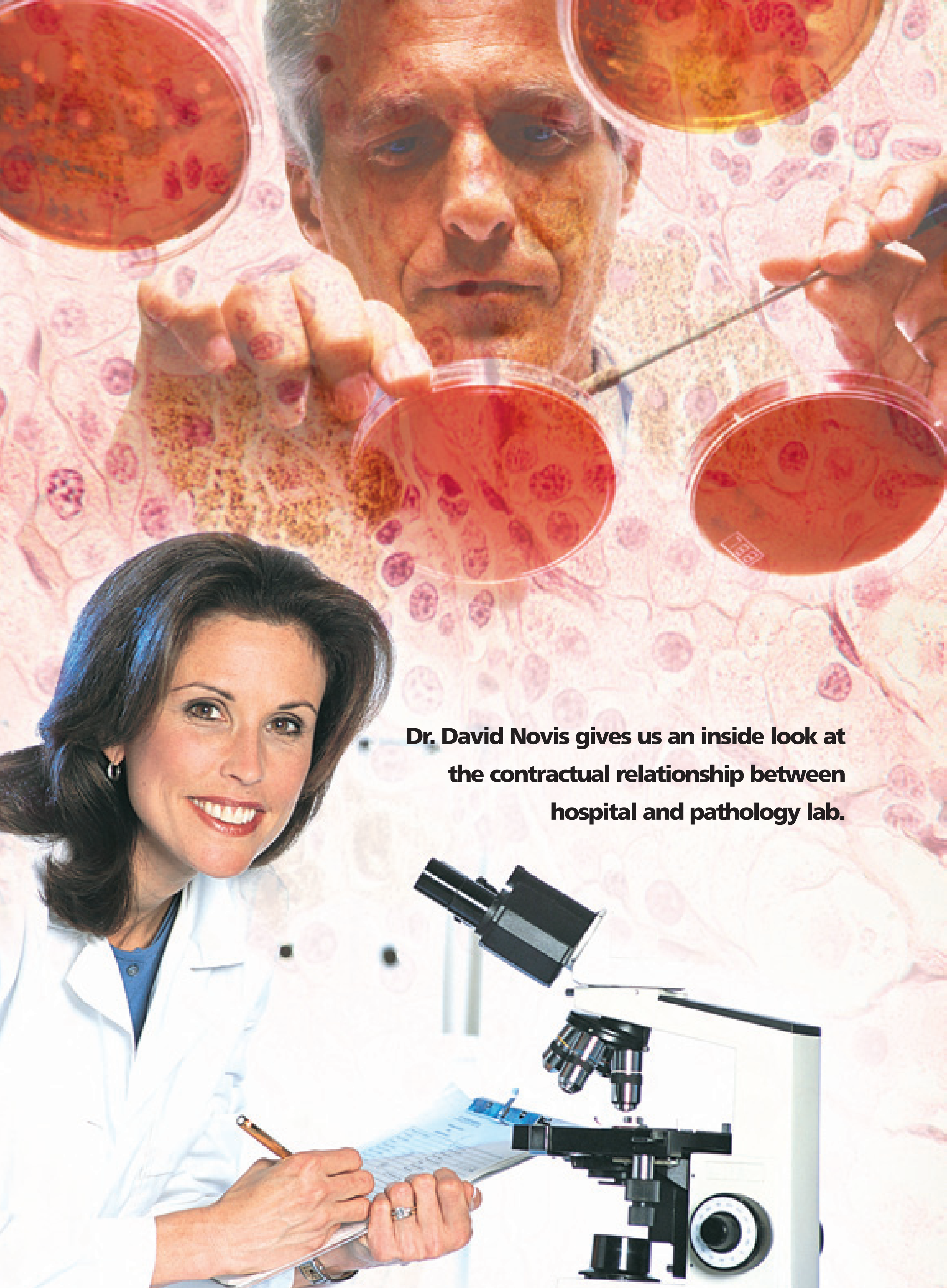
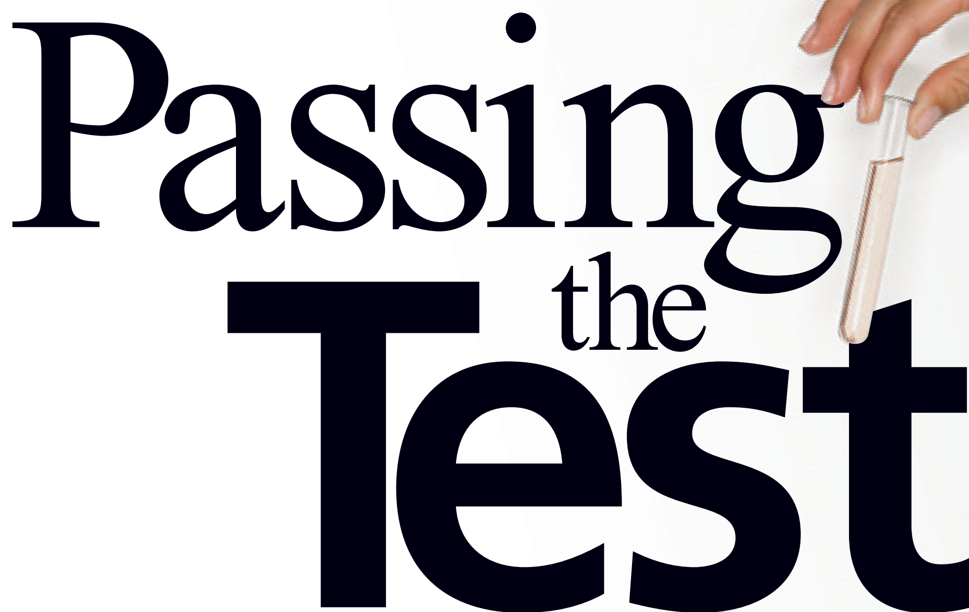


Dr. David Novis gives us an inside look at the contractual relationship between hospital and pathology lab.

Passing the Test



Most hospitals contract with pathologists for professional services and laboratory oversight, and in many cases, these contracts were arranged with parties long retired or gone. Because laboratory margins have thinned considerably in recent years, it's important for hospital administrators to refresh their understanding of the value their pathologists provide.

Pathologists provide two types of services. The first is consultative, performed directly for patients at the request of patients' caregivers. Consultations may be in the fields of anatomic or clinical pathology. Anatomic pathologists discover the presence of pathologic conditions that exist in tissue specimens. Clinical pathologists interpret the significance of laboratory test results. Most pathologists are certified by the American Board of Pathology in both areas. Medicare refers to services that pathologists provide to patients directly as Part B services.

Pathologists also provide general oversight of medical laboratories. They ensure that the quality of laboratory testing is maintained and that the services meet the needs of physicians and patients. Medicare refers to these general services that benefit patients indirectly as Part A services. In time-studies performed in more than 50 hospitals, Chi Solutions Inc., a laboratory consulting firm, determined that pathologists spend about 20% of their time on these administrative and oversight activities.

Pathologists and administrators have come to apply Part A and Part B terminology to the types of services that pathologists provide regardless of who pays the bill—Medicare, private payors, or patients themselves.

Many options

For consultative services delivered to specific patients, pathologists bill patients directly. For general oversight services that pathologists provide to laboratories, reimbursement is more complicated. In some instances, third-party payors reimburse pathologists directly for laboratory oversight, paying them a small fee for each test the laboratory performs. This fee recognizes the fraction of total oversight that can be apportioned to each test.

In other instances, third-party payors reimburse pathologists indirectly through a hospital intermediary. Pathologists' allotments of Medicare Diagnostic Related Group (DRG) reimbursements are usually handled in this manner.

Many hospitals provide laboratory services to physicians' community practices. These practices often pay the hospital for laboratory testing; the hospital then passes on the professional components of these payments to the pathologists.

Some third-party payors do not recognize general oversight functions and pay neither the pathologists nor the hospitals for these services. A survey of 672 member pathologists performed by the College of American Pathologists (CAP) in 2004 showed that 13% to 17% of pathologists receive no compensation for their oversight of the clinical laboratory.

Donna Meyer, assistant director of professional affairs for CAP said: "There is no complete compendium of all of the insurance payment policies, and even when there is a national directive [from a particular insurance payor], we sometimes see a regional plan with a different policy."

If insurance companies refuse to pay for oversight services, pathologists may look to the hospital for compensation, and unless administrators are able to recoup these fees from third-party payors, those payments will necessarily come off the hospital's (most likely the laboratory's) operating margin.

General principles of reimbursement

The principles by which reimbursement mechanisms are established for pathologists should be no different from those by which compensation is determined for any upper-level professional or clinical hospital manager. They include:

Relevancy. Accreditation of clinical laboratories by CAP requires that laboratory medical directors be responsible for certain oversight activities. The requirements are almost identical to those proscribed by Medicare. The list was created by pathologists, not hospital administrators. Administrators must determine what responsibilities they desire of pathologists, what specific duties they expect pathologists to perform in meeting these responsibilities, and how much they are willing to reimburse pathologists for performing them. Conversely, there may be responsibilities not on the CAP menu that administrators would like their hospital-based physicians to perform and for which they are willing to reimburse them.

Productivity and accountability. The responsibilities enumerated in the pathologists' contracts must be linked to a method that documents how and to what degree these responsibilities have been met and what constitutes acceptable and unacceptable performance.

Risk. In a partnership, one party should not be expected to shoulder all the risks or all the red ink—especially the party that brings most of the income to the table.

Incentive. Both parties should have incentives to attain common goals.

Mission and values. Pathologists must be motivated to advance the mission of the hospital, embrace the hospital's values, improve quality, and promote patient confidence and loyalty.

Consistency. Business relationships with pathologists must be in line with, and not jeopardize, those of other physicians in the medical community.

Compensation options

With these principles in mind, administrators have three basic options in arranging compensation packages with their pathologists: straight salary, scaled reimbursement, and fixed reimbursement **(see table below)**.

Controlling pathologists' salaries directly can eliminate losses resulting from inequities in third-party reimbursement. Employment contracts help administrators get a firm handle on what and how well pathologists discharge their responsibilities. Incentive bonuses can be tied to performance outcomes. Salaries must include provisions for retirement contributions, coverage for time off, professional dues, society memberships, and medical education.

With scaled reimbursement, compensation is proportional to some metric of volume. Pathologists may be paid fixed dollar

PATHOLOGIST REIMBURSEMENT OPTIONS

<table>
<tr><th rowspan="3">Business Relationship</th><th colspan="4">Hospital work
(Inpatients, clinics, etc.)</th><th colspan="2">Hospital outreach work
(Physicians' office testing)</th></tr>
<tr><th colspan="2">Laboratory oversight
(Part A)</th><th colspan="2">Professional components
(Anatomic and clinical pathology services)
(Part B)</th><th rowspan="2">Who bills patients or office clients
(Parts A and B)</th><th rowspan="2">Who pays pathologists
(Parts A and B)</th></tr>
<tr><th>Who bills patients</th><th>Who pays pathologists</th><th>Who bills patients</th><th>Who pays pathologists</th></tr>
<tr><td rowspan="3">Contracted Pathology Group</td><td rowspan="2">Hospital</td><td rowspan="2">Hospital</td><td rowspan="3">Pathologists</td><td rowspan="3">Patients, third-party payors</td><td rowspan="2">Hospital</td><td>No separate payment</td></tr>
<tr><td>Fixed dollar amount per test or a % of receipts</td></tr>
<tr><td>Pathologists</td><td>Patients and third-party payors in some states</td><td>Pathologists</td><td>Clients, patients, or payors</td></tr>
<tr><td>Salaried Pathologists</td><td colspan="6">Hospital</td></tr>
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amounts for each clinical test the laboratory performs but for which the pathologists are unable to bill patients. Some hospitals choose to pay pathologists a percentage of laboratory revenues, patient days, or hospital discharges.

Toni Berger, a senior consultant for Chi Solutions, warns that "regardless of how scaling is calculated, administrators must scrutinize fee schedules, test prices, and client and other third-party reimbursement arrangements. They need to make sure that the fees they pass through to pathologists are not losing them money." Pathologists' reimbursements must allow for third-party discounting and for costs related to accounting and billing.

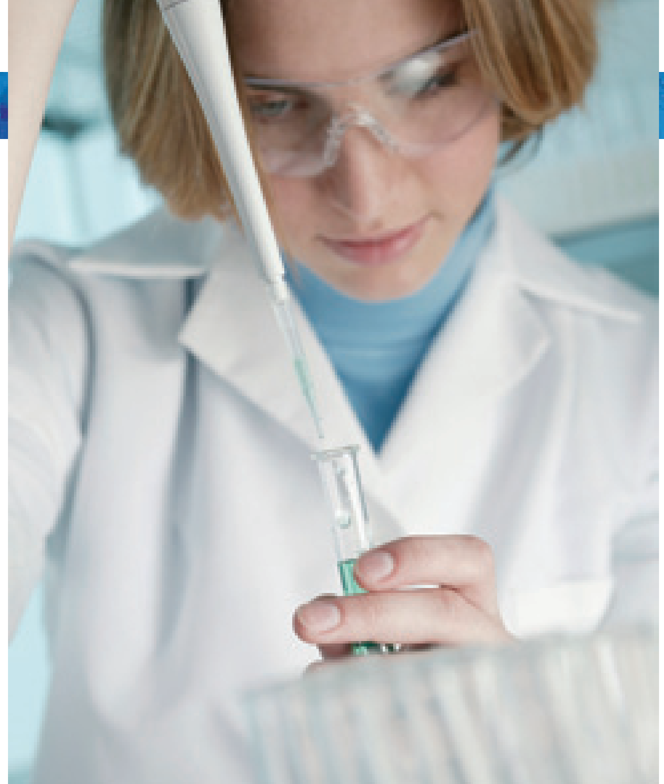
Some administrators may be suspicious of endorsing variable reimbursement for what is essentially a fixed management function. However, scaled reimbursement allows sharing of risk with the pathologists, such as the risk associated with downturns in sales. Scaling may also create incentives for the pathologists to participate in marketing the laboratory's outreach business. Keep in mind that any percentage arrangements require careful legal scrutiny.

With fixed reimbursement, one fee covers all general laboratory oversight and all services. This arrangement is well suited to situations in which pathologists are unable to bill patients directly (as is the case with Medicare patients). The fixed stipend is typically paid in equal monthly installments, and total compensation does not vary with laboratory volume or income. A fixed stipend may include an incentive bonus tied to attainment of performance objectives, such as increased productivity, profitability, or achievement of certain quality goals.

A level of reimbursement may be estimated from historical revenue patterns, adjusted to prevent compensating pathologists beyond what third-party, client reimbursement relationships, or other marginal contracts allow. Administrators can save themselves the rigors of calculating each fee separately by paying pathologists reasonable estimates of their yearly revenues in the form of fixed monthly stipends.

Fixed levels of compensation can also be indexed to some predetermined percentile of market rates—a percentile rate of what peer hospitals pay for laboratory oversight. As simple to compute as this may be, there is no guarantee that reimbursement schemes established by colleagues elsewhere are reasonable, equitable, or even applicable at home.

Administrators may choose to develop rates commensurate with what they pay other upper-level hospital executives or medical directors. Construction of such rates might consider variables



such as complexity of tasks, number of employees managed, laboratory budget, or billable charges. It may take some ingenuity to compare apples to apples. Unlike doctors, not all upper-level executives are expected to provide 24/7 coverage and carry hefty malpractice insurance premiums.

Finally, pathologists can be paid on the basis of the number of hours it takes them to perform their oversight functions. This requires pathologists to keep detailed logs of their daily activities. Well-constructed time-studies contain safeguards that limit participants' abilities to over-allocate hours to certain activities. Reimbursement levels can be compared to national benchmarks. Administrators must appreciate that fees based on "process" such as hours worked rather than on "outcomes" such as performance goals achieved may provide pathologists with no incentives to be innovative or efficient.

Pathologist responses to the CAP practice survey cited above indicated that most arrangements combine elements of both scaled and fixed reimbursement. Scaled reimbursement covers billable tests for which the pathologists issue interpretive reports, and fixed stipends cover general laboratory oversight, management, and administration for which pathologists are unable to bill patients. Whatever compensation method is selected, it must be tailored to the needs, missions, and culture of each institution.

Dr. David Novis has practiced laboratory medicine and pathology for 25 years and is a recognized expert in practice management, clinical quality, patient safety, and service delivery. He serves as a content resource and advisor for a wide range of laboratory, pathology, and general medical consulting firms. He can be reached at dnovis@comcast.net.