By Al H. Sirmon, CPA, PSA President &
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Pathology Practices: Are Your Payers Paying You Correctly?

Are You Sure? Can You Prove It?

Unfortunately in today's pathology practices, many of our contracted insurance companies pay significantly less than our charge. Also to complicate matters, each participating insurance company may have different plans with different reimbursement rates for each plan and most pathology practices participate with numerous insurance companies.

Hopefully your billing department or billing company (if you outsource billing) is verifying that these insurance companies are paying correctly as the payment comes in on a daily basis. But how can you be sure?

With this simple analysis you can gain confidence that you are being paid appropriately by each payer. Also you can develop an internal benchmark to monitor payment by your insurance companies in the future.

In most Pathology Practices, the amount written off as contract adjustments is significant, usually much greater than either bad debts or accounts receivables.

However, many times contract adjustments are not understood or scrutinized nearly as much as bad debt or accounts receivable, thus the ***"Black Hole" of pathology billing.***

There needs to be a "belt and suspenders" approach to monitoring contract adjustments. This ***Reimbursement Analysis*** *should not be used as a substitute for daily transaction level monitoring by your billing company. However, this monitoring tool can be utilized to develop internal benchmarks to monitor payer reimbursements monthly.*

Step 1-Compute an Internal Benchmark

The standard billing report for a pathology practice should contain the following summary information:

ABC Pathology Report A Summary of Activity YTD December 20XX	
Gross Charges	$ 8,013,007.30
Adjustments to Gross Charges	$ (2,176,232.41)
Net Charges	$ 5,836,774.89
Collections	$ (5,411,397.30)
Refunds	$ 66,341.87
Net Collections	$ (5,345,055.43)
Bad Debt	$ (317,106.32)
Change in Receivables	$ 174,613.14
Beginning Receivables	$ 757,047.77
Ending Receivables	$ 931,660.91
Benchmarks:	
Net Charge to Gross Charges %	73%
Collections / (Collections + Adjustments)	71%
Net Collection %	-92%
Bad Debt %	-5%
Days in Accounts Receivable	42

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The Reimbursement Analysis is based on a simple internal benchmark (Claims Paid %) calculated as follows:
Collections / (Collections + Contract Adjustments)

As you can see, contract adjustments ($2,176,232.41) are a significant amount of annual gross charges. While most billing companies track performance benchmarks for collections (net collection %), bad debts (bad debt %) and accounts receivables (days in A/R), most do not track a performance benchmark for contract adjustments. This is why we refer to contract adjustments as the "black hole" of billing. One reason for this oversight is that contract adjustments as a % of charges vary greatly by practice. Practices have different fee schedules, payer mixes, and contract reimbursement rates. Therefore, it is useless to compare one practice to another. However, an "internal benchmark" can be developed to assist in monitoring insurance payments.

This internal benchmark, referred to as Claim Paid %, can be computed as follows:

Collections / (Collections + Adjustments)

Or, using the data above:

$5,411,397.30 / ($5,411,397.30 + $2,176,232.41) = **71%**

The reason the net charge % or gross collection % cannot be used is because some of the contract adjustments and collections that came in during the first few months of the current year were a result of charges posted in November and December of the prior year. Also, many of the charges posted in November and December of the current year will not generate contract adjustments and collections until next year. By using just collections and contract adjustments, the effects of these timing differences are minimized.

Therefore, using the above benchmark, we know that for all payers and CPTs the practice is getting paid about 71% of their charges (when bad debt and change in receivables are excluded), or they are writing off 29% as contract adjustments. While this is useful information for managing a practice, it does not provide any assurance that this is the correct amount that should have been contractually adjusted.

Step 2-Breakdown by Insurance Company and CPT Code

The Claims Paid % benchmark is computed for:

- *The Practice in Total*
- *Each Insurance Company*
- *Each CPT for each Company*

The next step is to "breakdown" the above summary of activity by insurance company. For simplicity, let's assume that this practice has only four payers to deal with. Notice that the following ABC Pathology Report B shows the same information as the first summary of activity, with payer detail added. Also, note that this report includes the claims paid percentage for each payer. This is a very useful report since it allows us to compare performance for each insurance company to Medicare. However, it still does not provide any assurance that each one of these payers is paying correctly.

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ABC Pathology Report B-Summary of Activity by Third Party Payer YTD December 20XX								
Payer	**Charges**	**Adjustments**	**Payments**	**Refunds**	**Bad Debt**	**Ending AR**	**C/(C+A)**	**Net Coll %**
Blue	2,988,882.30	(753,674.77)	(2,256,221.50)	$14,642.57	(28,983.53)	213,610.08	75%	100%
ABC	2,035,925.05	(489,316.43)	(1,362,320.41)	9,834.42	(86,684.00)	281,638.36	74%	87%
Medicare	1,877,443.80	(804,615.90)	(1,066,087.07)	14,168.29	(8,569.79)	182,945.86	57%	98%
XYZ	726,445.10	(128,625.31)	(531,501.32)	4,417.68	(31,291.00)	111,814.23	81%	88%
Self Pay	384,311.05	-	(195,267.00)	23,278.91	(161,578.00)	141,652.38	100%	45%
Totals	**8,013,007.30**	**(2,176,232.41)**	**(5,411,397.30)**	**66,341.87**	**(317,106.32)**	**931,660.91**	**71%**	**92%**

The following summary of activity further breaks down the information, showing not only detail by payer but by CPT for each payer. Again, this is good information but it still does not provide any assurance that the individual insurance companies are paying correctly.

ABC Pathology Report C-Summary of Activity by Third Party Payer and Procedure YTD December 20XX									
Payer	Procedure	Beginning AR	Charges	Adjustments	Payments	Refunds	Bad Debt	Ending AR	C/(C+A)
Blue	88175	77,336.33	1,017,141.00	(259,650.07)	(754,220.48)	4,701.16	(10,952.62)	74,355.32	74%
Blue	88305	96,256.86	984,800.00	(48,092.56)	(952,498.74)	7,348.29	(13,057.78)	74,756.07	95%
Blue	8830526	53,631.43	673,081.00	(351,858.03)	(332,939.13)	1,638.51	(3,198.69)	40,355.09	49%
Blue	8830726	21,740.39	313,860.30	(94,074.11)	(216,563.15)	954.61	(1,774.44)	24,143.60	70%
		248,965.01	**2,988,882.30**	**(753,674.77)**	**(2,256,221.50)**	**14,642.57**	**(28,983.53)**	**213,610.08**	**75%**
ABC	88175	72,620.02	866,250.00	(208,548.00)	(551,378.00)	3,809.95	(40,845.00)	141,908.97	73%
ABC	88305	47,520.24	504,450.00	(34,933.65)	(479,513.58)	4,039.13	(17,007.00)	24,555.14	93%
ABC	8830526	36,997.49	438,900.05	(178,645.00)	(172,151.00)	1,682.34	(13,232.00)	113,551.88	49%
ABC	8830726	17,061.98	226,325.00	(67,189.78)	(159,277.83)	303.00	(15,600.00)	1,622.37	70%
		174,199.73	**2,035,925.05**	**(489,316.43)**	**(1,362,320.41)**	**9,834.42**	**(86,684.00)**	**281,638.36**	**74%**
Medicare	88305	90,396.88	889,050.00	(227,022.28)	(674,565.77)	10,320.08	(4,702.85)	83,476.06	75%
Medicare	8830526	53,045.61	675,642.90	(436,414.47)	(226,430.45)	2,352.40	(3,376.46)	64,819.53	34%
Medicare	8830726	13,538.06	196,020.90	(95,288.58)	(92,573.12)	734.14	(96.32)	22,335.08	49%
Medicare	88175	13,625.98	116,730.00	(45,890.57)	(72,517.73)	761.67	(394.16)	12,315.19	61%
		170,606.53	**1,877,443.80**	**(804,615.90)**	**(1,066,087.07)**	**14,168.29**	**(8,569.79)**	**182,945.86**	**57%**
XYZ	88175	27,861.88	297,752.00	(797.98)	(297,293.14)	1,716.74	(4,460.06)	24,779.44	100%
XYZ	88305	21,649.02	212,400.00	(73,710.29)	(136,703.18)	703.29	(5,396.48)	18,942.36	65%
XYZ	8830526	16,395.30	148,973.10	(49,742.94)	(50,467.00)	1,246.91	(20,871.00)	45,534.37	50%
XYZ	8830726	6,462.88	67,320.00	(4,374.10)	(47,038.00)	750.74	(563.46)	22,558.06	91%
		72,369.08	**726,445.10**	**(128,625.31)**	**(531,501.32)**	**4,417.68**	**(31,291.00)**	**111,814.23**	**81%**
Self Pay	All	90,907.42	384,311.05	0.00	(195,267.00)	23,278.91	(161,578.00)	141,652.38	100%
Grand Total		**757,047.77**	**8,013,007.30**	**(2,176,232.41)**	**(5,411,397.30)**	**66,341.87**	**(317,106.32)**	**931,660.91**	**71%**

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Step 3-Compare Benchmark to Standard

The following ABC Pathology Report C includes three additional columns to the right, under the heading "standard." It is by adding this section that some assurance can be gained regarding whether payers are reimbursing appropriately.

By calculating the contract allowable as a percent of the charge price for each CPT code by payer, a standard reimbursement percent can be calculated. When this "standard" % is compared to the actual claims paid % for each CPT code the variance should be minimal, providing a level of assurance related to the payer's reimbursing according to contract. Typically a variance of 2-3% is acceptable, but this is dependent on the demographics of your region.

There may be a slight difference between the actual and standard percentages since the standard % assumes a 100% collection (no bad debt or accounts receivable). If they are close, then your practice can have a strong level of assurance that the insurance company is paying according to contract. If the % is not close, then further investigation should be done to determine the reason.

One simple way to investigate a material discrepancy is to pull some recent Explanations of Benefits (EOBs) to compare what the insurance company is currently allowing to the contract rate.

*The critical part of the **Reimbursement Analysis** is to compare the **actual Claims Paid %** benchmark for each CPT for each insurance company to the **standard Claims Paid %** benchmark for each CPT for each insurance company.*

Example of the Standard Claims Paid % Benchmark:

- *Allowable for Medicare 88305 $100.00*
- *Practice's Charge for 88305 $200.00*
- *Claims Paid % Benchmark 50%*

If the variance between the actual benchmark and the standard benchmark is not minimal then further investigation should be done to determine the reason.

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ABC Pathology Report C-Summary of Activity by Third Party Payer and Procedure
YTD December 20XX

Payer	Procedure	Beg AR	Charges	Adjustments	Payments	Refunds	Bad Debt	Ending AR	Actual C/(C+A) %	Standard Charge	Standard Allowable	Standard %
Blue	88175	77,336.33	1,017,141.00	(259,650.07)	(754,220.48)	4,701.16	(10,952.62)	74,355.32	74%	52.00	38.50	74%
Blue	88305	96,256.86	984,800.00	(48,092.56)	(952,498.74)	7,348.29	(13,057.78)	74,756.07	95%	150.00	143.00	95%
Blue	8830526	53,631.43	673,081.00	(351,858.03)	(332,939.13)	1,638.51	(3,198.69)	40,355.09	49%	116.45	56.94	49%
Blue	8830726	21,740.39	313,860.30	(94,074.11)	(216,563.15)	954.61	(1,774.44)	24,143.60	70%	175.00	122.00	70%
		248,965.01	**2,988,882.30**	**(753,674.77)**	**(2,256,221.50)**	**14,642.57**	**(28,983.53)**	**213,610.08**	**75%**			
ABC	88175	72,620.02	866,250.00	(208,548.00)	(551,378.00)	3,809.95	(40,845.00)	141,908.97	73%	52.00	38.00	73%
ABC	88305	47,520.24	504,450.00	(34,933.65)	(479,513.58)	4,039.13	(17,007.00)	24,555.14	93%	150.00	139.23	93%
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		174,199.73	**2,035,925.05**	**(489,316.43)**	**(1,362,320.41)**	**9,834.42**	**(86,684.00)**	**281,638.36**	**74%**			
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XYZ	88175	27,861.88	297,752.00	(797.98)	(297,293.14)	1,716.74	(4,460.06)	24,779.44	100%	52.00	52.00	100%
XYZ	88305	21,649.02	212,400.00	(73,710.29)	(136,703.18)	703.29	(5,396.48)	18,942.36	65%	150.00	98.00	65%
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XYZ	8830726	6,462.88	67,320.00	(4,374.10)	(47,038.00)	750.74	(563.46)	22,558.06	91%	175.00	160.00	91%
		72,369.08	**726,445.10**	**(128,625.31)**	**(531,501.32)**	**4,417.68**	**(31,291.00)**	**111,814.23**	**81%**			
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Reasons why the actual and standard may not agree:

Insurance Company is

- *paying the wrong amount*
- *not paying all units*
- *paying professional only instead of global*

By preparing the ***Reimbursement Analysis annually,*** *the internal benchmark can be used monthly to monitor payers until either charge prices are adjusted or until contract fee schedules are changed.*

Step 4-Evaluate Claims Paid Percentage Monthly

Once the correct claims paid percentage benchmark is established for each payer, after examining reimbursement on a procedure level, that internal benchmark can be used to monitor future reimbursement for each payer. As long as this claims paid percentage does not fluctuate materially over time, your practice can have assurance that your payers are continuing to reimburse appropriately. One way to easily monitor each payer is to use a dashboard report as shown below.

Insurance Company	Claims Paid % Benchmark	Jan 20XX	Feb 20XX	Mar 20XX	Apr 20XX	May 20XX	Jun 20XX
Totals:	72	72	72	73	72	72	73
Blue	75	75	75	75	75	75	75
ABC	74	74	74	75	74	74	75
Medicare	58	57	58	60	59	59	59
XYZ	82	82	83	82	83	83	83

This Reimbursement Analysis should not be used as a substitute for daily transaction level monitoring by your billing company. However, this monitoring tool can be used to track payer performance according to the contract until your practice's charge prices are adjusted or until contract fee schedules are changed. Contract adjustments no longer have to be a "black hole" in your financial reports, unable to be analyzed. Using this analysis, your practice can have assurance that your payers are reimbursing correctly.

PSA partners with pathologists and clinical laboratories to strengthen their financial roots.
PSA is the leading provider of pathology/laboratory billing and collections services, practice marketing support, and business support services to practices and laboratories nationwide seeking to gain a competitive advantage in their markets.

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