

PATHOLOGY BILLING TIPSHEET: 4 WAYS TO REDUCE BILLING ERRORS AND INCREASE REVENUE



Pathology billing and coding have complex regulations and rules, and there are many steps involved. Mistakes can occur at many points in “front-end” and “back-end” processes and can reduce collections by five percent or more, costing a typical practice or department hundreds of thousands of dollars, and frequently more. Mistakes also increase days in A/R, delay reimbursement and lead to compliance violations or fines.

In today’s era of ongoing pressures on pathology reimbursement, finding and fixing mistakes is more important than ever. In this tipsheet, we describe the 4 areas most prone to error, namely front-end reconciliation, eligibility, underpayments and pathology documentation.

AT A GLANCE:

Fix these errors and drive up revenue:

- Unbilled tests
- Eligibility errors
- Underpayments
- Documentation Gaps

FRONT-END CHARGE CAPTURE RECONCILIATION

With the high volume of tests in a typical lab, it is very easy for tests to not be billed. The first control process that needs to be in place is accession reconciliation. It is typically done on a monthly basis (to allow for normal lag times) but can be performed at any time. The billing system should identify missing accessions based either on sequence numbers or a comparison with LIS or other lab reports. Without this control in place, you can be assured that a number of tests will not be billed.

Most billing systems interface with LIS, ADT and other systems electronically, which drastically reduces the error rate versus paper. However, electronic interfaces require careful management of exceptions, such as records that are rejected. Usually the reason has nothing to do with whether the test is billable. Also, it is possible for the sending system to suddenly “lose” or miss information. This is most insidious when it is a small fraction: e.g. one set of CPT codes or one type of lower volume test.

For most hospital-based pathology billing situations, the charge information from the LIS needs to be matched with demographics from the hospital ADT or EMR system. If not managed carefully, this matching process can result in tests not billed. Often, the timing of these interfaces differs. This coupled with the high error rate in demographics, especially patient insurance information, means that there are always exceptions. Managing these exceptions every day and assuring that they are resolved is an essential requirement to prevent lost revenue.

ELIGIBILITY ERRORS

Eligibility errors typically comprise at least 35 to 40 percent of denials, even in well-run groups and departments. In a hospital-based pathology practice, we recommend that the pathology chair and the billing experts internal or outsourced meet with hospital administration to review and discuss eligibility denial results. The hospital should be interested since they are most likely experiencing denials from the same faulty data. For that reason, suggesting improvements to the hospital's process, such as online eligibility checks, verification of insurance information at discharge, etc. can be well-received.

For patients presenting for a lab test, the front end process is somewhat easier to address to reduce eligibility errors. We recommend an online eligibility check at the time a test is ordered, wherever that is practical. A confirming eligibility check at the front desk when the patient presents for a lab test is a great "belt and suspenders" approach, but isn't always practical. Having the eligibility information readily at hand also means that the co-pay and, perhaps, deductible can be collected prior to the test.

Of course, there are some cases where the patient is simply not covered. The policy may not cover this particular test, or the patient may have run out of benefits, or the insurance may have expired. The increasing popularity of high deductible plans has a similar effect: the insurance carrier isn't going to pay (though the claim must be adjudicated), so the patient will need to be billed. Where possible, labs should identify and address these situations prior to performing the test. The best approach is to ask the patient, "Which credit card would you like to use?" Don't underestimate the need for patient education: they may not know which tests are covered by their insurance and many on high deductible plans bought them for the low premium. Similarly, don't underestimate the need for front desk staff training: most won't be comfortable asking for payment or credit card information without proper training.

UNDERPAYMENTS

Claim denials are an obvious source of missed revenue and each one needs to be worked, ideally by automatically routing to the right specialist; then tracking to assure it is worked on a timely basis. More subtle, but often a source of substantial revenue, are underpayments of various types.

The first type arises when a payer remits the incorrect amount. The only way to catch these errors is to have the expected amount programmed into your billing system or by doing a regular payment analysis. If these steps aren't in place, your practice or department is missing revenue.

But this assumes that you have a good handle on expected payment amounts. Too often, this is not the case. Many groups don't have current copies of commercial payer contracts! So this is an obvious first step. For those that do have copies, the next question is, when were they updated? Unless done recently, it is probable that more favorable rates could be negotiated.

An important related consideration is the fee schedule. If the fee schedule is out of date, you may be filing claims below some payers allowed amounts. Or you may have newer tests without a fee established. Plus having the proper fee schedule is always useful during payer negotiations.

One final consideration: groups compensated by a hospital for Part A work may not be billing some of the Medicare clinical codes that are billable.

DOCUMENTATION ERRORS

Pathologists know that correct coding is needed for insurers to accept their claims and pay them correctly. Particularly for Anatomic Pathology, the coding is only as good as the documentation dictation.

ICD-10 adds complexity since the lab and pathologist are now dependent on the referring provider for the actual ICD-10 code or for enough information to determine it. In these cases, labs will need to determine the appropriate code based on any narrative or will need to contact the ordering provider.

Of course, there is an ongoing need to make sure documentation captures all work done accurately and in a way that minimizes downstream denials. Practices and departments should be getting feedback from their coding organization on error rates by physician to highlight those doing well and those performing poorly. Physician training is often very productive, based on quarterly or semi-annual patterns and feedback. Pathology chairs and practice leadership need to stress the importance of accurate reports.

Considering the evolution of coding and payment mechanisms, documentation improvement processes even more critical. For example, considering skin uclers or neoplasms as an example, pathologists' now need to ask themselves if their documentation:

- Says which side the problem is on/located? i.e. Right vs. Left
- Indicates where the diagnosis can be found within the anatomy of the organ system? e.g.
- Polyp – where in the colon is it located?
- Neoplasm – which part of the structure? Very specifically
- Tells their coding team if it is the first time this problem is being treated (initial episode of care) or is it something that has been treated before?
- Is specific enough to reduce the use of unspecified codes as much as possible?

Coders must have this level of detail for accurate coding. Is much more efficient to have the information included in the first report to avoid any need for clarification and addenda.

SUMMARY

If your pathology practice or department focuses on reducing these errors, it will translate directly to improved revenue. Be sure to monitor the trends in your monthly reports so that you become aware of any future slippage. In addition, reducing these errors means you have improved compliance and reduced audit risk.

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