves targeted contracting and utilization controls. Payments from insurance and managed care can range from a percentage of billed charges to a negotiated (or take-it-or-leave-it) fee schedule, often some percentage of Medicare payments, to some form of "capitation" in which providers receive a set sum per month for all services provided to a patient or group of patients ("per-member-per-month" agreements). For patients who do not have any insurance or who are self-pay, the individuals are billed, and collections are quite variable from individual to individual. Usually, collections from this subset of patients are relatively limited.

Recent Trends and Changes

More recently, we see a growing call to move away from fee-for-service coupled with a trend to link payment rates to process and outcome measures. There is often a downside possibility for providers as well as upside potential (shared savings). In an attempt to reduce health-care costs, both federal and private insurers are experimenting with bundled payments and accountable care organizations (ACOs). Bundled payments use a larger single payment for either a range of services or a range of providers in an effort to reduce total payments. Providers may thereby be encouraged to reduce services or negotiate among themselves to achieve the savings. ACOs are groups of providers, sometimes including hospitals, that organize to become "accountable" for managing care across a population or chronic disease to encourage providers to better coordinate care in return for potential shared savings. For these new and growing models, it is important for the pathologist to be aware of what is happening in their service area and be proactive where possible by improving care pathways, test utilization, information management, and overall care coordination.

In April 2015, physicians rightly cheered the repeal of the sustainable growth rate (SGR) formula which was designed to limit the growth in Medicare payments to the growth in gross domestic product. Enacted by legislation in 1997, the SGR would have led to dramatic reductions in payments for Medicare services, but the cuts were routinely blocked by Congress with a series of legislative actions that blocked full implementation of SGR such that the indicated cuts in Medicare payments to physicians would have exceeded 20%. In fact, at the time of SGR repeal, a scheduled decrease of 21.2% in physician payments for Medicare patients hung over physicians as a distinct threat. While it is always treacherous to speculate on political wranglings, the SGR "fix" was a challenge because, on the one hand, repeal of the SGR has significant costs in federal dollars over a 10 year period in a time of substantial federal deficits, while on the other hand, a one-time cut in Medicare payments of the magnitude indicated (greater than 20%) would probably have disrupted provision of Medicare services creating access issues for America's seniors and creating undue hardship for some medical practices.

However, while newspapers and the mainstream media reported the SGR repeal and lauded the bipartisan nature of the legislation (Medicare Access and CHIP Reauthorization Act of 2015), there are other aspects of the legislation that are very significant. Put simply, the legislation will attempt to use increasing incentive payments to drive the change away from fee-for-service. The current system of incentives will run as previously designed through 2018, with annual fee payment increases of 0.5% through 2019, and then no payment updates through 2025. Beginning in 2019, a new incentive program, the Merit-Based Incentive Payment System (MIPS), will consolidate the existing programs (PQRS, value-based modifier, and meaningful use of electronic records) into a new 100-point measure with increased payment modifications (positive and negative) based on performance. Alternatively, providers with significant participation in "alternative payment mechanisms" such as ACOs, bundled payment arrangements, and medical homes would see a 5% bonus through 2024 with payment rates increasing faster than traditional fee-for-service in 2026 and beyond.

While much will become clearer through rule-making and actual implementation, the legislation has created drivers of growing strength that will encourage, or pressure, depending on your viewpoint, physicians to pursue the alternative payment mechanisms. Once again, this is a challenge for pathologists and pathology practices to appropriately position themselves in their local environments. As the alternate payment delivery models grow and develop, how do pathologists position themselves to ensure their professional services are appropriately valued?

Payment for Medical Direction

Case: Payment for Medical Direction

Dr. Carol Smith, AP/CP-boarded and now doing a surgical pathology fellowship, was perusing her e-mails and read and then reread the following message: Hello, Dr. Smith. You've been recommended as a possible medical director for our Clinical Laboratory Improvement Amendments (CLIA)-certified toxicology lab. We pay generously and only require one afternoon visit per quarter. Please reply to this e-mail if you would like more details.

Discussion: A pathologist should be paid for medical direction. Medical director work requires expertise and entails risk, and therefore should be compensated. Ideally, compensation should be similar in magnitude to a similar effort invested in signing out AP. A number of ways to establish reasonable compensation will be explored in this book. In this case, a freestanding toxicology lab is looking for a medical director who would have their name on the CLIA certificate and hence be responsible by law for the medically related aspects of the lab. While the e-mail indicates a rather minimal time commitment, any potential medical director would want to be sure enough time was accounted for to fulfill his/her duties (duties are delineated in CMS publication Clinical Laboratory Improvement Amendments (CLIA) *Laboratory Director Responsibilities*, Brochure #7; http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/brochure7.pdf). As well, ensuring that a laboratory reports accurate test results is an ongoing challenge and depends on having competent, motivated personnel, proper testing platforms, and close adherence to established processes and procedures. Therefore, in evaluating an opportunity such as that described in the e-mail, you must be sure compensation is adequate for the full job while also establishing that a good job can be done in that particular situation.

The second major category of work performed by the pathologists is medical direction. A medical director (such as laboratory medical director or director of surgical pathology) regularly provides professional services and oversight in quality assurance, validation, designing protocols, reviewing procedures, personnel oversight, medical staff issues, and education of physicians. These services are needed for quality health care, are valuable, and should be compensated. Typically, such services are compensated through a negotiated contract with the hospital laboratory, and payment should reflect the effort involved at compensation levels appropriate for practicing pathologists. There are many available educational tools for negotiating a contract for laboratory direction and many approaches. Pathologist effort can be determined by percentage full-time equivalent or on an hourly basis. Payment rates can reflect national norms for pathologists or can be developed using an updated and adjusted reasonable compensation equivalent (RCE) payment amount as described in the Federal Register and periodically updated by CMS. It

is critically important to develop ongoing relationships with people such as senior hospital administrators who ultimately would be negotiating this contract with you and educate them over time about how you and your fellow pathologists add value. For example, you might meet weekly with your hospital administration, updating your groups' progress and demonstrating your involvement while always asking for feedback and input on ways to improve your service. A good source of further information on this topic is the Practice Management Resource area of the CAP.org website.

The funds to pay for medical direction come to the hospital from two major sources. Within the Part A, DRG payment to the hospital is a portion that covers pathologist medical direction services, but the actual amount has never been specified for the federally related DRG payments. As such, the pathologist must directly negotiate for that payment and ideally would do so using time or value added as a basis for payment. For non-Medicare/non-Medicaid or Champus/Tricare (i.e., non-federally based payors), the pathologist may either assume the hospital is being paid by the insurance companies and negotiate for additional payments to cover these services or bill the so-named professional component of clinical pathology. For the PC of CP, the pathologist bills the patient/patient's insurance by the test. While some insurers resist paying these bills, the process is described by the American Medical Association and has withstood repeated legal challenges.

Key Concept
Major sources of pathology revenue under government payment system:
Medicare Part A = Medical direction services provided on behalf of Medicare patients generally
Medicare Part B = Services provided to individual, identifiable Medicare beneficiaries

Some practice settings may also have other contractual sources of revenue, such as revenue derived from governmental or industry contracts or grants (e.g., provision of forensic autopsy services, collection, or management of clinical trial samples or other research grants) or revenue related to non-patient care services they may provide, such as review of legal materials, collection of biospecimens, or similar activities. Since these are generally a minor component of pathologist income, they will not be further dealt with in this work.

Beyond this brief overview of money flows through the US health-care system of interest to a pathologist, we encourage you to continue learning about health-care finance, as change is sure to be a constant. In particular, the payment rules, mechanisms, and amounts are rapidly evolving with the implementation of the Patient Protection and Affordable Care Act and the growing tendency of insurance companies, states, and the federal government to evolve their systems in response to an inexorable rise in overall health-care expenditures. Good sources of information are knowledgeable individuals in your own practice or institution, the College of American Pathologists' (CAP) *Statline* publication, online educational programs by a number of providers, and programs at national meetings of organizations such as the American Pathology Foundation (APF), American Society for Clinical Pathology (ASCP), and CAP.

Case: The Stable Practice

Dr. Jack Paris is AP/CP-boarded and recently completed a surgical pathology fellowship. He is currently 2 months into a genitourinary pathology fellowship. Dr. Paris enjoys diagnosing surgical pathology specimens and teaching but believes he would be happy in almost any practice setting that allowed him to see interesting cases. Dr. Paris generally tuned out during management lectures throughout residency and lets his wife worry about bills and investments. Just thinking about these things raises his heart rate and blood pressure. While contemplating what type of practice positions to apply for, Dr. Paris thinks aloud, "What type of practice would be most stable so I wouldn't need to worry about money and business?"

Discussion: Each practice is on its own trajectory with some practices thriving, some just surviving, and others destined to fail or dissolve. Therefore, you must "kick the tires" of any employment opportunity under consideration (see case at the beginning of this chapter). That said, logic suggests that a position in a commercial laboratory, where changing workloads and quarterly business performance will be closely matched with professional staffing, may offer less stability than many other practice settings. Another potentially less stable setting would be an independent private practice that is not dominant in its market. Regional hospital affiliations and mergers will drive changes in pathology providers and create winners and losers. Hospital-employed pathologists are in a middle group for stability as hospitals continue to align, realign, merge, downsize, or simply close. Academic practices would, on average, tend to be the most stable due to their size and multiple missions. For example, it seems almost inconceivable (perhaps we will eat our words) that the only state-based medical school/academic medical center in a state would be allowed to close, although significant pressures and changes would not be unexpected. For the individual academic pathologist who is a low performer, though, the risk will remain high as academic centers continue to respond to resource pressures in their three missions of clinical service, teaching, and research.

Case: How Do I Pay for Myself?

Dr. Cindy George suddenly felt uneasy. The AP/CP-boarded and fellowship-trained medical microbiologist had felt that her first annual evaluation as a faculty member at State University was going well. Her chairman, Dr. Sparks, had been very complimentary about her ability to work with hospital personnel to introduce two major testing platforms in her first 8 months on the job. The residents were suddenly excited about microbiology, and two were even contemplating fellowships in medical microbiology. The chairman of medicine, an infectious disease physician, had commented several times to Dr. Sparks that Dr. George was a great hire. Everything about the evaluation had been going well until Dr. Sparks showed Dr. George the collected Part B PC revenue that had been attributed to her in her first 8 months on the job: US$612.00. "Six hundred and twelve dollars?" A sudden sense of panic seized Dr. George as she thought, "I'm about to get fired."

Discussion: Pathologists are paid in multiple ways for their professional services, and, in the academic setting, teaching and research are paid for (if they are paid for at all) through other mechanisms. For her professional services, Dr. George could be compensated through a medical directorship contract (most likely a component of a larger agreement) representing Part A monies from CMS with or without hospital monies for nonfederally covered patients. If her practice billed the PC of CP, collected money could be attributed to Dr. George's efforts. As well, certain specific Part B services, such as transfusion reaction investigations that Dr. George might perform on call, could provide additional revenue. Money for teaching can be from a variety of sources: state money, hospital money, or a pass-through of Medicare, graduate medical education (GME) money being the most common. Dr. George could also receive research-related money from a component of salary on grants or through contracted research, for example, from a contract with a pharmaceutical firm investigating a new antibiotic. Therefore, one would not expect Dr. George to have significant Part B collections. Her salary would more likely be covered by payments for medical direction, PC of CP billing, teaching, and research.

Case: In Vivo Microscopy

In vivo microscopy (IVM) is a relatively new technology with the potential for pathologist involvement that has matured the furthest as a tool to guide endoscopic identification and biopsy of Barrett's esophagus. One application of IVM allows for endoscopic evaluation of mucosa very much resembling histologic evaluation at low power (optical coherence tomography) and higher power (confocal laser microscopy). This allows for identification of the highest yield areas for biopsy of Barrett's esophagus with or without dysplasia. IVM can also help map lesions for endoscopic mucosal resection. IVM is performed by the endoscopist during upper endoscopy, but, arguably, the best person to interpret these "near-histology" studies would be the pathologist. There is a CPT code for this interpretation that would not be billed by the endoscopist (the procedural code cannot be billed with the IVM interpretive code by the same physician), so a pathologist could bill this code and not directly compete with the endoscopist's coding/billing.

Questions for discussion:

1. For late 2015, the average Medicare global fee for IVM interpretation (CPT 88375) is US$48.15. If this technology is indeed an analog of histology and will continue to find new approaches and the pathologist should be involved, how can you or your practice be involved?
2. Does it make sense for a pathologist to work side by side with the endoscopist during endoscopy for say 20 plus minutes for reporting of a global payment of US$48 and change? (Do you even know where the endoscopy suites that provide such studies are located?)
3. Is there a more efficient way for the pathologist to be involved, either through enhanced information technology or by nonconcurrent IVM interpretation that would occur separate from the endoscopy?
4. Should you think of participation in IVM by your group as a loss leader to gain experience and be a player in the future, or would it be better for your practice to take a "watchful waiting" approach to this technology with the attendant risk that the technology is embraced by other specialties such that pathology involvement at a later time is no longer practical?

Resources

1. *Pathology Service Coding Handbook*, American Pathology Foundation (updated and released to current subscribers each calendar quarter), see at www.apfconnect.org
2. www.cap.org →Practice Management Resources
3. "Your CPT Questions" in *CAP Today*
4. *Statline* available at CAP.org
5. CPT Manuals from AMA (www.amapress.org)
6. AMA CPT Codes and Resources link (www.ama-assn.org)

Chapter 2
Trends Towards Outcomes, Accountable Care, and Value-Based Purchasing

Dale W. Bratzler

Case: A Glimpse into the Future

Dr. Lucy Yu, chair of pathology at Mid-State University Medical Center, felt a sudden sense of fear as she stopped to consider the big picture. As chair of the faculty practice plan's finance committee, which oversaw contracts and finances for the nearly 600-strong group, she had been so focused on the execution of the meeting that she had not fully realized the discussion's potential impact on her department. The committee was meeting with the state's Medicaid Chief Medical Officer (CMO) to discuss a proposal to intensely manage congestive heart failure patients and diabetics with the goal of reducing hospitalizations and ultimately total care expenditures for these chronically ill patients. The CMO promised to fund several case managers and provide IT support with the potential additional gain to the practice of sharing half of any savings over projected expenditures for these patients.

Dr. Yu and the committee were excited at the potential savings but were even more interested in gaining experience with intensive case management for chronically ill patients. But as Dr. Yu reveled in the possibilities, it suddenly occurred to her: but what about pathology? How do we fit in this model?

Discussion: Two related trends are evident in this scenario: (1) the move to manage patients outside the hospital with the goal of keeping them healthy rather than waiting until acute care is needed, (2) delivering less acute care and reducing unnecessary care. Although, in some cases, more intense or frequent testing may facilitate managing patients outside the hospital, both trends otherwise run counter to how most pathologists have positioned their practices. Pathologists have thrived for years by doing testing, and more testing was generally better. While adapting to less testing is relatively straightforward, how to use our expertise to help manage patients at home and to improve the health of populations are areas in which few pathologists have had much experience. As the health-care system continues to move towards maintaining health in addition to mitigating sickness, pathologists must take on new roles. Will we bring our IT expertise to bear and provide seamless reporting across all environments? Can we design testing algorithms that focus on maintaining health? Or will we have a very limited role in the outpatient and even "pre-outpatient" (home) environments?

D. W. Bratzler (✉)
Health Administration and Policy, College of Public Health, University of Oklahoma Health Sciences Center, 801 N.E. 13th St., CHB 128B, Oklahoma City, OK 73104, USA
e-mail: dale-bratzler@ouhsc.edu

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Transformation of the US health-care system and payment models was inevitable. In 2013, US health-care spending reached $2.9 trillion annually, approaching 18% of the gross domestic product. Prior to passage of the Affordable Care Act, it was widely acknowledged that the Medicare Trust fund would enter deficit spending by approximately 2017. At the same time, there was growing consumer recognition that the costs of health insurance and the amount of out-of-pocket co-pays and deductible payments were outpacing rates of wage growth. The ever-increasing expenditures on health care in the USA were not sustainable and reports from the Institute of Medicine (http://resources.iom.edu/widgets/vsrt/healthcare-waste.html) highlighted that up to 30% of health-care spending is wasted on things such as unnecessary clinical services, excessive administrative costs, inefficiently delivered services, prices that are too high, fraud, and missed prevention opportunities.

Besides the rising costs of health care, there was also broad recognition that there were widespread gaps in the quality of health care. Many studies demonstrated significant variations between providers of care on a host of quality metrics including process of care measures and outcome measures. Although the USA has the most expensive health-care system in the world, we rank last on indicators of efficiency, equity, and outcomes as compared to other industrialized nations (http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror). While the USA has developed the best "sick care" system in the world with a focus on high-tech, complex, hospital- and specialty-based care that is very costly, our population is generally not healthy when compared to many other countries.

Another factor driving transformation of the health-care system is rising consumerism. Consumer groups have promoted policies of transparency particularly related to quality and costs of care. These efforts aim to expand choices for patients armed with better information about the quality, patient experience of care, and cost of care, resulting in informed treatment decisions and selection of providers and care systems.

With this background, a number of laws have been passed and implemented over the past decade that have promoted transparency related to health-care quality and have started shifting the way that health care is financed. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act created the first requirements for collection and public reporting of quality metrics for hospitals. Hospital quality transparency was enhanced in 2005 with implementation of the Deficit Reduction Act of 2005, which expanded the authority of the Secretary of the Department of Health and Human Services to add required public reporting of additional quality measures and increased the penalty for non-reporting. These efforts were not limited to hospitals. Congress authorized the Physician Quality Reporting System (PQRS) through the Tax Relief and Health Care Act of 2006, which provided incentives to physicians who report standardized quality metrics to the Centers for Medicare & Medicaid Services (CMS), and, as with the hospital reporting programs, penalties for failure to report. Similar efforts were implemented for other settings of care such as nursing homes, dialysis units, home health agencies, and cancer centers.

Passage of the Patient Protection and Affordable Care Act in 2010 accelerated transformation of the health-care system with many payment and quality provisions.

In addition to continued incentives for quality reporting and transparency, the act provided for a number of payment provisions to accelerate value-based payment for health-care services. For hospital systems, the law required modification of hospital payment based on quality of care through the Value-Based Purchasing (VBP) Program. For physicians, the act created the Value-Based Payment Modifier (VM) which mandated that by 2017 performance on measures of cost and quality of care is to be included for calculating payments to physicians. The act also provided incentives for physicians to join together to form "Accountable Care Organizations (ACOs)."

With the rapid trend to develop value-based contracting methods, a range of models has been developed to transform health-care payment to a system that rewards high-quality care and value. The models described below represent a progression that is characterized by increasing financial risk assumed by providers and greater need to coordinate across settings of care:

- *Payments for reporting*—widely implemented by CMS for many settings of care, there are incentive payments for reporting quality metrics for public release, and often penalties associated with failure to report the quality metrics. For example, there are hundreds of metrics that physicians can choose from, including measures developed by the College of American Pathologists, to report to CMS as a part of the PQRS program.
- *Incremental fee-for-service payments for value*—the hospital VBP Program and the physician VM exemplify this model. When physicians and hospitals can demonstrate higher quality of care and efficient delivery of service (high "value") through quality measures submitted to CMS or calculated through payment claims by CMS, there are small percentage adjustments to fee-for-service payments. For example, up to 2% of a physician's Medicare payment is at risk under the VM, but for physicians who demonstrate high-quality care at the lowest costs, there are incentive payments available above the typical Current Procedural Terminology (CPT)-based fee-for-service payments.
- *Bundled payments*—under this model, the health-care facility and providers enter into payment arrangements that include financial and performance accountability for episodes of care. Typically, these arrangements include a fixed payment for all services provided to the patient for the specific condition. An episode of care is the set of services required to manage a patient's specific medical condition over a defined period of time. These models typically result in improved coordination of care and reduce unnecessary care. While most of the initial bundled payment demonstrations have focused on discrete surgical procedures such as joint arthroplasty or cardiac surgery, there are multiple demonstrations ongoing for using bundled payments for chronic disease episodes.
- *Accountable Care*—ACOs are groups of doctors, hospitals, and other health-care providers who come together voluntarily to give coordinated high-quality care to their patients. The goal of these organizations is to provide coordinated care to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing

medical errors. There is considerable variation in the contracting models of accountable care that currently exist (Shortell SM, Health Affairs 2010). Tier 1 ACOs (such as the Medicare Shared Savings Program) involve providers receiving fee-for-service payment, but additionally, added incentives are possible, such as shared savings or bonuses, if per patient spending is below some agreed-upon target. Financial risks are increased in Tier 2 ACOs which typically include some mix of payment based on fee-for-service reimbursement, partial capitation, and bundled payments for some conditions. In these arrangements, the potential sharing of savings and bonuses is greater if overall spending for the patients is below the agreed-upon target; however, there is some risk to the ACO if spending is above the target. The greatest financial risk is found in Tier 3 ACOs. These organizations are often reimbursed through full or partial capitation based on the health of a population of patients, in addition to extensive bundled payments for a variety of conditions. There are greater potential rewards to the ACO, such as shared savings and bonuses, if overall spending is below some agreed-upon target; however, there is also increased risk if spending exceeds the target.

Key Concepts
Strategic choices for pathologists are -how to best use expertise when payments are based on value to the patients and organization rather than volumes of patients served, and-how to measurably impact newer measures of outcomes, rather than process.

Another major trend that has been implemented by CMS is the move away from process of care measures to a greater focus on outcomes of care. For hospitals, there has been a dramatic shift away from measures of care process to a variety of outcome measures such as 30-day mortality rates, hospital readmission rates, and infection rates. Not only are there fewer process of care measures that hospitals are required to report, the weighting of the scores for the VBP Program has shifted to emphasize other metrics including outcomes of care, costs of care, and patient experience. Similarly, in the early Medicare demonstrations for ACOs, a variety of outcome measures are used to assess quality performance and outcome measures (such as preventable admissions) are now routinely calculated for physician practices as part of the VM. CMS has increased the emphasis on outcome measures because they directly measure the end result of care, as experienced by the patient. By being more directly tied to results, they are also likely to be more relevant to, and more easily understood and embraced by, patients.

As providers become increasingly accountable for overall patient outcomes and costs of care, it is important for pathologists to understand these various payment arrangements. It is likely that they will impact both the volume of services provided and rates of reimbursement for those services. In January 2015, Secretary Burwell announced that CMS plans to have 90% of all Medicare fee-for-service payments tied to quality or value metrics by 2018 and plans to have 50% of all Medicare payments tied to alternative payment models—primarily ACOs and bundled payment arrangements—by the end of 2018. As noted in Chap. 1, with passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which resulted in the repeal of the sustainable growth rate (SGR) formula, beginning in 2019

physicians will either have to have a "substantial portion" of their revenues tied to approved alternate payment models or will be subject to the Merit-Based Incentive Payment System (MIPS), which will hold the practitioner accountable for quality and costs of care. This trend towards value-based contracting is not unique to CMS as an increasing number of private insurance companies are contracting with health systems and providers of care through various alternate payment models. Finally, as private insurers seek to develop value-based contracts, a growing trend is to organize "narrow networks." Narrow networks are health insurance plans that place limits on the doctors and hospitals available to their subscribers. The most restrictive plans will not pay for care received outside of the defined network. The other way for implementation is to charge higher co-payments when patients seek care from providers who are not part of the narrow network. With either implementation, the primary goal is to emphasize high-quality care at the lowest cost.

Case: The Push Toward Outcomes, Bundled Payments and Value-Based Purchasing

The fee-for-service environment in which payments are made on a per-service basis has been successful for pathology practices, other medical practices, and hospitals. The more services that were delivered, the more payments that would be received by the service providers. This was founded on the trust between a patient, society, and the professionals bound by oath to do no harm and deliver care in the best interest of the patient. With the growth of bundled payments, where payments are made for an episode of care and the growing focus of paying for value, where value is defined as better results for the resources invested or similar results for less resources (value = outcomes ÷ cost), health-care experts are predicting a significant transition away from fee-for-service payments. Some experts project a decline in fee-for-service to as low as 30% of payments by the end of the decade. One complication is that these changes will not occur evenly across the country, and some practices will be affected to a much greater extent than others.

1. What changes have you seen in your environment?
2. How have the changes affected your practice?
3. How will the further development of these trends affect your practice?
4. Are there advantageous steps your practice can proactively take?
5. Would it make sense to attempt to drive the changes in your environment perhaps through new models with major insurance companies or large local employers?

Resources

CAP.org website

Statline available at CAP.org

Chapter 3
Coding and Billing

Dennis L. Padget, Lewis A. Hassell and Michael L. Talbert

CPT® Coding

Case: Simple CPT (Current Procedural Terminology) Coding

A right colectomy specimen consisting of 4 cm of terminal ileum, appendix, and 8 cm of colon with attached mesentery is received with a working diagnosis of colon cancer. The gallbladder is in a separate container. How would you CPT code this case?

Discussion: 88309 and 88304 would be used for the neoplastic colon and gallbladder, respectively. A separate code would not be assigned for the segment of terminal ileum or appendix.

CPT: Physicians' *Current Procedural Terminology* codebook published annually by the American Medical Association (AMA). Each 5-digit numeric code describes a unique physician medical service (e.g., frozen section diagnosis, consultation on referred slides) or laboratory test (e.g., glucose, Papanicolaou test (Pap test)). CPT codes (a.k.a. Healthcare Common Procedure Coding System (HCPCS) level I codes) must be used by physicians and laboratories

D. L. Padget (✉)
APF Consulting Services, Inc., 1540 South Coast Highway, Suite 204,
Laguna Beach, CA 92651, USA
e-mail: DennisPadget@embarqmail.com

L. A. Hassell · M. L. Talbert
Department of Pathology, University of Oklahoma Health Sciences Center, 940 Stanton L. Young Blvd., BMSB 451, Oklahoma City, OK 73104, USA
e-mail: lewis-hassell@ouhsc.edu

M. L. Talbert
e-mail: michael-talbert@ouhsc.edu

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