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DIAGNOSTICS LAB EXECS REVEAL THEIR BIGGEST REVENUE CYCLE CHALLENGES

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We asked revenue cycle professionals at diagnostics labs to reveal their biggest pain points. Here's what they told us.

INTRODUCTION

Revenue cycle departments at diagnostics labs face unique challenges when it comes to managing increasingly complex prior authorization, eligibility and patient financial responsibility requirements.

We wanted to get a better understanding for the billing-related pain points that they face on a day-to-day basis, so we commissioned a market research firm to conduct a series of interviews with revenue cycle professionals from across a spectrum of lab services types. These included large national diagnostics labs with a broad portfolio of services, as well as more specialized labs focused on areas such as oncology, radiology, and genomics. To maintain confidentiality, we have removed any personally identifying information regarding the findings.

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PAIN POINT 1

POOR PATIENT VISIBILITY

The typical patient interactions that are common at hospitals, health systems or physicians' offices are largely absent at most lab and diagnostics providers. Physician offices and hospitals communicate with patients in person prior to service when it is most timely to run eligibility checks and field prior authorization requests. Doing so at the point of care allows the administrative staff to verify whether the patient has adequate health insurance and to gather any missing patient information.

"When working for a hospital or doctor's office you have direct access to the information you need. You can call the patient, print your own medical records or access the EHR," said the Director of Revenue Cycle for a diversified commercial laboratory.

In contrast, lab and diagnostic providers rarely interact directly with patients, especially prior to a visit. Instead, they commonly receive specimens from a referring hospital or physician along with a paper or electronic order containing patient demographics, procedure codes and diagnosis codes—some of which may be inaccurate or incomplete. This can create a "garbage in, garbage out" scenario. Diagnostics labs are reliant on the referring provider to furnish complete and correct data; if the data is flawed from the start the lab is likely to have the corresponding claim be denied when it submits it to the payer. When this happens it sets off a cascading series of time-wasting events for the lab, payer and patient.

The Director of Revenue Cycle for a national diagnostics service said, "Patient information comes over in either paper form or electronically. If there's a problem with insurance information or the patient's name is misspelled, then incorrect information is carried through the entire lifecycle. That's a major pain point in the process."

Because diagnostics labs don't communicate directly with patients, they have to work through the referring hospital or physician's office to track down any missing information or correct any errors so that they can resubmit a claim that has been previously denied. As you can imagine, this requires a lot of back and forth between the two parties. Emails get exchanged. Phone calls go to voicemail. Faxes

pile up. If the dollar amount for a specific accession isn't significant enough, it doesn't make financial sense for the revenue cycle team to expend the effort and they are often forced to write it off as bad debt.

Since diagnostics providers also have limited visibility into a patient's insurance coverage, they don't always have a good sense for what tests he or she is eligible. Nor do they understand the patient's financial responsibility for the accession. As a result, when a patient receives a bill from the lab, they may be frustrated to learn that the procedure isn't covered by their health plan. Since the charge is an unwelcome surprise, the patient may be reluctant to pay the bill. That reluctance may turn into full-scale resistance that leads the lab to write off the charge.

"Every claim has multiple variables. If we don't get all the correct information, it becomes what we call 'unbillable.' The claim is not a clean claim that can go out the door. At that point we reach back out to the entity to see if we can get the missing or the invalid information prior to submitting the claim."

Associate Vice President of Revenue Cycle at a global clinical laboratory

PAIN POINT 2

CLAIM DENIALS AND PRIOR AUTHORIZATIONS

Unacceptable levels of claim denials and an escalating number of prior authorization requests were identified as significant pain points for all of the revenue cycle management professionals interviewed.

Claim Denials

For lab and diagnostic providers, the complexity and scope of claim denials is one of the biggest issues in denials management. The sheer volume of health plans—which can number in the thousands for national labs—and the corresponding price schedules, make it very difficult for billing teams to keep everything straight. The problem compounds further because each payer has its own rules for denied claims, including the reasons behind a denial and how it is communicated to the provider. It's difficult to develop a consistently successful claims denial strategy based on so many variables.

"Most payers now have restrictive policies on certain tests, but when you go to their website, those policies are not listed like they are under CMS," said an Associate Vice President of Revenue Cycle at a global laboratory. "It's been a very big challenge for our revenue cycle team."

"Our organization is nationwide. Instead of being a regional facility and dealing with only a handful of large payers, we deal with thousands, which really opens up an opportunity for leakage if we're not careful

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Associate Vice President of Revenue Cycle at a global laboratory

and if we're not understanding what we're doing," said a Director of Revenue Cycle for a national diagnostics service. "You have to address problems quickly. If I find a problem today, I need to address it. By tomorrow, I'm going to have 1,000 more instances of it. And then the next day, 1,000 more. The volume is unbelievable."

Whereas hospital billing generally deals with a lower volume of high dollar claims, diagnostics labs must cope with a significantly higher volume of low dollar accessions. As a result, the revenue cycle team at these labs are not able to work all the denials. It simply doesn't make sense to scale up a billing staff to pursue low dollar collections, so revenue cycle personnel are thrust into triage mode to follow up on claims with more meaningful dollar amounts and write off claims with more negligible sums. This make-do strategy leads some labs to write off as much as 15-20% of their revenue due to denied claims.

"Claim rework is very labor intensive. You have to get somebody on the phone and providers don't want to talk to you about more than five patients," said a Senior Director of Revenue Cycle for a national radiology provider. "Sometimes, we send out somebody with a list to talk to providers about why we keep getting bad information."

Lack of automation also hinders a lab or diagnostic provider's ability to check claims for errors or missing information before they are submitted for reimbursement. The reimbursement process as currently designed, and regardless of outcome, costs lab providers an unacceptable amount of time, money, and resources to manage. This uncontrolled drain on cash and resources inevitably leads to greater inefficiencies, administrative burdens and lower collection recoveries.

To complicate things further, because of the limited time between when an order is placed and when testing must begin, there is often little opportunity to conduct an electronic eligibility check or to assess whether a prior authorization is needed. Oftentimes, the revenue cycle team is required to "fly blind" and submit a claim that hasn't been fully vetted and therefore has a higher than

average likelihood of being denied by the payer.

Prior Authorizations

Most of the revenue cycle management professionals interviewed cited the surge in prior authorization requirements as a significant challenge. According to a 2017 survey by the American Medical Association (AMA), 84% of providers consider prior authorizations to be overly burdensome, and 91% say they negatively impact patient outcomes.

A lot of things have to go right for a prior authorization request to be resolved quickly and accurately. The rendering diagnostics lab, referring provider, payer and patient are all involved in the intricate choreography that makes up the prior auth dance; the number of participants and steps increases the potential for errors, delays, and redundant work. Often, the referring hospital or physician isn't even aware that pre-authorization is required. Request-and-review requirements vary by health plan and provider too, which only magnifies the complexity.

If there is a single misstep in the prior authorization process — a denial triggered by incomplete patient data, for instance — then the diagnostics lab is put in the untenable position of having to work through the referring provider as an intermediary and rely on them to resolve the issue with the payer. Because rendering providers depend on referrals from the originating providers, they know that they can only push the referring hospitals and physicians offices so hard or risk losing future business.

Cost is the primary driver that dictates the level of review rigor that labs can apply to prior authorization requests. "We do not have the

"Hospitals sometimes have claims that are worth $300,000. If somebody has to fix that claim, it's worthwhile. The juice is worth the squeeze. When you start doing that in the lab or radiology world, your profit margin goes way down, your cost to collect relative to your revenue goes way up."

Director of Revenue Cycle for a national diagnostics service

manpower as prior auth continues to be a bigger and bigger issue, especially as more genetic testing is added to the mix," said an Associate Vice President of Revenue Cycle at a global laboratory.

Prior authorizations are increasingly common for molecular diagnostics and genetic testing, given their high average unit cost and growing usage. For specialized lab panels that require prior authorization, if just one of the CPT-based services in the panel is considered inappropriate, it is common for the entire panel to get denied.

The incremental processes, people and systems that support prior authorization appeals and claims adjustments also add a degree of uncertainty to final claims disposition for the lab service under question.

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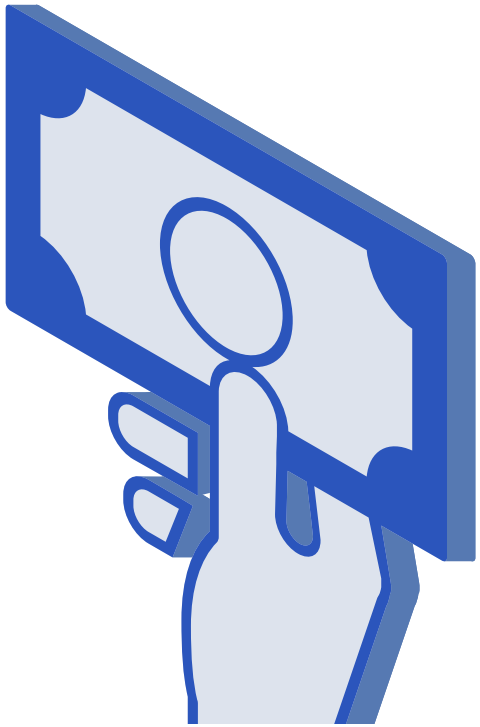
PAIN POINT 3

BAD DEBT



As a result of the growing popularity of high-deductible health plans, patients are now collectively the largest non-governmental payer in the nation. However, as more of the monetary burden is transferred to patients, many of whom struggle to meet their financial obligations or fully comprehend the invoices they receive, providers have found themselves crushed under billions in bad debt. Few providers, whether hospitals or lab providers, have had the tools to make billing more transparent.

"Oftentimes, patients don't know who the testing company is. You have to send out a letter to explain the testing and the billing—and the patient balances are often very high," explained an Associate Vice President of Revenue Cycle at a global laboratory. "Companies have to decide what they want to do as far as what they will take payment on, or if they'll process them as in-network, or process them as out-of-network which often leaves patients very upset."

Revisiting the first pain point—poor patient visibility—many lab and diagnostic providers remain in the dark about a patient's financial situation, propensity to pay and insurance benefit coverage. Patients themselves often don't understand their financial responsibility with regard to the lab services performed, nor are they aware of the payment options available to them that could affect their out-of-pocket liability.

More often than not, they are not even aware of what lab conducted their tests. Since invoices from the rendering lab provider may not be delivered for weeks or months after testing is performed, there can be confusion among patients in trying to identify what procedure the invoice correlates to, which only serves to make patients more reluctant to pay.

If the ordering provider doesn't offer a specific lab service, it might have trouble referring to a cost-competitive alternative beyond one that it is financially tethered or with which it is already familiar. Less-advanced healthcare organizations or lab service organizations may be unaware when payment for prior services are aging into bad-debt risk. Transparency into past-due bills, especially on non-emergent labs, would at least trigger further review to avoid another bill going unpaid.

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Associate Vice President of Revenue Cycle at a global laboratory

PAIN POINT 4

BILLING COMPLEXITY

First-hand interviews with revenue cycle management executives revealed that billing complexity was also a significant pain point. There are several hand-offs that happen between stakeholders, systems, processes and contracts that are ripe for errors that lead to payment leakage. For example, certain procedures need to be rolled up into a bundle or panel before a claim is sent to the payer. Additionally, payers have differing requirements related to billing processes which creates a lack of consistency in how to successfully submit claims from health plan to health plan.

"The billing systems don't really offer an interface from the physician's office to the billing system," explained the Director of Billing Process Improvement for a diagnostics and pharma services company. "Some companies will not run the test until they get a prior auth. But in oncology testing, you don't want to do a biopsy and then say, 'Sorry, we can't run this test.' So, until you start losing a lot of money, that's what you do."

Interviewees noted that while new lab offerings are introduced to the market at a steady, regular clip, payers respond to how they will cover these new services differently. The process is highly unpredictable and generally includes a lag of a few months.

Even when a payer makes a coverage determination on a new lab service, it may take weeks for claims adjudication systems to properly accommodate all the rules. Provider and lab service staff often keep "cheat sheets" that detail the

particular rules for each of the large payers, but because these rules are continuously changing, these cheat sheets quickly become outdated.

Inconsistencies in how each payer reimburses for services creates complexity and chaos for the providers and labs that must track across these entities. Contracting that determines covered services and payment levels for members and providers, respectively adds to the complexity. The process grows even more complex if dealing with patients who are covered by multiple insurance plans.

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Director of Billing Process Improvement for a diagnostics and pharma services company

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PAIN POINT 5

TECHNOLOGY AND PERSONNEL

The constant stream of claims that must be managed, the increasing frequency of prior authorization requests that must be addressed, and the sheer complexity of the billing process combine to make revenue cycle management at diagnostics labs an order of magnitude more challenging than traditional hospital settings. Revenue cycle staff must be able to manage all the nuances relative to payer changes, reimbursement cuts and the move from fee-based billing to value-based billing. So, it is perhaps no surprise that it can take even a seasoned healthcare billing professional an extended period of time to ramp up and fully grasp the intricacies of RCM at diagnostics labs.

"It's a complex system. Even if you have a revenue cycle and billing healthcare background, training and proficiency take at least six months to get fully acclimated into the laboratory because it is different than working in any other healthcare system," said the Director of Revenue Cycle for a national diagnostics service.

One interviewee mentioned that in order to ensure

> *"You have to be really smart about how you tackle things. You just can't print out all of your outstanding bills over $50,000 and have somebody work it. You are dealing with a large volume of low dollar charges, and trying to make sense of that."*
>
> Director of Revenue Cycle for a national imaging provider

that prior authorizations were obtained, significant technology and customer service investments were needed to communicate with ordering physicians to alert them that a prior authorization was missing and that the test would be held.

Due to the difficulty in finding skilled revenue cycle personnel, labs often resort to outsourcing. But a growing number of the nation's larger laboratories are leveraging health IT to automate management of the laboratory revenue cycle.

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CONCLUSION

Feedback from our interviews indicated a desire by revenue cycle professionals for a technology solution that automates many of their most manually-intensive administrative tasks, and does so in real-time at the point of care. There was also a preference for solutions that can integrate directly with their existing workflow and systems rather than require them to log in and out of payer portals. Additionally, those interviewed expressed interest in solutions and platforms that can provide critical insights into specific patient needs, identify coordination opportunities among stakeholders, simplify billing and mitigate risks to reimbursement.

Solutions driven by process automation and artificial intelligence capabilities present an enormous opportunity for lab and diagnostic providers. For example, tedious, error-prone prior authorization and claims-filing workflows that are currently handled manually can be automated to accelerate operations and improve accuracy. Artificial intelligence can identify and eliminate common errors that contribute to costly claims rejection, rework and appeals.

About Myndshft Technologies

Myndshft commissioned this research. We are a software-as-a-service that automates and simplifies time-consuming healthcare administrative tasks associated with prior authorization, eligibility verification, and patient financial responsibility, freeing providers and payers to concentrate more fully on patient care again. Myndshft was founded in 2015, and works with leading providers, payers, and health information exchanges. For more information, visit myndshft.com.