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The Pathologists' Meeting™



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Education by the Experts

PM100 Practice Management Institute: Laboratory and Practice Finance

James C. Dechene, JD

Richard J. Hausner, MD, FCAP

Harry J. Zemel, MD, FCAP



How Pathologists Earn A Living

Richard J. Hausner, MD, FCAP
rjhausner@earthlink.net

September 30, 2007

Disclosure

I have no financial interest in any commercial entity related to this talk.

Goals

- Principal goal:
Understand payment methods for anatomic and clinical pathology services
- Place today's pathology payment environment in historical perspective
- Appreciate the importance of the Medicare program
- Be aware of controversies and problems encountered in today's payment environment

Agenda

Topic	Time
Opening/ Introductions	8:30-8:40
Richard Hausner, MD, FCAP	8:40-9:35
Break	9:35-10:05
Jim Dechene, JD	10:05-11:00
Harry Zemel, MD, FCAP	11:00-11:45
Questions	11:45-12:00
Summary and Closing	

Pathologist Professional Activities

- Teaching
- Research
- Service – We're focusing on Anatomic Pathology and Clinical Pathology Service

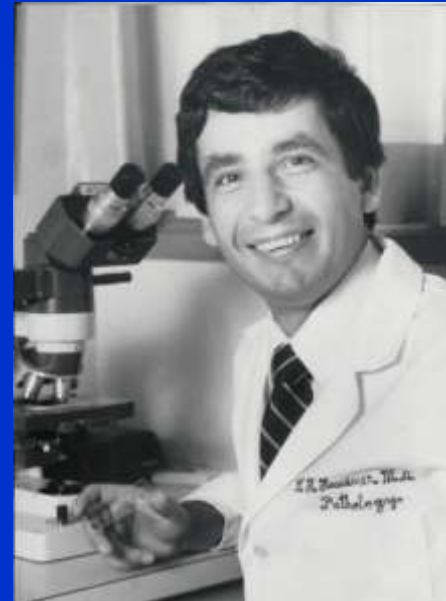
“This is a business – that’s the sad part of this profession.”

Steve McNair, quarterback,
Tennessee Titans, upon awakening
to the economic realities of
professional football.



“This is a business – that’s the sad part of this profession.”

Richard Hausner, Assistant Professor, Baylor College of Medicine, upon awakening to the economic realities of pathology practice.



How Are Pathologists Paid?

- By what pathways do our departments or practices receive the funds for our salary?
- The pathways to pathologist payment, as they exist in 2007, are not simple and are not intuitive.
- The history of pathology payment in the US provides a framework to help explain these pathways.

Pathology Economics, Before 1965

- Pathologists were paid by salary, management fee, or a percentage of the hospital laboratory revenues.
- Few hospital-based pathologists were billing patients for anything, anatomic or clinical.
- Some pathologists owned their laboratory or leased the laboratory from the hospital – these laboratories billed the patient for the test, not clearly for the professional service.

Pathology Economics, Before 1965

- We lived in the basement of the hospital, literally and figuratively.
- We had a public non-image
- We were not clearly engaged in the practice of medicine.
- Indeed, the highest priority for pathology advocates of the era was advancement of the principle that the practice of pathology is the practice of medicine.

The Medicare Act of 1965

- The Medicare Act of 1965 marked the beginning of the modern epoch of medical practice as Medicare became the largest and most influential health insurer in the US.
- Private health insurance tended to emulate Medicare, a trend that continues (with favorable and unfavorable implications for pathologists) to this day.
- Medicare released pathologists from “the basement of the hospital” – pathologists were encouraged (in some cases forced) to bill patients as did any other physician for the services they performed.

The Medicare Act of 1965

- Under the original Medicare system pathologists were encouraged accept payment *directly* by Medicare for their anatomic and clinical pathology services on a “*fee-for-service*” basis.
- Thus, Medicare, in the early years, seemed to confirm that pathology is, indeed, the practice of medicine and payment to the pathologist could be in a format similar to other physicians.

Fee-for-Service/Component Billing

- The physician providing the service *directly bills* for the service – and that physician can be a pathologist.
- Most medical services are a team effort – the facility and the physician each provide a *component* of the service.
- The total fee, including all components (facility and physician) is *the global fee*.
- For this presentation *fee-for-service* and *component billing* are interchangeable terms

Fee-for-Service/Component Billing

- The portion of the service provided by the facility is *the technical component*.
- The portion of the service provided by the physician is *the professional component*.
- *technical + professional = global fee*

CPT – Current Procedural Terminology

A Compendium of Medical Procedures

- CPT is the designated nomenclature for Medicare and has come to be widely used by private health insurance programs.
- Each service or procedure for which the physician and/or hospital can bill is assigned a “CPT Code,” usually numeric.
- The full global code can be split, for billing purposes, into a “technical component” and a “professional component”.
- The CPT format, when followed correctly, permits the party providing a service to be paid directly for that service.

Fee-for-Service/ Component Billing

- Under a *Component Billing* arrangement, the hospital bills for its services (technical component) and the pathologist bills for his/her services (professional component).
- For anatomic pathology it is clear that the pathologist is performing a “hands-on” service for an individual patient.
- For clinical pathology the patient pays for the service of the pathologist for each and every laboratory procedure - Some patients receive more “hands-on” time than others.... But all are charged in the same manner.
- Costs are spread in an even-handed way across all patients.

Relevant 'Parts' of Medicare

Part A

"Hospital Insurance"

Pays for hospital stays

Generally covers the technical component of a CPT code

Part B

"Medical Insurance"

Pays for physician services

Generally covers the professional component of a CPT code

Tax Equity and Fiscal Responsibility Act of 1982

- So, until the mid-1980s, under Medicare, all anatomic and clinical laboratory services of the pathologist could be covered as a physician service, and billed directly by the pathologist under Part B
- This changed with the passage of bill: “TEFRA” - the massive economic legacy of the Reagan years
- TEFRA remains, in 2007, the basis of our Medicare physician payment system

Tax Equity and Fiscal Responsibility Act of 1982

Implications for Clinical Pathology

For clinical pathology, TEFRA:

- Devastated fee-for-service/component billing, but only under Medicare
- Damaged, but did not destroy fee-for-service/component billing in the non-Medicare world

Tax Equity and Fiscal Responsibility Act of 1982

Implications for Clinical Pathology

- Under TEFRA, Medicare decided that some clinical pathology services (such as quality assurance) are not performed for an individual patient – these services, according to Medicare, are provided to the hospital
- Thus, payment for those services are bundled into the hospital's Part A payment
- Pathologists are required to negotiate a “management fee” with their hospital administration for Part A payment

Tax Equity and Fiscal Responsibility Act of 1982

Implications for Clinical Pathology

- Although negotiable, pathologists are required by law to be paid a “fair-market value” for their Part A services
- Certain “hands-on” services, consultations, some hematology and blood bank services remain Payable under Part B

Professional Services of a Clinical Pathologist

- Assure accuracy of test results
- ✓ Interact with medical staff regarding laboratory issues
- Establish parameters for performance of clinical tests
- ✓ Recommend additional diagnostic or therapeutic tests
- Advise laboratory technical personnel regarding aberrant results
- Select, evaluate and validate test methodologies
- Direct performance and evaluation of quality control and quality assurance procedures
- ✓ Evaluate clinical data; establish a process for review of tests prior to issuance of patient reports
- Assure the hospital's compliance with inspection and accrediting agencies
- Pathologists are present or on call 24 hours a day to provide these services

A Problem for Clinical Pathologists: The Medicare Part A Management Fee

- Congress intended that pathologists would be paid fairly for their Part A services.
- Nonetheless, because Part A negotiations are usually a relatively small part of the pathology group's relationship with the hospital, pathologists are at a disadvantage in these negotiations - the fairness of these negotiations is variable.

Office of the Inspector General of the Department of Health and Human Services 2005 Supplemental Compliance Program Guidance for Hospitals

"Arrangements that require physicians to provide Medicare Part A ...services for token or no payment ...should be closely scrutinized...(and is)...one possible form of illegal kickbacks between hospitals and hospital-based physicians."

A Problem for Clinical Pathologists: The Medicare Part A Management Fee

- But Medicare has never taken action against hospitals that have failed to negotiate a proper contract with their pathologists for Part A services.
- No payment or token payment for Part A is reported as a problem by about 25% of pathologists.

Tax Equity and Fiscal Responsibility Act of 1982

Implications for Anatomic Pathology

For anatomic pathology under Medicare, TEFRA:

- Solidified fee-for-service billing for surgical pathology and cytopathology under Medicare Part B
- Medicare defined the unit of service in anatomic pathology as the *specimen* – it is this definition that permits several specimens from the same patient on the same day derived from the same clinical procedure to be billed separately
- Moved autopsy pathology to Part A as part of the pathologist's management fee under the banner of a "quality assurance activity"



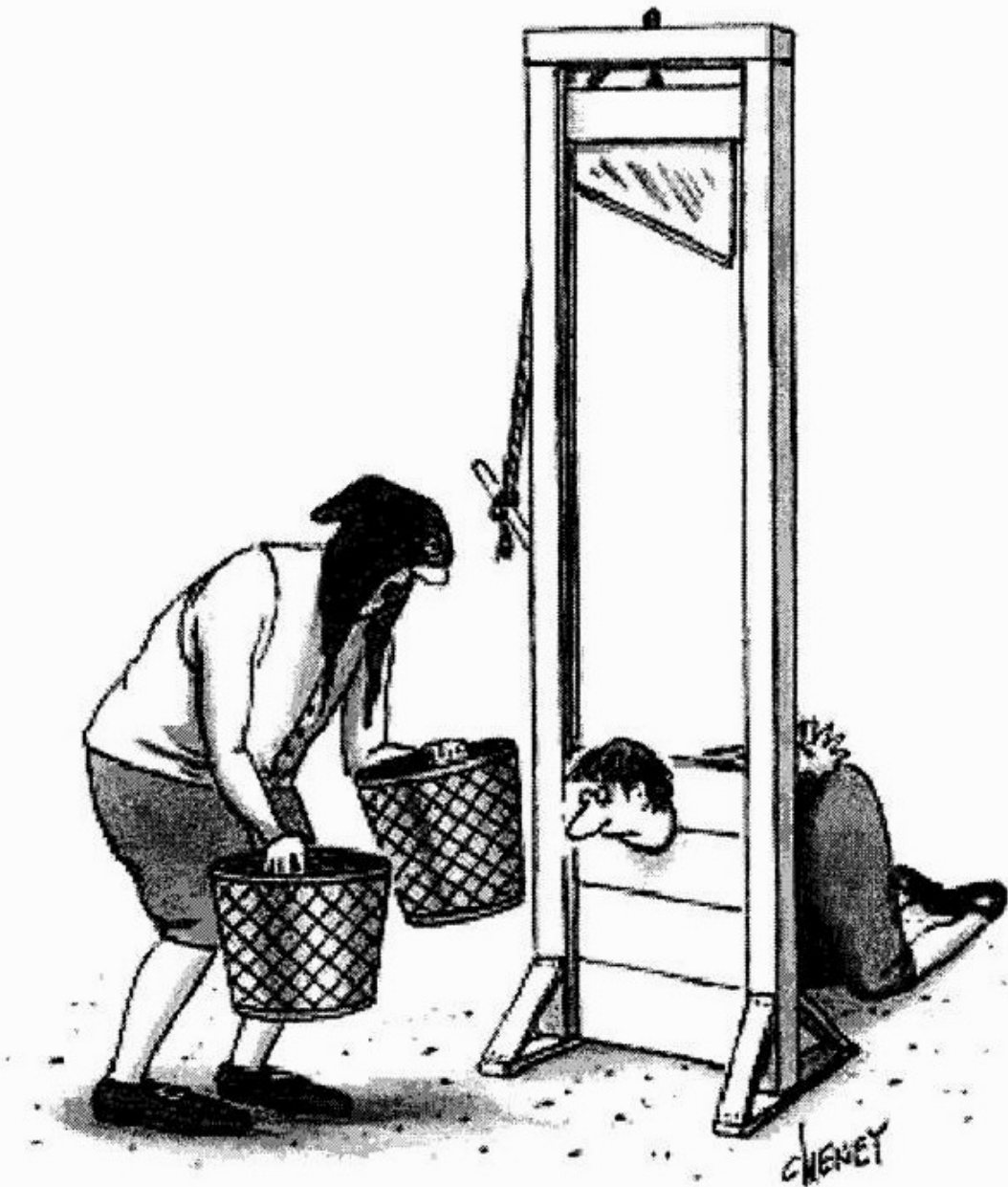
Medicare Payment for Pathologist Services in the USA After TEFRA

Clinical Pathology

1. Management fee for “non hands-on” services (Part A)
2. Professional component for “hands-on” services, consultations, some hematology and blood bank services (Part B)

Anatomic Pathology

1. Professional component for surgical pathology and cytopathology services (Part B)
2. Management fee for autopsy pathology (Part A)



"Paper or plastic?"

Tax Equity and Fiscal Responsibility Act of 1982

Implications for Non-Medicare Clinical Pathology

TEFRA applied only to Medicare. To the surprise of many pathologists, clinical pathology component billing remained a viable mechanism for payment in the private sector and even in some other Federal programs.

Pathologists of that era who component billed for clinical pathology had a choice:

1. Try to work out a Medicare-like arrangement with their hospital and their patients' health plans, or
2. Continue with a dual system - Part A payment from the hospital and continue to component bill for the private sector portion of the practice

Fee-for-Service/Component Billing Non-Medicare Clinical Pathology

- The professional component includes payment for all of the pathologist's services in the laboratory, including time-consuming, detailed consultations
- The pathology group has its own fee schedule for professional services, just like physicians in other specialties
- The group may choose to contract with a health plan and agree to a reduced fee schedule

Fee-for-Service/Component Billing Non-Medicare Clinical Pathology

- Insurance companies and private health plans have sometimes taken the position that their payment to the hospital includes the payment due to the pathologist (“just like Medicare”)
- In most cases, the hospital has no such understanding and feels no obligation to pay the pathologist – the hospital expects the pathologist to use the Professional Component Billing system

Fee-for-Service/Component Billing Non-Medicare Clinical Pathology

- The controversy has led to several lawsuits
- Most courts have tended to agree that the pathologist, like any physician, has a relationship with the patient to whom he or she provides a professional service
- The issue is sometimes framed as a disclosure issue
- The concept of professional component billing for clinical pathology will continue to evolve

Non-Medicare Clinical Pathology Methods of Payment

- Component Billing/Fee-for Service
- Management fee (akin to Medicare)
- Salary
- Capitation - fixed fee per covered life
- Per diem – fixed fee per patient day in hospital
- Fixed fee per procedure – a variant of professional component billing
- Indirect payment via Anatomic Codes



Non-Medicare Payment for Pathologist Services in the USA

Clinical Pathology

1. Management Fee with professional component for hands-on services and consultations
2. Professional Component
3. Other arrangements (salary, per diem, fixed fee per procedure)

Anatomic Pathology

1. Professional Component – most practices work under this arrangement
2. A few practices have other arrangements (salary, per diem, fixed fee per procedure)
3. Autopsy payment variable



Payment for Autopsy

MEDICARE

Pathologist payment for the autopsy is bundled into the Part A payment to the hospital (the autopsy is considered a quality assurance activity by Medicare)

Some hospitals recognize the value and pay the pathologist, many do not.

NON-MEDICARE

Health insurance ceases at death

Some hospitals recognize the value and pay the pathologist, many do not

In certain circumstances it may be appropriate to seek payment from the family



"Unfortunately, you have what we call 'no insurance.'"

Pearls of Pathology

Why Does Any of This Matter to Me?

- I'm in academics, my Chair handles all this
- I'm in a large group, the partners take care of this
- I work for the County
- I work for the State
- I'm a hospital employee
- I'm.....

Pearls of Pathology

Why Does Any of This Matter to Me?

- All pathologists in the US are, in the end, bound together by the same economic reality
- Every practice or department of pathology engaged in patient care must achieve payment for the pathologist's services, whatever the payment mechanism

Summary

We discussed payment methods for anatomic and clinical pathology services

Today's pathology payment environment has evolved over many decades

The Medicare program, now over 40 years old, is the largest and most important medical insurance program in the nation

The economic basis of pathology service, is, in the end, the same for all of us

There are controversies and problems for pathologists in Medicare and non-Medicare programs

1. *Medicare – Fee schedules, unit of service and Part A payment*
2. *Non-Medicare – Fee schedules and clinical pathology payment methods*
3. *Autopsy payment*

Break Time!