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# Pathologists Compensation: Models and Options

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# Disclosure

- I have no financial interests/relationships or non-FDA approved uses to disclose:
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# Course Objectives

- Understand Clinical Pathology reimbursement history
- Appreciate breadth of compensation models available
- Learn strategies for increasing Part A Compensation

# Agenda

Topic	Time
History of Part A Issues	20 Minutes
Part A Compensation	7 Minutes
Incentive Compensation	5 Minutes
Private Payer P/C Issues	10 Minutes
Part B	5 Minutes
Managed Care Issues	10 Minutes
Summary and Closing	

# History of Part A Issues

- Prior to 1980, Treatment of Part A Varied Across the Country
- In Northeast, Pathologists tended to be salaried employees or contractors of Hospitals
  - Hospitals billed and collected for all pathology services
  - Most often, Pathologists were treated as costs, reimbursable on the Cost Report

# History of Part A Issues

- In most of rest of country, Pathology treated as Physician Service
  - Pathologists billed for both Clinical Pathology and Anatomic Pathology services
  - In some parts of the country, Pathologists earned disproportionate incomes from Professional Component Billing
  - Florida Expose on Pathologists earning \$750,000+ on PC Billing in late 1970's

# History of Part A Issues

- HCFA Analysts sought mechanism to rationalize differences
- Most HCFA analysts are from Northeast
- Sought to institutionalize model of Northeast
- Published Federal Register Notice in 1980 requiring that Clinical Pathology be treated as a Part A service

# History of Part A Issues

- 1980 Notice
  - CAP brought action challenging Notice
  - Judge Arnold preliminarily enjoined Notice
  - Recognized Nature of Clinical Pathology
  - History of Paying for Clinical Pathology under Part B
  - HCFA continued to reimburse Clinical Pathology under Part A and Part B
  - Status Quo Maintained

# History of Part A Issues

- 1982 TEFRA Legislation
  - HCFA sought Congressional Authority for Regulation
  - Congress directed HCFA to distinguish between Part A Services of Hospital Based Physicians and services that require performance by a Physician for Individual Patients
  - No specific guidance on Clinical Pathology

# History of Part A Issues

- HCFA proposed regulations treating all Clinical Pathology as Part A
- Final regulations did recognize Clinical Pathology consultations as Part B
- Also recognized Cytology as Part B
- Regulations also required that Leased Labs also would need to be Part A

# History of Part A Issues

- Final Regulations set forth general requirement for Part B
  - Personally furnished for individual patient
  - Contribute to diagnosis or treatment
  - Ordinarily require performance by physician
  - Meet additional requirements

# History of Part A Issues

- Path Requirements
  - Anatomic pathology
  - Consultative Pathology
  - Personal administration of test

# History of Part A Issues

- 4 requirements for Consultative Pathology
  - Requested by attending physician
  - Test result outside of normal or expected range
  - Written narrative report
  - Require the exercise of medical judgment

# CAP v. Heckler

- Challenge to regs that
  - denied Part B for most clinical pathology services
  - denied leased lab billing

# CAP v. Heckler

- Court: Regulations reasonably consistent with statute
  - Checks possible abuses
  - Limit Part B for Clinical Pathology
  - Reflection of Congressional Intent
- “Horrible Examples” addressed by Letter excepting hematology

# CAP v. Heckler

- Lab costs viewed as anti-spin-off provision
- Without the “under arrangements” limitation, would have been a huge loophole
- Non-interference not a limitation with how Medicare reimburses
- Criticism of regulatory drafting
  - “serious medical judgment”
  - Consultations not to be frequent

# History of Part A Issues

- Subsequent to *CAP v. Heckler*, HCFA recognized interpretation of certain tests as Part B
- Otherwise, Clinical Pathology Part A
- HCFA Directed Hospitals to file Form 1008
  - Identify % of time on Part A and Part B
  - Put into cost Part A % and Base Cost

# History of Part A Issues

- Hospitals often pressured HBPs to overstate % Part A
- Adverse Impact on Pathologists initially shifting to Direct Billing for Part B after Oct. 1, 1983
- Compensation Related Customary Charges grossly understated
- Locked in during period of Physician Fee Freeze: 7/1/84-12/31/86

# History of Part A Issues

- 1983: Congress Passed DRG Prospective Payment Reimbursement
- Clinical Pathology Reimbursement wrapped up in DRGs
- Through DRGs, all hospitals are reimbursed for Clinical Pathology Services
- Proxy for Reimbursement: 1008 %

# Contract Compensation Options

- Part A Stipend
- Clinical Pathology Professional Component
- Part B
- Managed Care

# Part A Compensation

- Different Part A Elements:
  - Medical Director and Administration Services
  - Clinical Pathology for Medicare/Medicaid
  - Clinical Pathology for non-Governmental payors
- Part A must cover overall Medical Director/Administration and Clinical Pathology for Medicare/Medicaid
- Part A may, but need not, also cover Clinical Pathology Professional Component for non-Governmental

# Part A Compensation (2)

- Medicare reimbursement regulations do not establish minimums or maximums for Hospital Part A payments
- Medicare does not dictate structure of Hospital Payments
- Hospitals generally driven to reduce Part A to reduce costs and increase profits
- OIG Kickback concerns with inadequate Part A Compensation

# Part A Compensation (3)

- Several Options for Medicare Part A
  - Fixed Part A payment for Medicare only/all patients
  - Hourly or time based payment for Medicare only/all patients
  - Per test payment for Medicare only/all patients
  - % of laboratory revenues
  - Incentive compensation

# Incentive Compensation

- Some groups now receive 80% or more of total Part A compensation from Incentives
  - Reducing costs
  - Increasing volume
  - Reducing lab test turn-around time
  - Quality Measures
  - Integrating laboratory services

# Incentive Compensation (2)

- Are incentives attainable?
- How will targets be adjusted each year?
- Are incentives impeded by hospital decisions?
- Seek objective arbitrator of satisfaction of targets

# Incentive Compensation (3)

- View incentives as add-on, not expected
- Seek involvement in determining targets
- Focus on things Pathologist can control
- Require hospital support of initiatives
- Guarantee payment if no hospital support

# Strategies if No/Low Part A

- OIG analysis in 1991 Management Advisory Report
- HBPs with Exclusive Contracts get hospital referrals
- “Value” provided by HBPs to hospitals may be illegal financial inducement for exclusive contract

# Strategies if No/Low Part A (2)

- OIG re-affirmed position in Subsequent Letter to CAP
- OIG also re-affirmed in Compliance Guidelines for Hospitals
- Analysis suggests area of potential risk
- But: OIG has not enforced

# Strategies if No/Low Part A (3)

- Several Possible Financial Inducements
  - Low/No Part A
  - Office Rent
  - Transcription Charges
  - Billing charges
  - Computer access charges
  - Other service charges

# Strategies if No/Low Part A (4)

- Analysis:
  - Are there comparable charges to physicians who admit to hospital?
  - Are surgeons charged for access to OR?  
Transcription Services?
  - Do other medical directors get office space?
  - Is Part A reasonable?

# Strategies if No/Low Part A (5)

- Several possible measures of Part A
- Adjusted RCE level: ~\$220,000
- Look to MGMA, AMA, other data
- Document time commitment
- Focus on professional nature of Clinical Pathology

# Strategies if No/Low Part A (6)

- How to negotiate Issue
  - Provide copy of MAR
  - Identify Compliance Officer
  - Refer to OIG Compliance Guidelines for Hospitals
  - Avoid letter identifying issue
  - May be forced into Hobson choice regarding Issue

# Strategies if No/Low Part A (7)

- Avoid documentation that boxes in parties
- Try creative approaches to address issue
- If low Part A: use to leverage opportunity for Professional Component Billing

# Private Payer P/C Issues

- Medicare Rules only apply to Medicare
- Arguably same rules for Medicaid
- Some Medicaid programs do pay professional component for Clinical Pathology
- Check rules before billing Medicaid

# Private Payer P/C Issues (2)

- A number of private payers deny coverage for Clinical Pathology
- There is no specific law mandating private payer coverage for Clinical Pathology Professional Component
- Key is whether plan design and coverage documents clearly specify nature of Clinical Pathology Coverage
- Relying on Professional Component Billing is Risky: Constant Battle with Payors

# Private Payer P/C Issues (3)

- If your practice is considering commencing Professional Component Billing
  - May raise issues with Hospital and lead to reduced Hospital Part A
  - Probably not worth giving up sizable Part A
  - May be an opportunity to make up some of loss of Part A from Hospital

# Private Payer P/C Issues (4)

- If your practice now relies on Professional Component Billing
  - Contract should make clear that (1) Hospital is not paying Part A for non-Medicare; and (2) Pathologist is permitted to bill patients for P/C
  - Notice to patients of P/C Service

# Part B

- Most contracts give pathologist right to bill and collect for Part B
- Hospital should provide access to billing information
- Contract may seek to limit pathologist discretion on Part B charges
- Avoid providing aggregate collection information to hospital
- Pathologist should only agree to keeping charges competitive with the market
- Do not give hospital veto over your charges!

# Managed Care Issues

- Contract likely will include some managed care contracting requirement
- Hospital has legitimate interest in making sure all hospital based physicians have contracts with same MCOs as hospital
- Pathologist needs some protections and limitations on managed care contract obligations

# Managed Care Issues

- Limit obligation to “best efforts” to contract
- Insert a floor:
  - % of Medicare
  - Discounts comparable to other physicians (not hospitals) in the area
  - Some other floor

# Managed Care Issues

- Avoid permitting hospital to bind you to managed care contract terms
- Avoid permitting Physician Organization dominated by non-hospital-based physicians bind you to contract terms
- Seek to maintain some level of discretion

# Managed Care concerns

- Contract with each managed care plan with which Hospital contracts
- Avoid cancellation of key managed care contracts
- Work with local IPA
- Be active on IPA Committees/Board
- More than one IPA has caused termination of Pathology Agreement

# Summary

- Avoid control over Part B charges
- Avoid control over Managed Care pricing
- Document your Part A value
- Be creative to support alternatives that can increase Part A

# Pearls of Pathology

Quantify and sell your value to the hospital

Make your hospital, administrator and medical staff want to keep you!

Think of creative options that do not become hospital budget line items

# Questions?

# References

- **OIG Management Advisory Report:**  
<http://oig.hhs.gov/oei/reports/oei-09-89-00330.pdf>
- **OIG Compliance Guidelines for Hospitals:**  
<http://oig.hhs.gov/authorities/docs/cpghosp.pdf>
- **OIG Supplemental Compliance Guidelines for Hospitals:**  
<http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>