Optimizing Lab Outreach Revenues as Payers Get Tougher on Claims

Wednesday, May 6 - 2:10 PM to 3:00 PM
Presentation Overview

- Setting the Stage
- Payment Types
- Billing Process
- Where to Focus
- Audits
- Outreach Growth
- Connectivity
- Business Intelligence
- Summary
Healthcare Reimbursement Environment
Shifting Medicare Reimbursements from Volume to Value

- HHS goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by the end of 2016
  - Accountable Care Organizations (ACOs)
  - Patient-Centered Medical Homes (PCMH)
  - Bundled and Value-based payments
  - 50 percent of payments to these models by the end of 2018

- Tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the
  - Hospital Value Based Purchasing
  - Hospital Readmissions Reduction Programs
Value-Based Health Care Delivery Model

What does it look like:

- Deliver the best outcomes
- Penalties for failure
- Episode-based or bundled payments
- Align providers’ incentives
- Payment coverage
# HHS Healthcare Payment Categories

## Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Fee for Service—No Link to Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>Limited in Medicare fee-for-service. Majority of Medicare payments now are linked to quality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Fee for Service—Link to Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>At least a portion of payments vary based on the quality or efficiency of healthcare delivery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Alternative Payment Models Built on Fee-for-Service Architecture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>Hospital value-based purchasing, Physician Value-Based Modifier, Readmissions/Hospital Acquired Condition Reduction Program</td>
</tr>
<tr>
<td>Key Payment Models</td>
<td>Accountable care organizations, Medical homes, Bundled payments, Comprehensive primary care initiative, Comprehensive ESRD, Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payment is not directly triggered by service delivery, so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)</td>
</tr>
</tbody>
</table>

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**CMS.gov**  
**Fact Sheet**  
**2015-01-26**
Trends in Payment Type

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 30% All Medicare FFS
- 85% All Medicare FFS

2018
- 50% All Medicare FFS
- 90% All Medicare FFS
Patient Centric Delivery of Value

According to Michael Porter, a professor at The Institute for Strategy and Competitiveness, based at the Harvard Business School, a Value-Based Delivery System is achieved through 6 components and revolves around delivering value for patient.
Value Measurement

$$\text{Patient Value} = \frac{\text{Health Outcomes}}{\text{Cost}}$$
Hospital Lab Outreach Programs
Future Payment for Clinical Lab Services

PAMA

- Medicare to reimburse CLFS based on Private Payer Rates
- Protecting Access to Medicare Act – Beginning 2016 Laboratories will be required to report extensive pricing & volume information to CMS next year, or face significant fines and penalties
- CMS will determine the weighted median prices for tests on the CLFS, and these weighted medians will be the Medicare rates that are effective beginning on January 1, 2017
- CLFS no longer will be subject to geographic adjustments, budget neutrality adjustments, annual updates or “other adjustments.”
- CMS must finalize rules by June 30, 2015 that explain how the agency will collect private market data and set new CLFS rates
Type of Bill – Old (prior to January 2014) Hospital Outpatient Prospective Payment System (OPPS)

- “For all hospitals except CAHs and Maryland waiver hospitals, if a beneficiary receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. However if the non-CAH or Maryland waiver hospital only collects or draws a specimen from the beneficiary and the beneficiary does not also receive hospital outpatient services on that day, the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14X bill type.”

Medicare Benefit Policy Manual
Chapter 6 - Hospital Services Covered Under Part B
Table of Contents
(Rev. 107, 05-22-09)
70.5 - Laboratory Services Furnished to Nonhospital Patients by Hospital Laboratory
(Rev. 82; Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)
Defining Outreach

ACO

In-reach

Outreach

Employed Physicians

Strategic Physicians

Independent Physicians

HIS/LIS

Medical Home

Web Outreach

EMR

Practice Management

Connectivity
### Type of Bill – New Hospital Outpatient Prospective Payment System (OPPS) – L1 Modifier

<table>
<thead>
<tr>
<th>Condition</th>
<th>Claims with Dates of Service on or after January 1, 2014, and received Prior to July 1, 2014</th>
<th>Claims with Dates of Service on or after January 1, 2014 and received on or after July 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Non-patient (referred) specimen;</td>
<td>TOB 14x</td>
<td>TOB 14x without the new modifier</td>
</tr>
<tr>
<td>(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service;</td>
<td>*TOB 14x</td>
<td>TOB 13x and the new modifier, effective January 1, 2014</td>
</tr>
<tr>
<td>(3) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day</td>
<td>*TOB 14x</td>
<td>TOB 13x and the new modifier, effective January 1, 2014</td>
</tr>
</tbody>
</table>
Outpatient vs Non-Patient Method of Payment for Clinical Laboratory Tests - Place of Service Variation

- Outpatient laboratory tests are generally packaged as ancillary services and do not receive separate payment
- Outpatients eligible for separate payment under the CLFS
  - Outpatient lab tests only
  - Unrelated outpatient lab tests
- Non-Patients are paid under the CLFS
- Be sure your staff knows the difference and assigns correct patient type
Billing Strategies
Billing Process Focus

- Problem areas with Improper Payments
- Focus on front-end
  - Test orders & Compliance
  - Patient type & OPPS
  - Modifiers
  - Improve Connectivity
- Optimize Billing Processes
- Deliver Actionable Business Intelligence
Appendix B: Projected Improper Payments and Type of Error by Type of Service for Each Claim Type

This series of tables is sorted in descending order by projected improper payments. All estimates in this table are based on a minimum of 30 lines in the sample.

Table B1: Top 20 Service Types with Highest Improper Payments: Part B

<table>
<thead>
<tr>
<th>Part B Services (BETOS Codes)</th>
<th>Projected Improper Payments</th>
<th>Improper Payment Rate</th>
<th>95% Confidence Interval</th>
<th>Type of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Doc</td>
</tr>
<tr>
<td>All Other Codes</td>
<td>$2,092,821,992</td>
<td>6.6%</td>
<td>5.5% - 7.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>$1,174,125,211</td>
<td>20.7%</td>
<td>18.9% - 22.5%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Lab tests - other (non-Medicare fee schedule)</td>
<td>$1,069,657,944</td>
<td>36.1%</td>
<td>30.6% - 41.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>$1,042,121,031</td>
<td>7.2%</td>
<td>6.2% - 8.2%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Hospital visit - initial</td>
<td>$912,148,529</td>
<td>31.3%</td>
<td>29.1% - 33.5%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>
# Laboratory Error Types

<table>
<thead>
<tr>
<th>Part B Services (BETOS Codes)</th>
<th>Projected Improper Payments</th>
<th>Improper Payment Rate</th>
<th>95% Confidence Interval</th>
<th>No Doc</th>
<th>Insufficient Doc</th>
<th>Medical Necessity</th>
<th>Incorrect Coding</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab tests - other (non-Medicare fee schedule)</td>
<td>$1,069,657,944</td>
<td>36.1%</td>
<td>30.6% - 41.6%</td>
<td>0.5%</td>
<td>93.6%</td>
<td>5.7%</td>
<td>0.0%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

- Improper Payments – 36.1%
  - Insufficient Documentation – 93.6%
  - Medical Necessity – 5.7%
### Closer Look at Improper Payment Rates

<table>
<thead>
<tr>
<th>Part B Services (BETOS Codes)</th>
<th>Improper Payment Rate</th>
<th>Number of Line Items (Sample)</th>
<th>Projected Improper Payments</th>
<th>Standard Error</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab tests - urinalysis</td>
<td>31.5%</td>
<td>403</td>
<td>$21,679,716</td>
<td>2.4%</td>
<td>26.9% - 36.1%</td>
</tr>
<tr>
<td>Lab tests - blood counts</td>
<td>28.4%</td>
<td>577</td>
<td>$86,732,770</td>
<td>2.7%</td>
<td>23.1% - 33.6%</td>
</tr>
<tr>
<td>Lab tests - bacterial cultures</td>
<td>23.1%</td>
<td>101</td>
<td>$20,686,338</td>
<td>4.1%</td>
<td>15.0% - 31.2%</td>
</tr>
<tr>
<td>Lab tests - routine venipuncture (non-Medicare fee schedule)</td>
<td>18.4%</td>
<td>787</td>
<td>$27,215,006</td>
<td>2.0%</td>
<td>14.4% - 22.3%</td>
</tr>
<tr>
<td>Lab tests - glucose</td>
<td>14.7%</td>
<td>74</td>
<td>$2,766,817</td>
<td>2.3%</td>
<td>10.2% - 19.2%</td>
</tr>
</tbody>
</table>

- Urinalysis – 31.5%
- Blood Counts – 28.4%
- Bacterial Cultures – 23.1%
- Venipuncture – 18.4%
- Glucose – 14.7%
Documented Test Orders

- Having a lab requisition for the order itself isn’t enough
- Tests billed must have a specific order for the test in the patient’s chart/EMR
- Review the medical record documentation and physician’s orders for laboratory tests and validate that each test ordered is supported by documentation of medical necessity and billed with the appropriate CPT-4 laboratory procedure code.
- Applicability of order to the patient condition and ICD code
- Some suggest to have the requisitions signed or an electronic signature but this isn’t fool proof
Billing Process Flow Issues

1. Order Entry Errors cause Charge issues
2. Charge problems cause Claim issues
3. Claim problems cause Reimbursement issues
4. Reimbursement issues impacts CASH
Billing Process Flow Issues

Order Entry Errors cause Charge issues

Charge problems cause Claim issues

Claim problems cause Reimbursement issues

Reimbursement issues impacts CASH
Clean Claims

- Review PSC and registration processes for opportunities to capture of information and improve accuracy
- Review error processing procedures for timeliness and missing component resolution
  - Well-designed and electronic process to request and collect missing information
- Up to date front end edits, NCCI, NCDs, LCDs, CCI, MUE, 72 hour
- Utilize denial information to improve front-end/clean claim
  - Denial reporting by type, payer, provider, test
  - Educate providers on problem areas - Scorecard
- Connectivity & education of providers is paramount
59 Modifier

- Identify procedures and services that are not normally reported together, but identify separate and distinct services
  - procedure or service is distinct or independent from other tests
  - not normally reported together
- Documentation in the medical record must support
- CCI Edits: providers may override CCI edits by appending a -59 modifier to the secondary procedure
  - Modifier Indicator of “0,” the Column 1 and Column 2 codes should never be reported together
  - Modifier Indicator of “1,” the Column 1 and Column 2 codes may be reported together
Four new –X(EPSU) modifiers
Define specific subsets of the -59 modifier

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

MLN Matters SE1503
Compliant Billing, Coding and Documentation

Avoid RAC Audits

- Perform your own internal audits periodically
  - Medical necessity – CPT & ICD-9 in EMR
  - Accession auditing to assure 100% accessions captured
  - Test auditing to assure all CPT capture
  - Review the CPT-4 codes billed for validity and obsolescence
  - Correct modifier application – front end preferable
  - SNF billing compliance

- Consider outsourcing the billing to a third party lab specific vendor
  - Well developed compliance plan and resources to stay up to date
Clinical Laboratory Fee Schedule
Medicare Travel Allowance Fees for Outreach Collection of Specimens

- Be sure to capture this revenue where applicable
- Covers the estimated travel costs of collecting a specimen
- MAC discretion allows the MAC to choose either a mileage basis or a flat rate
- Multiple specimens in one trip, travel payment is prorated based on volume
- Review your policies of using the P9603 or P9604 codes
Billing Process Flow Issues

1. Order Entry Errors cause Charge issues
2. Charge problems cause Claim issues
3. Claim problems cause Reimbursement issues
4. Reimbursement issues impacts CASH
Assembly Line Billing
Room for Error at any Phase
Outreach Billing Operational Mechanics

- Focus on billing staff should be geared towards achieving quality production from every resource at every phase of revenue cycle
  - Monitor a quality metric of production staffing not just a volume metric
  - Monitor errors
- Image scanning capabilities – tied to patient account
- Fraud and abuse monitoring software
- Customer Service Center – Track calls and patient satisfaction
- Issue refunds on time
- Robust clearinghouse to help further scrub for clean claim goal
Billing Process Flow Issues

Order Entry Errors cause Charge issues

Charge problems cause Claim issues

Claim problems cause Reimbursement issues

Reimbursement issues impacts CASH
Review AR Management Benchmarks

- Days Sales Outstanding (DSO)
- Bad debt %
- Write-offs
- Aged AR balances
  - How well do you collect on your allowed amounts
  - AR % > 90 days
- Understand your cash flow
- Clean Claims %
- Revenue/Test & Accession
- GCR & NCR
A/R Follow-up and Denials

- Denials
  - Track Appeals, Recovered, Denied, and Pending by aging and outcome
- Under-payment & Unpaid monitoring
- Write-offs?
- Monitor bad debt & contractual adjustment
  - Correlation between self pay and bad debt
  - Contractual adjustments must be monitored by payer
- Review areas of backlogs & charge lags
- What accounts are on hold – why & for how long
- 72 hour Rule
- Consider predictive modeling tools
Medicare Administrative Contractors
The Hub of the Medicare Fee-for-Service Program

MACs and 8 of CMS’ Functional Contractors

- Recovery Auditors (RAs)
- Qualified Independent Contractors (QICs)
- Benefits Coordination & Recovery Center (BCRC)
- Zone Program Integrity Contractors (ZPICs)
- Call Center Operations (CCO)
- Virtual Data Centers (VDCs)
- Quality Improvement Organizations (QIOs)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
Who May Contact You for (CMS) Activities

**Claims Processing Contractors**

- **MACs** may contact you for a variety of reasons:
  - Resolving issues regarding your initial and renewal enrollment applications
  - Providing education and guidance on procedures for billing Medicare
  - Resolving issues regarding claims you submit
  - Requesting medical records related to the claims you submit for medical review
  - Paying you for approved claims and/or explaining why some claims are not processed or are denied
  - Recovering overpayments on claims previously processed.
Who May Contact You about CMS Activities

Program Integrity Contractors

- Zone Program Integrity Contractors (ZPICs)
  - Identify cases of suspected fraud and taking appropriate actions

- Recovery Auditors
  - Identify and correct underpayments and overpayments
    - Comprehensive Error Rate Testing (CERT) program
    - Payment Error Rate Measurement (PERM) program
    - Medicaid Integrity Contractors (MICs)
    - Specialty Medical Review Contractors
      - Medicare Coordination of Benefits Contractor (COBC)
      - Medicare Secondary Payer Recovery Contractor (MSPRC)
  - Appeals Contractors and Entities
  - Quality Improvement Contractors
Know your MAC

- Interactive Map allows you to access state-specific CMS contractor contact information
- Use this website to access their contact information including emails, phone numbers and websites
Audit - Appeals

- Challenging with an appeal
- Retrieve, review and understand ALL the documents associated with a denial or refund demand
- Provide what they ask for and explain if you cannot; provide comments to also reduce misunderstandings of documents
- Review, Review, Review
- Be timely - Keep a record
- Only provide what they ask for
- Look for trends
- Contact a specialist
Billing Process Flow Issues

Order Entry Errors cause Charge issues

Charge problems cause Claim issues

Claim problems cause Reimbursement issues

Reimbursement issues impacts CASH
Proactively Pursue Self-Pay

- Ability to receive web based payments – Patient Web Portal
  - 24/7 availability
  - Post real-time to patient account
  - Ability to review and update billing information
- Ability to take credit card payments over the phone
- Automatic payment reminders via outbound calling
- Review patient billing cycles for effectiveness
- Review the statements messages to patients
- Actively monitor Bad Debt% of Self Pay
## Managing Bad Debt

### Self Pay vs Insured Patients

<table>
<thead>
<tr>
<th></th>
<th>Accounts Receivable</th>
<th>Self Pay</th>
<th>Bad Debt</th>
<th>Bad Debt of Total AR</th>
<th>Bad Debt of Self Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Lab 1</td>
<td>$200,000,000</td>
<td>$10,000,000</td>
<td>$3,000,000</td>
<td>1.5%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Outreach Lab 2</td>
<td>$200,000,000</td>
<td>$30,000,000</td>
<td>$5,000,000</td>
<td>2.5%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
Consider a Retail Model

- High-deductible health plans
- Patient out-of-pocket expenses
- Payer reimbursement
- Bad – debt
- Write-offs
- Collection methods
- Retail model
  - Collection efforts at time of service
Other Outreach Strategies
Maximize Outreach Contracts

- Labs get involved – Have contract copies
- Establish relationships and leverage Health System
- Develop a report to organize contracts with dates, term, fee schedules and carve outs – know termination deadlines!
- Be aware of renegotiations that are coming up
- Know how well you are getting paid….is it correct?
- Ancillary Contract Manager for Outreach labs
  - What they are looking for – Value Proposition
    - Same day testing
    - In-house pathologists available to consult with ordering physicians
    - True STAT testing (within 2 hours vs 4-6 hours for the commercial labs)
    - Extended business hours for draw sites
    - More experienced phlebotomists
    - Consolidated medical record for inpatient and outpatient testing (reduces duplicates)
    - Same test methodologies used for both inpatients and outpatients
    - Existing relationship with physicians because of their inpatients
    - Increased physician satisfaction using your lab versus commercial labs
Outreach Revenue Growth

- Thorough Analysis
- Competitor Pricing
- Payer Reimbursement
- Flexible Pricing

- Cost / Test
- Buy vs Make
- Payer Reimbursement
- Add complex Testing

- Eligibility
- MNV
- EMR
- Network
- Direct Access
- Compliance
- Business Intelligence

- Fee Schedules
- Test Mix
- Sales and Marketing

- Add Clients
- Keep Clients
- Customer 1st
- Marketing Plan
- Sales Tools
- Physician Relationships
Enhance Outreach Sales

- Know your clients well
- What tests and volumes / Territory
- Understand what clients are profitability
- Are they sending you tests - Supply usage
- What payers – are they cherry picking
- What locations
- Trends – drifting volumes
- Spend time on the right clients
- Align sales reps with incentives geared toward quality & growth
- Utilize CRM software
Outreach Marketing

- Selling to referring physicians
- Be cognizant of Anti-Kickback & Stark Laws
- Carefully review safe harbors
- Reduce risk of violating federal fraud and abuse provisions
- Be aware of financial arrangements
- Educate your sales team
Connectivity and Reporting
Integration Capabilities

Client
EMR
PMS

Client
EMR
PMS

Client
EMR
PMS

Client
EMR
PMS

Connectivity
Engine
Hub

HIS

EMR

DFT

O/R

ADT

O/R

O/R

O/R

O/R

O/R

O/R

Web
Portal
Outreach

Billing

LIS

Reference
Lab
The Connectivity Picture

Population Health Management
Integrated information technology systems share patient care information (dotted lines)
PCMH (Patient-centered Medical Homes)
IT-powered medical homes emphasizing prevention, illness avoidance

Public health resources (e.g., screenings)

Hospitals (e.g., acute care)

Nursing homes/Long-term care

Population

Pharmacies

Home care/Visiting nurses

Ambulatory/Specialty clinics

Rehab clinics
Outreach Lab Financial Reports

- Total Accession Volume – Month to Date (MTD) and Year to Date (YTD)
- Gross Sales – MTD/YTD
- Cash Collections – MTD/YTD
- Cash per Accession – MTD/YTD
- % Gross Sales to Collections – MTD/YTD
- Unbilled Accessions by Reason – MTD/YTD
- Cash Analysis by Charge to
- Trend Analysis by Volume, Billed Charges, CPTs, Gross Sales, Cash Receipts, Price per Accession, Price per Test, CPTs per Requisition, 30-45-60 day lag
- Billed Volume by Payer

- 3 Month Gross Sales Comparison by Gross Sales, Billed Invoices, Price per Invoice
- 6 Month Comparison of Unbilled by Reason
- 3 Month Cash Collection Comparison by Cash Collections, Billed Invoices, Cash per Accession
- 6 Month Adjustment Report
- Diagnosis Summary Report by Client including patient volumes, missing diagnosis codes, estimated dollar values
- Test utilization by CPT by Lab Charges
- Test utilization by CPT by Volume
Executive Dashboards by Client
Denial Reports by Provider

Demographic denials by client (Top 10)

<table>
<thead>
<tr>
<th>Referring Physician</th>
<th>Denied Gross Charge Amount</th>
<th>Denial Count</th>
<th>% of Jan. 2013 Demo Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>$25,400</td>
<td>131</td>
<td>8%</td>
</tr>
<tr>
<td>Dr. B</td>
<td>$20,000</td>
<td>88</td>
<td>5%</td>
</tr>
<tr>
<td>Dr. C</td>
<td>$18,900</td>
<td>76</td>
<td>5%</td>
</tr>
<tr>
<td>Dr. D</td>
<td>$16,800</td>
<td>64</td>
<td>4%</td>
</tr>
<tr>
<td>Dr. E</td>
<td>$12,900</td>
<td>72</td>
<td>4%</td>
</tr>
<tr>
<td>Dr. F</td>
<td>$12,800</td>
<td>48</td>
<td>3%</td>
</tr>
<tr>
<td>Dr. G</td>
<td>$12,800</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td>Dr. H</td>
<td>$12,300</td>
<td>57</td>
<td>3%</td>
</tr>
<tr>
<td>Dr. I</td>
<td>$12,100</td>
<td>40</td>
<td>2%</td>
</tr>
</tbody>
</table>

April 2013 Demographic Denials by Client (Top Ten)
What is Being Adjusted Off and Why

### Lab ABC Adjustment Report

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Jan 13</th>
<th>Feb 13</th>
<th>Mar 13</th>
<th>Apr 13</th>
<th>May 13</th>
<th>Jun 13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Auto Bad Debt</td>
<td>($28.67 )</td>
<td>($4,014.20 )</td>
<td>0.00</td>
<td>($630.00 )</td>
<td>($770.10)</td>
<td>($10,242.76)</td>
<td>($15,685.73)</td>
</tr>
<tr>
<td>02</td>
<td>Auto Courtesy Discount</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03</td>
<td>Auto Non-Approval</td>
<td>($35,875.40)</td>
<td>($125,160.10)</td>
<td>($137,354.30)</td>
<td>($61,537.01)</td>
<td>($63,510.50)</td>
<td>($80,163.20)</td>
<td>($503,600.51)</td>
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<tr>
<td>04</td>
<td>Auto Trade/Volume Discount</td>
<td>($3,966.53)</td>
<td>($3,432.87)</td>
<td>($6,045.58)</td>
<td>($8,403.61)</td>
<td>($6,742.77)</td>
<td>($8,892.39)</td>
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<td>B</td>
<td>Balance forward</td>
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<td>BILLING ERROR</td>
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<tr>
<td>S</td>
<td>Charge-off - small balance</td>
<td>($112.58 )</td>
<td>($245.63 )</td>
<td>($359.50)</td>
<td>($295.55)</td>
<td>($455.29)</td>
<td>($397.27)</td>
<td>($2,879.14)</td>
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<td>Charity Case Discount</td>
<td>($140,393.50)</td>
<td>($94,927.40)</td>
<td>($170,442.60)</td>
<td>($277,799.70)</td>
<td>($217,210.10)</td>
<td>($178,643.12)</td>
<td>($1,079,416.42)</td>
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<td>COINSURANCE WRITEOFF</td>
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<tr>
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<td>COLLECTION AGENCY</td>
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<tr>
<td>CP</td>
<td>COPAY WRITEOFF</td>
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<td>Funds credited</td>
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<td>Ins. non-approval</td>
<td>($235,400.88)</td>
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<td>($297,356.25)</td>
<td>($64,137.20)</td>
<td>($155,102.54)</td>
<td>($73,025.50)</td>
<td>($1,024,476.94)</td>
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<tr>
<td>O</td>
<td>MESC, MANUAL ADJUSTMENT</td>
<td>($14,062.16)</td>
<td>($8,865.80)</td>
<td>($22,871.85)</td>
<td>($33,085.75)</td>
<td>($34,590.09)</td>
<td>($6,513.40)</td>
<td>($119,969.15)</td>
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<td>NJ Ceed</td>
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<td>0.00</td>
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<tr>
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<tr>
<td>EMP</td>
<td>RWJ Employee W/O COPAY/DED</td>
<td>($71,206.70)</td>
<td>($27,504.20)</td>
<td>($56,166.60)</td>
<td>($89,363.90)</td>
<td>($72,110.33)</td>
<td>($49,461.50)</td>
<td>($365,833.23)</td>
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<td>UNTIMELY FILING</td>
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<td>0.00</td>
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<td>0.00</td>
</tr>
</tbody>
</table>

**Totals**

- Jan 13: ($1,653,833.28)
- Feb 13: ($1,588,565.02)
- Mar 13: ($1,351,093.35)
- Apr 13: ($2,047,086.73)
- May 13: ($2,370,248.35)
- Jun 13: ($1,987,011.48)
- Total: ($11,597,838.21)
Value in Informatics

- Use technology and data to deliver value
- Help your providers by flagging patients at risk
  - Offer special questionnaires around disease states
- Understand how test utilization management is a key component of success in the future
- Connectivity solutions that support business and clinical intelligence dashboards
- Use your test report formats to educate for appropriate test utilization and new testing
- Longitudinal lab data
- Develop actionable insight data sets to improve quality of care
  - Providers to better manage a patient population
  - Data to prove they are practicing high quality medicine - NCQA
## Value in Informatics

### DRP Content for January 1, 2015

<table>
<thead>
<tr>
<th>Clinical Measures (Required)</th>
<th>Criteria</th>
<th>2012 Version Points</th>
<th>2015 Version Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Poor Control $\geq 9.0%$</td>
<td>$\leq 15%$ of patients in sample</td>
<td>12.0</td>
<td>15.0</td>
</tr>
<tr>
<td>HbA1c Control $&lt; 8.0%$</td>
<td>65% of patients in sample</td>
<td>8.0</td>
<td>10.0</td>
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<tr>
<td>HbA1c Control $&lt; 7.0%$</td>
<td>40% of patients in sample</td>
<td>5.0</td>
<td>7.0</td>
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<tr>
<td>Blood Pressure Control $\geq 140/90$ mm Hg$^{**}$</td>
<td>$\leq 35%$ of patients in sample</td>
<td>15.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Blood Pressure Control $&lt; 130/80$ mm Hg$^{**}$</td>
<td>25% of patients in sample</td>
<td>10.0 removed</td>
<td></td>
</tr>
<tr>
<td>Eye Examination</td>
<td>60% of patients in sample</td>
<td>10.0</td>
<td>12.0</td>
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<tr>
<td>Smoking and Tobacco Use and Cessation and Treatment Assistance</td>
<td>85% of patients in sample</td>
<td>10.0</td>
<td>12.0</td>
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<tr>
<td>LDL-Control $\geq 130$ mg/dl$^{**}$</td>
<td>$\leq 35%$ of patients in sample</td>
<td>-10.0 removed</td>
<td></td>
</tr>
</tbody>
</table>

[http://www.ncqa.org/Programs/Recognition/ChangestoDRP.aspx](http://www.ncqa.org/Programs/Recognition/ChangestoDRP.aspx)
Outreach Direct Patient Resulting – Add Value

- Effective April 6, 2014 with full compliance on October 6, 2014
- Modified CLIA to allow labs to release results
- Applies to all labs that are covered entities under HIPAA
- Must authenticate the patient or designated representatives
  - Lab doesn’t have to supply if they cannot authenticate
- Only release finalized reports – electronic format; encrypt emails
- In a format requested by patient if available
- Utilize web based patient portals as able
- Hospitals can use normal release of record procedures
- 30 days to provide – Reference Labs are not exempt
- Charge for this service
Outreach Revenue Optimization Summary

1. Understand the current trends in Healthcare environment & payment changes
2. Consider outsourcing your billing for greater focus on AR management
3. Guide transformational change through a robust front-end process
4. Develop sales and marketing to grow your Outreach market share
5. Define metrics and monitor reports to know your fiscal viability
6. Develop strategies to set yourself apart and deliver value
THE JOURNEY OF A THOUSAND MILES

BEGINNS WITH A BABY
References

- http://www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx
- http://www.cdc.gov/chronicdisease/overview/
- https://hbr.org/2013/10/the-strategy-that-will-fix-health-care/