Taming the Cost of Esoteric and Reference Testing: Winning Strategies that Reduced Spending and Moved More Value to Physicians

Executive War College, Tuesday April 29, 2014
Key Learning Objectives

• To develop a greater understanding of various strategies to manage test utilization, especially highly expensive reference laboratory tests.

• To understand a few essential steps to take when working with clinicians and referral labs to manage utilization.

• To identify new strategies or how to enhance the current approach in the participant’s own laboratory in managing referral test utilization.
Wake Forest Baptist Medical Center

• Founded in 1902

• Academic Medical Center of the Wake Forest Baptist Health System located in Winston-Salem, NC
  ➢ 21 subsidiary or affiliate hospitals and operates more than 120 outreach activities in region
  ➢ Affiliated with Wake Forest University Health Sciences

• Department of Pathology:
  ➢ 320 FTE’s
  ➢ 4 million billable tests / year
  ➢ Specialty Labs: Cytogenetics, molecular, flow, stem cell processing, etc.
Diagnosing the “Pain”

- Referral expenses were 16% of total expenses and increasing each year.
- Industry benchmarking results indicated expense per referral reportable result was the highest of peer group.
- Major health system cost reduction initiatives required laboratory to reduce overall productivity to the 25th percentile.
- Data **RICH**; but analysis **POOR**.
- This major initiative began with a substantial analysis of data.
The Challenge

Primary Challenge – balancing the needs of:

• Administration (cost reduction)
• Clinicians (patient diagnosis and treatment)
• Pathologists and Staff (manage utilization)

Secondary Challenge:

Understanding the complexity of key activities that need to be executed… where to start?

- A High Quality Analysis of the data
The Approach

Form Test Utilization Task Force

Control Referral Laboratory Costs
- Review Referral Lab Contract & Pricing
- Benchmark within Laboratory Industry
- Conduct Profitability Analysis
  - Select Strategy by Lab/Test

Control Referral Utilization
- Review Top 50-100 Referred Tests by Volume
- Review Top 50-100 Referred Tests by Total Expense
- Conduct Cost Analysis
  - Select Top 10 to 20 Tests for Wave 1 Focus

Control Test Utilization
- Review Top 100 Tests by Volume
- Review Top 10-25 IP DRGs
- Review Unit Admit Order Sets
- Analyze by 1. Ordering Location 2. Clinician
  - Review Common Order Sets by each DRG
- Compare Current Order Sets by Patient Care Area
- Identify Opportunities for Improvement
  - Select Strategy by Test/DRG

Control IP Test Utilization
- Review Top 100 Tests by Volume

Establish Metrics to Monitor Test Utilization & Expense Performance
- Report Performance to Test Utilization Task Force

Color Key:
- Activities completed unless in italics
- Activities discovered to be not necessary or not possible to do.

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## Key Strategies

### Control Referral Lab Costs
- RFP Purchasing Process
- Contract Fee Schedules
- Consolidate Number of Labs
- Make vs. Buy Analysis
- ABN and Third-Party Billing

### Control Referral Utilization
- Pathologist Review
- Decision Tree/Algorithms
- Educate Physicians
- Identify Physician Champions
- Test Formulary
- Laboratory Practice Council
Managing Reference Laboratories

Key Strategies:

• RFP/Pricing Agreement: Three-year commitment, annual renewals
• Provided vendors with fee submission format (Excel)
• Divided tests into Top 100 and Additional Testing
• Included additional elements:
  - CPT codes
  - Added fees (e.g., specimen handling)
  - Vendor referred lab testing – internal and external
  - Third-party billing capability

Results: ~15% reduction in referral laboratory fees of “Top 100” Tests
Controlling Secondary Referral Labs

Consolidated Number of Labs

- No longer… “What the doctor wants, the doctor gets!”
- Audited number of referral labs

**Key strategies:**
- Selected primary vs. secondary labs
  - Redirected testing
- Selected contracted vs. non-contracted

Contract Fee Schedules – All Labs

- “We are getting a good deal already, 20% off of list!” – realized this was not always GOOD enough.
- “It’s cheaper to send direct” – realized this is not always true.

**Key strategies:**
- It never hurts to ask…
- Systematically required BAA and fee schedules
Innovative Price Negotiation: Reverse Auction

What the Buyer Sees:
1. Time remaining
2. Competing suppliers
3. Data summary

What the Supplier Sees:
1. Time remaining
2. Current bid amount and rank
3. Edit button

eBridge www.ebridgeglobal.com
Midpoint Strategies:

- Standing orders, admission orders, all order sets were limited to 3 days for recurring orders, CBC, CMP, etc.
  - Reduced CBC w diff to CBC when possible
  - Reduced CMP to BMP when possible
- Ongoing physician discussion regarding ordering of expensive referral testing – documented in *Send Out Review Log*, current savings at $130K
- Drafted Test Formulary Policy and Procedure
- Laboratory Test Utilization Task Force - first meeting 10 months into project
- Make vs. Buy process defined and implemented in January
Third-Party Billing Analysis – The Approach

1. Gathered performance data:
   - Estimated annual billable test volume (IP, OP, Outreach)
     • Included “Misc. Test Codes” – tests not on chargemaster
   - Cost/test from reference laboratory
   - Revenue/test – CPT code(s), used NC Medicare reimbursement

2. Analyzed cost vs. reimbursement by:
   - Individual test difference (identified high cost/test)
   - Annualized total cost (identified high annual cost, not volume-driven)

3. Identified top 25 opportunities and key activities:
   - Mapped new process
   - Piloted changes with Neurology (major user), then implemented by service and referral test volume
Educate Physicians – Identify Champions

• Bring **analyzed** data!
  - Test cost vs. reimbursement
  - Industry best practices (e.g., Medical Society Practice Guidelines)
  - *PROCEED WITH CAUTION* – Shared collective service line metrics with rare sharing of individual clinician usage metrics

• **Seized opportunities to educate:**
  - New physician orientation
  - Medical rounds
  - Medical staff meetings/conferences
Third-Party Billing – The Clinical Approach

- Provide the physicians with the facts – both financial and clinical – WE WILL UNDERSTAND
- Outline a simple approach to begin resolving the issues
- Funnel testing towards preferred labs when possible
Third-Party Billing – The Clinical Approach

• Meet with executive physician leadership to outline proposal and receive full support
• Communicate with physicians and caregivers
• Meet with key physician stakeholders during departmental grand rounds to scope the problem and outline process
  - Departmental and/or Section Conferences with:
    • Internal Medicine, Pediatrics, Neurology, Medical Genetics, Gastroenterology, Endocrinology
Third-Party Billing:  
“Physician discussion talking points”

Who qualifies for third-party billing?

Potentially qualified:

- Medicare: Non-patients only
- Medicaid: Outpatients and non-patients (varies by state)
- Commercial Payer: Outpatients and non-patients
- Explain DRG payment system
  - Understand the 3 Day rule when ordering send out tests
  - If a patient is admitted to the hospital within 3 days of ordering tests, the tests will fall under the DRG
Third-Party Billing:
“Physician discussion talking points”

What is third-party billing in the laboratory?

• When a reference lab bills the insurance payer directly for testing
  - Reference labs try to avoid this because hospital labs will pay more

• Explain third party billing process for managed care
  - The referral laboratory will bill the patient directly for tests
  - Discuss with your patients the expectation that the testing under consideration is expensive

  * Used a “$$$$” or “$$$” estimation rather than exact test cost (more description of this later in presentation)
  * Prepare your patient that the testing may effect their annual deductible
  * Obtain buy-in that hospital was historically the guarantor for send out testing, and the hospital is struggling sustain this outdated practice
Third-Party Billing:
“Physician discussion talking points”

• Educate physicians and PAs regarding basic billing

  Q: Most common question received in 2014, “How much will this test cost for my patient?”

  A1: The DRG system was first used in NJ in 1980, with nationwide roll-out in 1983. DRGs have been in place for 31 years. If your patient is an inpatient, their insurance carrier will reimburse based on DRG rather than cost-based itemized list.

  • It’s not like the bill at a sushi restaurant (ibid. For a referral laboratory’s test list)

  A2: If your patient is an outpatient, the price paid for the test is highly variable depending on circumstances.

  - (Similar to the price paid for an automobile – highly negotiable)
How Much Does a Test / “Car” Cost?

Illustration of Pricing Proportions for a Referral Test

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<th>“MSRP”</th>
<th>“Educated Consumer”</th>
<th>“Tough Negotiator”</th>
<th>“Hertz”</th>
<th>“GM”</th>
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RESULTS OF PROJECT
Third-Party Billing Results: Referral Lab A

Volumes

Expenses
Third-Party Billing Results: Referral Lab B

**Volumes**

- FY13
- FY14
- FY15

**Expenses**

- FY13
- FY14
- FY15

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Pathologist Review & Algorithms / Decision Tree

Referral test criteria:

- Cost (e.g., pre-determined threshold)
  - Started at $2000 and incrementally reduced ($1500, 1000) to a $500 ceiling as a single test or test combination on one patient
- Performing laboratory (e.g., primary or proprietary)
- Algorithms/decision tree (e.g., Parkinson’s Panel)
- Discipline-specific (e.g., genetic testing)

Results: Direct interventions have contributed 130,500 in reduction.
Test Formulary and Laboratory Test Utilization
Task Force

Test Formulary – Keep it Simple:

• Extent of control is IT dependent:
  • If there is a code built - anyone can order
  • No code built – ordered as MISC

• IP vs. OP appropriate testing (e.g., genetic tests)

Task Force Considerations:

• High level reporting structure
• Multi-disciplinary with non-lab chair
• Primary discussion topics:
  • Test formulary
  • Utilization parameters
  • Practice guidelines/algorithms
  • Limit or eliminate “daily” orders without an endpoint
Lessons Learned

• #1 Critical Success Factor: Obtain needed support from pathologists, executive, and high level medical staff
• Prioritize opportunities, focus on the “big rocks”
• Determine metrics to monitor performance early in process to track and communicate improvements
• Involve purchasing, compliance, billing and finance
• Integrate processes when possible (e.g. ABN and third-party billing)
• Never say never or assuming it will not work— it’s a new day!
Results: Overall Budget Impact

Comparing FY14 to FY13:
45% cost reduction, 16% volume reduction
TO THE FUTURE

• Developed a model for ordering send out tests that is dove-tailing off of the established pre-authorization process

  - Pre-authorization is very familiar to physicians
  - Pre-authorization is completely unfamiliar to most laboratories

1. Schedule send out laboratory test before it is collected
2. Perform pre-authorization process
3. Collect test and send after receiving a pre-authorized review of insurance plan and test coverage
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Questions & Comments