WhitePaper

Patient Access Antidote: Retaining More Revenue with Front-End Solutions

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Produced by DARK Daily in partnership with

Quadax Revenue Cycle Optimizers

Table of Contents

Introduction

Patients' financial liability in paying for healthcare services is almost unrecognizable from that prior to the early 2000s; yet many organizations, including clinical laboratories, have struggled to modernize their collection practices in turn. As a result of this mismatch, labs risk not just losing out on uncollected revenue, but also wasting time and resources on futile or minimally effective back-end collection efforts.

Reversing the problem is possible, however, by implementing the right best practices and revenue cycle management technologies. In particular, maximizing patient access early in the revenue cycle can help patients manage their financial responsibility and preempt many unnecessary denials, payment delays, and uncollected balances.

This white paper will explore the consumer trends having an impact on revenue cycle management, best practices in patient access management, and the expert-recommended tools and solutions that clinical laboratories can employ to respond.

Chapter 1:

The Trend: Consumer Healthcare Costs Keep Climbing

On the healthcare consumer's side of the equation, patients' annual financial liability continues to rise. Family premiums for employer-sponsored health insurance plans rose 5% from 2017 to 2018, with employees contributing an average of $5,547 toward a $19,616 premium, according to the 2018 Kaiser Family Foundation Health Benefits Survey.[1] Meanwhile, annual premiums for individual coverage increased 3%, with workers paying an average of $1,186 out of $6,896.

According to the same survey, 85% of covered employees have a deductible in their plan, which averaged $1,573 for single plans, while 26% of all covered workers carry a deductible of $2,000 or more.

On top of the expenses of the insured and underinsured, the uninsured rate among working-age adults (between 19 and 64) in the United States increased to 15.5% in 2019, according to a report from The Commonwealth Fund.[2] Among the 19 states that have not expanded their Medicaid programs, 21.9% of residents remain uninsured.

Adding to the complexity, clinical labs play a critical role in delivering healthcare to millions of Medicare beneficiaries,[3] and a new payment system for lab tests, with payment cuts of up to 30%, took effect Jan. 1, 2018.

"As labs now see the 2018 rates reflected in their books, the real effects of the Protecting Access to Medicare Act (PAMA) that called

for the new market-based payment scheme is coming into sharp relief," notes an article from the American Association for Clinical Chemistry.[4]

Furthermore, enrollment in Medicare Advantage is expected to reach record totals in 2019. More than 22.6 million new Medicare beneficiaries are anticipated, with 14 new private companies offering plans, *Kaiser Health News* (*KHN*) reports.[5] As enrollment shifts from traditional Medicare to Medicare Advantage, the health of regional clinical laboratories can suffer, as smaller labs lose access to beneficiaries, *DARK Daily* reports.[6]

In the new era of consumer-driven healthcare, patients themselves are absorbing more of the cost of healthcare delivery. Labs are struggling to modernize their collection practices.

As financial burdens mount—without proactive strategies to meet them—patients are increasingly likely to face bad debt, resulting in collections calls and letters, lowered credit scores and difficulty securing loans, legal proceedings, liens on properties and estates, and even bankruptcy.

In fact, about 530,000 families turn to bankruptcy each year due to medical bills they cannot pay, according to a study in the *American Journal of Public Health* published in March 2019.[7] Citing court records of bankruptcy filers from 2013 to 2016, the study also found that 66.5% of the bankruptcies were tied to medical issues, such as being unable to afford medical bills, lost income due to illness, or both. The researchers noted that bankruptcy was most common among the middle class, and in general, medical costs outpace incomes.

The situation is forecasted to worsen, as a 2017 analysis from TransUnion Healthcare projected that by the year 2020, the percentage of patients not paying their medical bills in full will rise to 95%.[8]

Chapter 2:

The Role of Financial Education: A Primer for Guiding Patients

At the same time, healthcare providers have become dependent on patients for 30% of their revenue. Therefore, the need to collect payment is paramount, as labs can no longer afford to provide the leeway for patients that was once common practice.

Healthcare providers have become dependent on patients for 30% of their revenue. Medical laboratories can no longer afford to provide the leeway for patients that was once common practice.

"The old mentality was that we take our lumps by not getting paid, but there's still generally enough [revenue] to be profitable without having to burden the patient," says Walt Williams, Director of Revenue Optimization and Strategy for Quadax, an Ohio-based firm specializing in revenue cycle optimization. "Now, when people have $1,500 to $2,000 deductibles, the math doesn't add up," he says.

Therefore, labs are behooved to educate and engage their consumers as early in the revenue cycle as possible. These opportunities are of increased importance to labs compared to other healthcare providers, Williams notes, as laboratories rarely share continuous relationships with patients.

Nonetheless, deeper consumer engagement can benefit healthcare providers in general, through improved customer acquisition and retention, strengthened brand premium, lower administrative costs, and enhanced competitive advantages, notes an article from McKinsey and Company.[9]

"To effectively guide consumers, payers and providers should be prepared to heighten consumer awareness by giving them the right information at the right time, at each stop along the consumer-decision journey," McKinsey authors note.

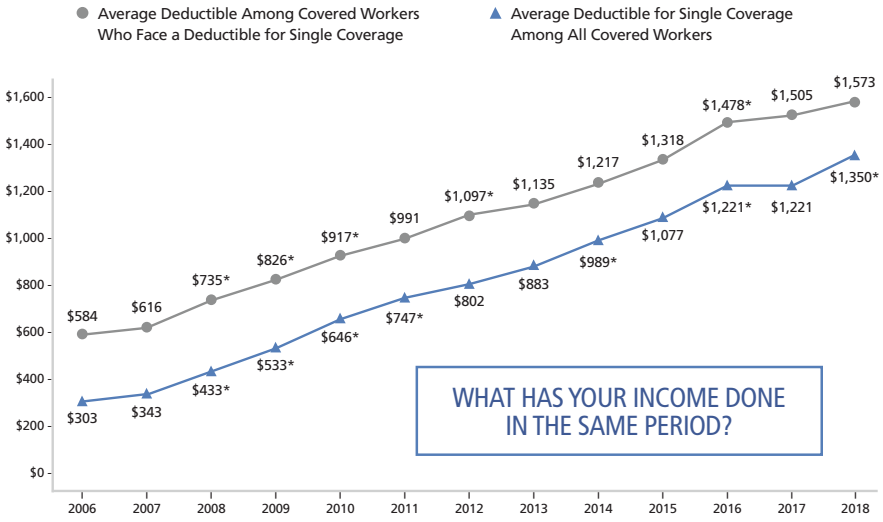
Thus, labs must provide consumers a clear explanation of their financial policies along with detailed and reliable estimates of their out-of-pocket expenses.

"Clearly, patient responsibility can only be calculated after the provider can ascertain their eligibility status, plus the amount the patient owes for copay and their deductible balance, plus the information on their estimated fees," notes a report from JPMorgan.[10]

"Therefore, the healthcare provider should be providing the patient with all of this information and establishing a payment method as soon as possible, ideally while the patient is still present," the authors wrote.

Deductibles on the Rise — Single Coverage Example

Average General Annual Health Plan Deductibles for Single Coverage, 2006–2018



Year	Average Deductible	Average Deductible
2006	$584	$303
2018	$1,573	$1,350
Increase	169%	346%

*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2018

Chapter 3:

The Challenge of Meeting Complex Payer Requirements

Of course, labs can't afford to lose payer revenue either. On top of protecting their thin margins, labs also have greater insurer requirements to satisfy. "The concerns of the past were making sure the patient was eligible and getting a claim in clean," says Williams, who has 26 years of experience working in laboratories. "Now, layered on top of that, we have additional concerns that require tools for the physicians and the patients to know whether there are requirements for medical necessity or prior authorization," he says.

Chances are that such burdens will be present, as a 2017 survey from the Medical Group Management Association revealed that approximately 86% of medical practice leaders reported that prior authorization requirements had increased over the past year—up from 82% making the same claim in 2016.[11]

Lab studies are a common source of denials due to noncovered services.[12] However, the majority of claim denials can be prevented or avoided. Checking healthcare payer requirements, including prior authorization and medical necessity, prior to or at the time of service, can minimize a leading source of claim denials. The additional result is that patients will be able to make more informed financial decisions about their care.

Medical billing software with a tool, such as that offered by Quadax, can help medical billing specialists navigate the preauthorization maze, Williams says. Using such a tool, healthcare providers can submit prior authorizations for virtually any payer, through a single

portal. Once a provider initiates an authorization, the system will provide payer-specific criteria to reduce, but not eliminate, the chance of a denial, as payer contracts stipulate that prior authorization does not guarantee coverage. However, if prior authorization is required but not present, the claim will be denied.

After submission, users can track all authorizations through a single dashboard and receive real-time notifications when the status of a case changes. Approved cases will include dates of approval, approved codes, and authorization numbers—all without the need to fax or call health plans, he notes.

To effectively guide consumers, payers and providers should be prepared to heighten consumer awareness by giving them the right information at the right time, at each stop along the consumer-decision journey.

And despite most hospitals having medical necessity software, medical necessity errors still account for too many claim denials, according to Williams.

Medical necessity, as defined by the American Medical Association, refers to healthcare services or products provided to a patient "for the purpose of preventing, diagnosing or treating an illness, injury, disease, or its symptoms." This is in keeping with generally accepted standards of medical practice, that are clinically appropriate, and "not primarily for the economic benefit of the health plans and purchasers."

Due to the volume of new lab tests being developed and introduced to the market, medical necessity within the lab space is more of a moving target than with more established hospital procedures, notes Williams.

Medical necessity rules are a growing concern for healthcare providers. Medicare publishes thousands of rules, between national coverage determinations (NCDs) and local coverage determinations (LCDs), plus articles that in some cases define billing and coding

guidelines for LCDs and, in other cases, stand alone. Commercial payers have their medical necessity policies as well. Policies can change frequently and can be applied retroactively.

"It makes for a very complex policy environment," Williams says, adding that in general, payers will err on the side of not covering tests until stated otherwise.

However, the medical necessity module offered by Quadax helps registration staff verify that a diagnosis-procedure combination supports Medicare medical necessity requirements and flag any coverage issues prior to service, Williams says. If a procedure code does not pass medical necessity requirements, the tool generates the advanced beneficiary notice (ABN) for patient review.

"As a result, providers are able to produce a credible estimate that clearly indicates what the patient will owe for both covered and noncovered codes," he says. "This helps minimize the provider's financial risk exposure by flagging unapproved medical procedures prior to claim submission and improves patient education by delivering transparent pricing information before receiving medical services."

Common Points of Breakdown in Medical Necessity Denials

- Is the ordering physician's documentation complete and effective?
- Has the correct diagnosis code been selected?
- Has the registration or intake department checked medical necessity policy and obtained a signed ABN from the patient when needed?
- Has the encounter been coded appropriately?
- Has the claim been billed properly?

Chapter 4:

Meeting Revenue Cycle Objectives and Implications for Patient Access

Central to managing revenue cycle challenges is comprehensive patient access management. Through diligent focus on front-end details, labs can successfully meet their key revenue cycle objectives, which include getting paid for the services they provide, proactively managing exceptions, and retaining what they get paid.

Action items for patients' and referring physicians' first contact with the lab—

In today's healthcare business paradigm, patients' and referring physicians' first contact with the lab is also the first step of the revenue cycle. Tasks that must be completed during this stage—before service is rendered—include the following:

- ☐ Identify benefit verification
- ☐ Identify out-of-pocket costs
- ☐ Identify financial assistance
- ☐ Communicate coverage for service
- ☐ Communicate payment expectations
- ☐ Collect copays
- ☐ Collect remaining deductible
- ☐ Collect coinsurance

With Quadax solutions, middleware that electronically provides labs with insight into the patient, payer, and test being ordered can be integrated into the ordering process. "If you don't have any advance knowledge of these details, you prolong payment," Williams says. "In the past, labs could muddle along without it and remain profitable; but with the proliferation of payer requirements, it's not been sustainable for the industry to keep operating the same way."

Moreover, completing the above tasks up front can help prevent the following typical sources of patient collections problems:

- Unidentified patient responsibility
- Incomplete patient collections
- Unclear/misclassified ability to pay
- Unknown qualification for financial aid

The consequences of poor patient access management are substantial. In particular, the historical model of addressing the bulk of these mistakes on the back end leads to lost revenue, poor patient and physician experience, inefficiency, unnecessary work, and excessive strain on business office staff. Such preventable overwork often stems from excessive denials requiring claims resubmission, appeals, or both. Additional troubling risks include repetition of the same errors, surprise bills to patients, and higher risk of noncollection.

These issues can negatively impact labs, patients, and ordering physicians. "Physicians are having to bear a bigger administrative burden because there isn't an efficient way to navigate through all of these issues," Williams says. "They're having to pay staff to research medical policies, perform prior authorizations, and rework diagnosis codes that didn't meet medical necessity." Much of this extra effort can be prevented with patient access tools.

When we look at accounts receivable (A/R) and see that we're $200,000 short, we want to break that down. If insurance has made its payment, that $200,000 is patient responsibility. Once you identify that, you can turn your attention to patient responsibility.

Exacerbating the problems with reactive claims management is the fact that the revenue cycle for labs is quite long, notes Williams. From a lab's first receipt of a specimen and testing it, to the time it receives final claim adjudication, could be six to nine months, especially if there are requests for medical records, appeals being sent in, and so on. "What if the patient has moved during that nine months? There's a lot of mail that gets bounced back when labs send statements out," he says.

And when patients do receive the bill several months after a test, it is that much harder for them to recall the service and understand why they are receiving a bill from a pathology lab they may not recognize. According to a poll from the Kaiser Family Foundation, four in 10 insured adults ages 18-64 said there has been a time in the past 12 months when they received an unexpected medical bill, while one in 10 said they received a "surprise" medical bill from an out-of-network provider in the past year.[13]

That was the case for 59-year-old Glen Thibedeau in April 2017, who received a bill for more than $1,000 after his physician ordered routine blood work, according to an article from *Bloomberg*.[14]

As it turned out, the lab was covered under Thibedeau's insurance plan, leaving him with an actual financial responsibility of $230. To express his anger, he paid just $130 of the total. "I thought that was ridiculous," he told *Bloomberg* a year after getting the surprise bill. "Basic blood work for over $1,000? I haven't paid them $100, and I'm doing that out of spite.''

Chapter 5:

How to Maximize Patient Access: A Four-Pronged Approach

Stories like Thibedeau's can have happier endings with a more proactive approach to collecting and submitting correct information up front.

"The earlier in the revenue cycle the patient is engaged, the better the likelihood of payment, and the lower the chances of claim denial," Williams says. Issues are best resolved up front through a combination of [the following] technological solutions and patient collection best practices, he adds.

1 Automated Insurance Verification

Automated insurance verification tools are among the most valuable technologies that a lab can implement to enhance patient access. It doesn't help organizations to merely move administrative busywork from the back end to the front end when automation is possible.

A private orthopedic surgery practice based in Tennessee recently discussed the benefits of switching to automated insurance verification. According to the article in *HealthLeaders*,[15] the verification tool allowed the practice to "reduce its denial rate, significantly cut down accounts receivable days, and eliminate an entire back-end department altogether, allowing those employees to be relocated to more patient-centric positions."

Specifically, the practice decreased its denial rate from 11% to 4% and shrunk days in accounts receivable from 45 to 26, and even fewer for certain payers, the article reports.

While many insurance verification tools provide labs with basic information such as coverage eligibility on the date of service, coinsurance, and deductible details, more advanced systems such as those offered by Quadax also provide real-time deductible monitoring, plan specificity, additional coverages, identity verification, and estimation of patient out-of-pocket responsibility, as well as information on financial clearance or propensity to pay.

Validating plan types has become a major pain point for labs, a problem made worse as the number of healthcare exchange plans grows.

Deductible monitoring with batch processing, for example, not only helps labs predict out-of-pocket costs for patients, but also enables labs to ascertain the best time to submit the claim. "You'd rather wait as long as you can to submit your claim so some other provider can consume the deductible," Williams explains. "You can also assign groups of patients for continuous deductible monitoring, so that when they've met their deductible you can be notified."

This monitoring capability can then trigger a lab to recontact patients who chose to forego certain tests they'd have to pay for under their deductible, Williams adds. "You could go back to the patient or ordering physician and relay that the patient has met her deductible, and the test would cost 'X', or nothing, under insurance."

Sophisticated systems also provide users with granular health plan information, such as whether the product is an HMO, PPO, self-funded, or fully funded—details that often have coverage implications. In addition to understanding the coverage, labs can also use this data to aid in the contracting process with payers.

Quadax's system provides users with access to a national patient demographic database to connect to thousands of private and government payers, Williams says, to determine a patient's existing health insurance coverage and identify demographic errors and omissions for accessions with no coverage on file that are unbillable.

"It's also a very big efficiency step for the tool to scrub all of the demographic data and fix it, without having to go back to the physician," Williams says.

Insurance Verification Best Practices

- Verify coverage early (and often).
- Collect copays based on data in eligibility response.
- Check self-pay patients for insurance coverage.

Medical Necessity Best Practices

- Integrate and automate the medical necessity verification and ABN generation process.
- Ensure ABNs provide patient financial responsibility.
- Publish ABN acceptance and collection policy.

2 Accurate Pre-Service Estimation

In today's world of consumer-driven healthcare, cost estimates are essential. In fact, consumers are increasingly pursuing this information through online tools such as New Choice Health, Health Care Blue Book, and Guroo. "If labs don't control the pricing narrative, someone else will," Williams says.

However, despite the business imperative and fact that more than half of the U.S. states require healthcare providers to make cost estimates available to patients, useful estimates have been largely elusive.

"It remains very difficult for patients to get reliable price information that they can act on," Ateev Mehrotra, MD, MPH, Associate Professor of Healthcare Policy and Medicine at Harvard Medical School, told *AAMC News*.[16] That's because costs are affected by many variables, including diverse insurance plans, negotiated discounts, and more.

"We talk about price transparency, but the question is, what price?" says Mehrotra. "The list price in a chargemaster? The price a hospital negotiates with an insurer? The price a consumer will actually pay out of pocket? Creating a useful and reliable way to give patients an estimate of what an episode of healthcare will cost is enormously challenging."

Labs that take a proactive approach to revenue cycle management are more likely to submit clean claims up front.

Thankfully, cutting-edge systems are rising to the challenge. For example, Quadax's fully automated out-of-pocket estimation tool analyzes the historical procedural information with the charge description master information, and patient-specific year-to-date benefit data, to arrive at an accurate individual or combined facility/technical professional estimate and the provider's negotiated contractual reimbursements. It's important to note that labs do a great deal of out-of-network business, Williams says, so the complementary insights provided by the tool often carry the most weight.

The benefits of providing upfront estimates have been long known. A 2009 survey from *McKinsey Quarterly* showed that 52% of healthcare consumers would pay $200 to $500 or more by credit or debit card when they visit a physician, if an estimate were provided at the point of care.[17] The study also found that 74% of insured consumers reported that they were both able and willing to pay their out-of-pocket medical expenses up to $1,000 per year, and 90% would pay healthcare bills of up to $500 per year.

Patients' willingness to pay up front is crucial, as the chances of collecting money from them after they receive service decrease

and become more expensive the more time passes. According to JPMorgan, at 60 days the value of a collection drops to 75% of the bill; at 90 days it is worth 60%; and after 180 days the value is just 25%.[18]

Estimation Best Practices

- Calculate patient financial responsibility using a solution that combines payer contract terms, historic charges, and patient benefits, if in-network, and/or historical reimbursement trend data when out of network.
- Provide estimates for all scheduled services.
- Provide easily understood estimate letters.
- Publish average charges on your website to provide transparency.
- Upload estimates to patient portal.

3 Targeted Propensity to Pay

"There are not unlimited resources in revenue cycle operation, especially for smaller labs," says Williams. "Sometimes you have to make some hard decisions about what you touch. All the time you definitely want to be prioritizing what you touch."

Thus, Williams recommends labs use tools that determine a patient's propensity to pay to inform these decisions. On the front end, a lab can use a consumer's propensity-to-pay score to determine what proportion of a bill to attempt to collect when, as well as an appropriate discount to offer, he says. For example, using a 10-point scale (with one indicating the lowest propensity to pay), a lab's policies might indicate that for scores of three or lower the entire patient responsibility must be paid up front; for four to six, you collect at least 50%; and for six or higher, consider offering a moderate discount for prompt payment in full.

Patient access management facilitates critical components of the revenue cycle. A major avenue consists of precisely addressing the patient's financial responsibility—and fine-tuning the process to fit appropriately into the healthcare provider's unique revenue cycle equation.

"There's a lot of psychology that goes into advanced patient collection approaches," Williams says. "People who have a propensity to pay are usually a bit savvier financially, and they're the ones who figure out they can get a deal," he says.

On the back end, the tool enables labs to sort accounts based not just on dollar amount but also on propensity to pay. "To those patients who are much more likely to pay—they will be the first phone calls you make," Williams says.

With Quadax's system, propensity-to-pay scores are generated using a combination of public data based on ZIP codes and information from credit bureaus. "The service will factor in all of that based on some advanced analytics and come up with a score that will allow you to then prioritize your work list," Williams says. This condensed information will also be available for quick decision making during registration, financial counseling, and billing and collections, to enable staff to consistently apply payment policies correctly to every patient based on their unique financial situation.

"The key is to use this solution as early as possible in the account lifecycle, preferably on day one, to collect more, earlier, and for less," said Jonathan Wiik, author of *Healthcare Revolution: The Patient is the New Payer*, and Principal for Healthcare Strategy at TransUnion Healthcare, in *Becker's Hospital Review*.[19] "By taking this step, providers are able to reduce costs by keeping more accounts in-house, thus minimizing collection vendor contingency fees," he added.

Propensity to Pay Best Practices

- Define financial thresholds for checking propensity to pay.
- Leverage multiple scoring models.
- Score 100% of patients.
- Implement configurable technology, guiding staff communication.
- Create workflows for segmenting results for staff follow-up.
- Segment accounts into appropriate workflows:
    - Potential charity care or Medicaid;
    - Collectable at time of service;
    - Potential fraud to investigate; or,
    - Eligible for financing solutions.

4 Seamless Payment Processing

Many revenue cycle management systems are not designed to enable upfront collections, Williams explains, as there is no service rendered at this stage to which the system can apply a receipt.

Quadax's system, on the other hand, allows billing at multiple points, including when the lab receives a requisition and sends a shipper to the client—before the lab has incurred any costs for testing or return shipping, Williams explains.

Payment Processing Best Practices

- Enable all front-end staff to collect payments.
- Provide flexible payment options.
- Store patient payment information.
- Integrate with your laboratory accounting and billing systems.
- Integrate patient payments with the laboratory patient portal.
- Create a reward system for staff collections.

Chapter 6:

Patient Collections Best Practices

The historical model of addressing poor patient access management on the back end leads to lost revenue, poor patient and physician experience, inefficiency, unnecessary work, and excessive strain on business office staff.

With automation relieving a portion of administrative burden from staff, more attention can go toward creating positive human interactions with clients. It is important to make known your collection and refund policy, and to educate staff on consistent messaging during patient interaction.

Failure to comply with contractual obligations to collect patient financial responsibility can result in payers reducing their allowed amounts, Williams notes. "We have had payers conduct patient surveys or call labs to learn about laboratories' financial assistance policies to ensure they are compliant."

Crucially, customer service employees must be equipped to explain payment options to both patients and ordering physicians.

Be Equipped to Explain Third-Party Billing

- Billed charge or "price" versus allowed amount
- Patient cost share estimates
- Discount opportunities—e.g., income-based, prompt pay
- Payment plans—minimums, duration, fees

Know How to Explain Patient Direct Bill (Foregoing Insurance)

- Lower price, but no credit toward deductible

To make training stick, commitment to the policies has to start at the top, Williams says. "There has to be an understanding of the issue

within the ranks of senior management at the lab to support that 'we've got to have a patient billing policy that is rational and fair,' and that 'we can't continue to not collect these patient amounts,'" he adds.

PUBLISH YOUR COLLECTION AND REFUND POLICY: This policy should be publicly available via the lab's website. Rates for insurance and self-pay consumers also should be included, Williams says, noting that charging the two different rates does not constitute "fee-forgiving," an illegal practice in which the lab makes no attempt to collect patient responsibility required by insurance contract.

The lower rate for clients paying out of pocket up front is justified—legally and financially—because of the expense saved from not having to bill an insurance company, such as time spent on prior authorizations, appeals, and so on, Williams explains.

UNDERSTAND THE BIG PICTURE OF FINANCIAL HEALTH: To truly understand the financial health of a lab, one must measure and track several key performance indicators (KPIs), including aged accounts receivable (A/R), net days in A/R, cash collection as a percentage of net patient services revenue (net collections rate), claim denial rate, cost to collect, and others. In addition to showing how a lab's performance compares to industry benchmarks, these metrics can also indicate how well employees are performing the tasks needed for fast, accurate reimbursement.

Ideally, labs should monitor these KPIs daily, rather than weekly or monthly, according to an article from *THE DARK REPORT*.[20] In the article, Thomas P. Joseph, MBA, MT(ASCP), President and CEO of Visiun Inc., located in Ann Arbor, Mich., says that top labs share one key trait: "This attribute is a commitment to performance monitoring, informed by detailed data reported in real time. [High-performing] labs are diligent about collecting data on performance and operations

and reporting these metrics daily. This information is used to rapidly fix problems. It also allows the process improvement team to identify opportunities to reduce cost and improve performance on an accelerated timeline."

Labs rarely share continuous relationships with patients. It is important for them to educate and engage their consumers as early in the revenue cycle as possible.

Industry benchmarks for popular KPIs, as reported by *Medical Laboratory Observer*,[21] are as follows:

- Days in A/R: For a commercial clinical lab, a benchmark of 35 to 50 days is fairly standard. For advanced genetic testing, however, 70 to 90 days is more common. The more contracts a lab carries, the lower its days in A/R should be.
- Net collections rate: The national rate average for net collections is 88% to 92%, based on payer mix and patient demographics.
- Denial rate: Labs should aim for a denial rate of lower than 10%.

Regarding days in A/R, Williams notes, "What we've learned is that it's common to see DSOs (days sales outstanding) extend beyond 150 days. Fighting denials will cause the DSO to grow."

Additionally, Williams recommends labs run a detail report of statement success metrics, or where payments come in based upon statements sent out. In other words, A/R should be broken down into categories representing insurance payments and patient responsibility.

"So, when we look at A/R and see that we're $200,000 short, we want to break that down. If insurance has made its payment, that $200,000 is patient responsibility. Once you identify that, you can turn your attention to patient responsibility."

Conclusion

The adage, "An ounce of prevention is worth a pound of cure" holds up when it comes to revenue cycle management for clinical laboratories, especially regarding challenges related to consumer-driven healthcare and higher payer requirements.

On the payer side, a host of automated technologies can be used up front to not just determine patient eligibility, but also to identify additional coverages, meet preauthorization and medical necessity requirements, submit claims seamlessly, and ensure accurate and up-to-date demographic information—thus pre-empting many common causes of insurance denials and payment delays.

These systems also help enable informed decision making for patients through accurate pre-service estimates. These estimation tools don't just help patients prepare to fulfill their financial obligations to labs, but also increase the likelihood of their doing so.

Finally, these patient-access solutions—used in conjunction with industry best practices—make diligent focus on front-end tasks feasible for lab employees, as well as freeing up staff to engage patients as early as possible in the revenue cycle.

Labs that take this proactive approach to revenue cycle management are more likely to submit clean claims to insurers up front and receive timely payment of patient balances—achievements that are critical for financially healthy, high-performing labs.

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