PAMA Lab Test Private Payor Rate Reporting

December 2021

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Program Description

Title:

PAMA Lab Test Private Payor Rate Reporting

Description:

CMS added a new reporting requirement to hospital “outreach” laboratories which submit claims for non-patient services.

This presentation will focus on the new Medicare requirement that hospitals report private payor rates for the same tests reimbursed under the CMS clinical laboratory fee schedule. The requirement applies to hospitals which received at least $12,500 in Medicare payments for claims billed on the 14x TOB between January 1, 2019 through June 30, 2019.

Objectives:

At the end of this presentation, participants will be able to:

- Learn whether the CMS mandate for private payor applies to their facility
- Comprehend the data collection process and reporting requirements
- Learn about potential penalties for failure to report or incomplete reporting

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Medicare's Clinical Lab Fee Schedule

- In 2014, Medicare paid approximately $7 billion for Clinical Lab Diagnostic Tests (CDLTs.)

- Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which established a new methodology for determining Medicare payment rates for CDLTs.

- In the new law, Congress directed HHS to set the clinical lab fee schedule payment amounts by calculating a **weighted median of private payor rates** using reported private payor rates and associated volume (number of tests).

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Congressional Intent

Congressional Record – May 8, 2014, page S2860
Senator Orrin Hatch

"…Reform of the Clinical Laboratory Fee Schedule is an important priority. The current system does not allow for changes in reimbursement for specific tests and instead, cuts to lab reimbursement have been broad reductions to the fee schedule overall. This imprecise approach has hampered the ability of labs across the country to continue to innovate and improve the diagnosis and treatment of disease. The Protecting Access to Medicare Act reforms this outdated approach and establishes a system requiring laboratories to report market rates to establish Medicare reimbursement. …"

Congressional Intent

Congressional Record – May 8, 2014, page S2860
Senator Orrin Hatch (R/UT)

"It is my understanding that the intent of this provision is to ensure that Medicare rates reflect true market rates for laboratory services, and as such, that all sectors of the laboratory market should be represented in the reporting system, including independent laboratories and hospital outreach laboratories that receive payment on a fee-for-service basis under the fee schedule. …"

Congressional Intent

Congressional Record – May 8, 2014, page S2860
Senator Richard Burr (R/NC)

"…I concur; the intent of the provisions of the bill reforming the Medicare Clinical Laboratory Fee Schedule is to ensure that Medicare rates reflect true market rates, and that commercial payment rates to all sectors of the lab market should be represented, including independent laboratories and hospital outreach laboratories."

Data Collection Process

- The new law requires Medicare to calculate a weighted median for each test for the data collection period by arraying the distribution of:
  - all payment rates reported for the period
  - for each test
  - weighted by volume
  - for each laboratory.

- Section 1834A(a)(1) of the Act requires that “Applicable Laboratories” must report private payor payment rates for Clinical Diagnostic Lab Tests (CDLTs)

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First Round Data Collection

- CMS will collect data every 3 years to set the weighted median of private payor rates for the following 3 years
- The first collection period was January through June of 2016
- Medicare originally defined an “Applicable laboratory” narrowly
- Only large regional and national laboratories performing a high volume of non-patient specimen lab work were required to report payment rates in the first data collection period (January through June, 2016.)

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The result: Lower Payment on Most CDLTs

For Example: The CLFS national rate paid for 80053, Comprehensive Metabolic Panel:

- 2017 -- $14.49
- 2018 -- $13.04 (first 10% cut)
- 2019 -- $11.74 (the second 10% cut)
- 2020-2021 -- $10.56

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Rate Reductions Capped at 10% per Year

- Medicare decided to reduce rates on tests by no more than 10% per year to soften the impact; here are some common lab tests which will reduced by 10% per year until the rate matches the median private payor calculated rate.

Final Payment Rates in 2018, 2019, and 2020 (with 10% Reduction Cap-where applicable)

Payment rates with 10% phase-in reduction in 2018, 2019 and 2020

*Note: *HCPCS codes with one asterisk indicate codes that had payment or volume amounts equal to 0.*

***HCPCS codes with two asterisks indicate codes that were introduced in 2017.*

					Weighted Median vs NLA		
Sort Order	HCPCS_CD	HCPCS_CD Description	2017 NLA	Weighted Median	Payment Difference	Pct. Change in Payment	2018 Payment w/ Cap
10	80053	Comprehen metabolic panel	$14.49	$9.08	-$5.41	-37.34%	$13.04
9	80051	Electrolyte panel	$9.62	$6.04	-$3.58	-37.21%	$8.66
711	85025	Complete cbc w/auto diff wbc	$10.66	$6.88	-$3.78	-35.46%	$9.59
712	85027	Complete cbc automated	$8.87	$5.91	-$2.96	-33.37%	$7.98
8	80048	Metabolic panel total ca	$11.60	$8.06	-$3.54	-30.52%	$10.44

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Higher than expected Savings

- Amount that CMS predicted that its payments to laboratories would decrease during 2018 as a result of the new rate methodology:

$390 million

- Actual reimbursement decreased in 2018:

$670 million.

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Data Collection Process Criticized

- Laboratories and hospitals complained that the payments calculated from the 2016 data were inaccurately low.
- Critics said that data-collection methods were flawed because CMS collected data from less than 1% of laboratories nationwide.
- The data collected excluded hospitals and physician office payments, which were arguably higher.
- The American Clinical Laboratory Association (ACLA) brought a lawsuit against Health and Human Services Secretary Alex M. Azar to correct its data collection methods.

"Applicable Laboratory"

In response to hospital concerns, Medicare expanded the definition of an "Applicable Laboratory" beginning with the 2019 data collection period to include:

- Hospitals and physician practices which…
- Bill for reference lab testing (non-patient), and
- Were paid at least $12,500 by Medicare for non-patient lab services rendered between January 1 through June 30, 2019.

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An Applicable Laboratory is:

- A laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) regulatory definition of a laboratory (that is, 42 C.F.R. § 493.2)
- Which bills Medicare Part B under its own NPI or for hospital outreach laboratories, bills Medicare Part B on the Form CMS-1450 under bill type 14x.
- Which meets a "majority of Medicare revenues" threshold, that is, within the 14X bill types sent to Medicare, more than 50 percent of its Medicare revenues from one or a combination of the CLFS or the PFS.
- And meets a low expenditure threshold, that is, it receives at least $12,500 of its Medicare revenues from the CLFS in a data collection period.

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Majority of Medicare Revenues

Medicare revenues *from the Form CMS-1450 14x Type of Bill* (TOB) are used by hospitals to determine whether its hospital outreach laboratories meet the majority of Medicare revenues threshold and low expenditure threshold.

The “majority” in this case means that the majority of the revenues paid by Medicare ***for a 14X bill type*** were paid under the Clinical Lab Fee Schedule or the Medicare Physician Fee Schedule.

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Majority of Medicare Revenues

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19006.pdf

*"**NOTE:** Hospital outreach laboratories that bill Medicare Part B under the hospital's NPI, and therefore determine applicable laboratory status based on its Medicare revenues from the 14x TOB, **will most likely meet the majority of Medicare revenues threshold."***

***"**They will most likely meet the majority of Medicare revenues threshold because their Medicare revenues are primarily, if not entirely, derived from the CLFS and or PFS. In other words, the revenues from the CLFS and or PFS services included in the numerator are essentially the same as the total Medicare revenues included in the denominator."*

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Critical Access Hospitals Too

https://www.cms.gov/files/document/frequently-asked-questions-cy-2021-clfs.pdf

Q5.4. Does the data reporting requirement apply to critical access hospitals?

A5.4. All applicable laboratories are subject to the data collection and data reporting requirements. To the extent that a critical access hospital has an outreach laboratory (that is, a CLIA certified laboratory that performs testing for non-hospital patients), and the outreach laboratory meets the majority of Medicare revenues threshold and low expenditure threshold, it would meet the definition of an applicable laboratory and be subject to the data reporting requirements.

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Check the PS&R for Jan-June 2019 Revenues

SERVICES APPLIED FOR THE PERIODS: 01/01/2019 - 12/31/2019

REPORT TYPE		CHARGES	GROSS REIMBURSEMENT	DEDUCTIBLES	COINSURANCE	MSP	SEQUESTRATION	REBILLING ADJUSTMENT	ESRD RDCTN/ NTWK PYMTS	MSP OTHER	OTHER ADJUSTMENTS	NET REIMBURSEMENT
INPATIENT REPORTS	110											
	118											
	11A											
TOTAL												
OUTPATIENT REPORTS (excluding MSP-LCC)	120											
	122											
	125											
	12P											
	130											
	132											
	135											
	13P											
	140											
	145											
	14P											
TOTAL												
OUTPATIENT MSP-LCC REPORTS	13A											
TOTAL												
SERVICE PERIOD TOTAL												

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Definition of a Private Payor

Section 1834A(a)(8) of the Act defines the term "private payor" as

- a health insurance issuer and a group health plan
- a Medicare Advantage plan under Medicare Part C,
- or a Medicaid managed care organization

Schedule of Festivities

Jan – Jun 2019: Data Collection Period

Jul – Dec 2019: Data analysis, preparation

Jan – Mar 2022*: Submit data to Medicare website

*(the original deadline was Jan-Mar 2020; CMS has delayed the deadline twice since then.)

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A little problem….

- Most large regional laboratories account for payments at the line item level; they have payment data tied to each billed test within their accounting systems. They can generate a report for this purpose.

- Hospitals (in general) do not maintain line item detail in posting payments to the accounting system. The payment detail (of $X per CPT) is available on the payor remittance advice, but that information is not transferred to the patient accounting system in sufficient detail to support reporting.

- Consequently, hospitals are especially challenged in reporting payor rate details (amount paid per lab test CPT®.)

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Another little problem….

- Some hospitals have failed to correctly report “specimen only” services on the correct TOB 14X.
- A short-lived Medicare instruction (MLN SE1412 1/6/2014) to use the 14X TOB for outpatient hospital lab testing was rescinded in mid-2014.
- When Medicare discontinued that instruction, some hospitals discontinued use of 14X altogether – although the MLN announcing the change reiterated that 14X was still required for non-patient lab testing.
- Consequently, some hospitals have been incorrectly reporting specimen-only testing on the 131 TOB, which is non-compliant.

MLN SE1412 01/06/2014

MLN Matters® Number: SE1412 | Related Change Request (CR) #: 8572

Related CR Release Date: December 27, 2013 | Effective Date: January 1, 2014

Related CR Transmittal #: R2845CP | Implementation Date: January 6, 2014

Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

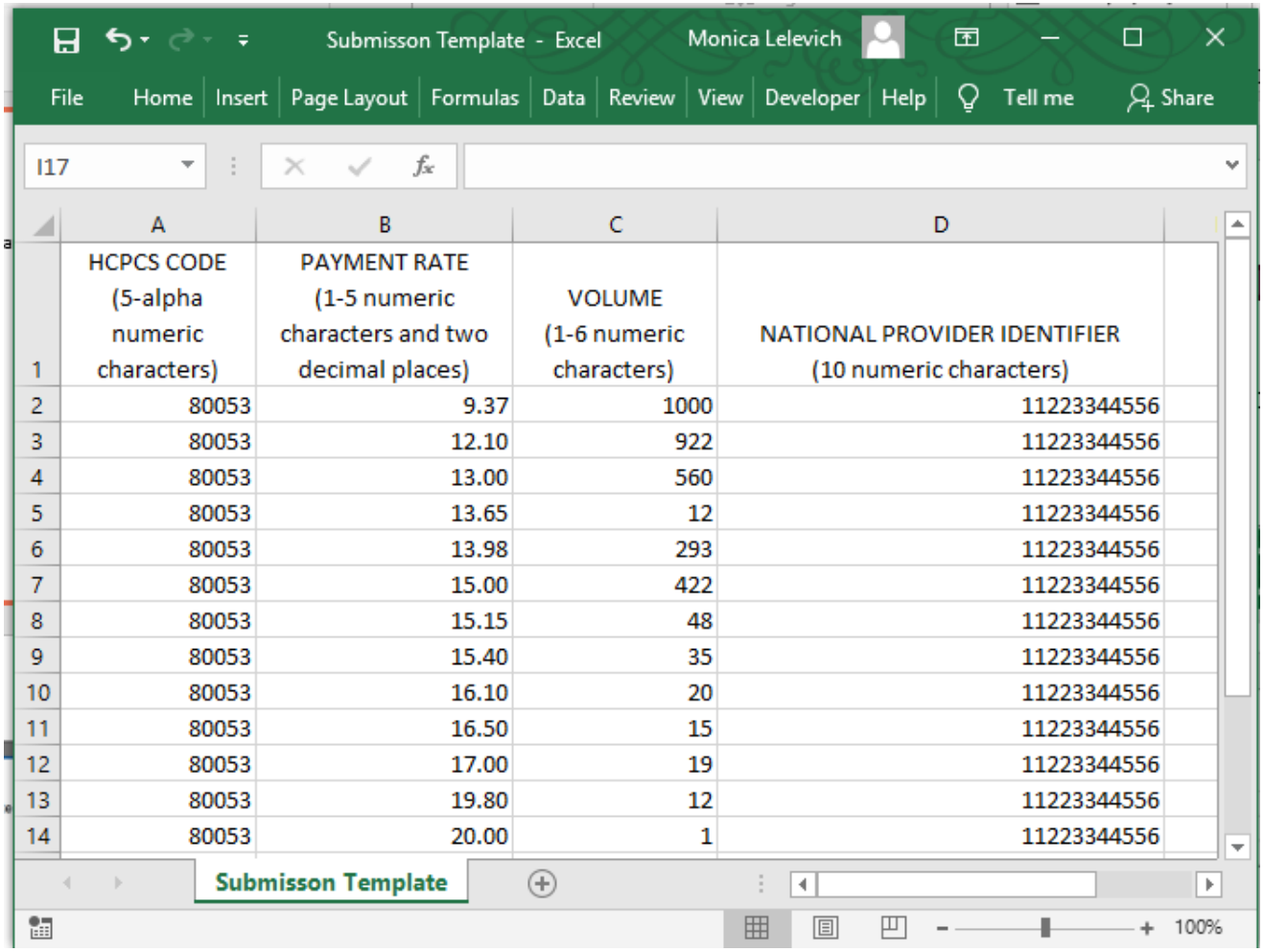
MLN Matters® Number: SE1412 Related Change Request Number: 8572

As a reminder, for claims received on or after July 1, 2014, OPPS providers are instructed to submit "specimen only" services on the 014x TOB. OPPS providers are instructed not to use the new modifier on 014x TOB.

What if we didn't use TOB 014X for non-patient lab testing?

- OPPS Hospitals which reported non-patient specimen services on the 13x TOB should take steps immediately to correct the problem – the next data collection period appears to be scheduled for January through June 2024.
- Critical Access Hospitals which reported non-patient specimens on the 851 TOB may have been overpaid at the CAH cost-reimbursement rate. Non-patient specimen claims (TOB 014X) are paid under the CLFS, even for CAHs.
- If the hospital improperly evaded the requirement to report by using an inaccurate TOB, it may choose to report its payment data anyway; and correct the TOB to prepare for 2024.

Sample Submission Form



	A	B	C	D
1	HCPCS CODE (5-alpha numeric characters)	PAYMENT RATE (1-5 numeric characters and two decimal places)	VOLUME (1-6 numeric characters)	NATIONAL PROVIDER IDENTIFIER (10 numeric characters)
2	80053	9.37	1000	11223344556
3	80053	12.10	922	11223344556
4	80053	13.00	560	11223344556
5	80053	13.65	12	11223344556
6	80053	13.98	293	11223344556
7	80053	15.00	422	11223344556
8	80053	15.15	48	11223344556
9	80053	15.40	35	11223344556
10	80053	16.10	20	11223344556
11	80053	16.50	15	11223344556
12	80053	17.00	19	11223344556
13	80053	19.80	12	11223344556
14	80053	20.00	1	11223344556

Report the Allowable

The “allowable” includes any portion that is adjudicated to patient liability

CPT®:	80053
Payment:	$10.00
Patient Deductible:	-
Patient Coinsurance:	5.00
Total allowable:	$15.00

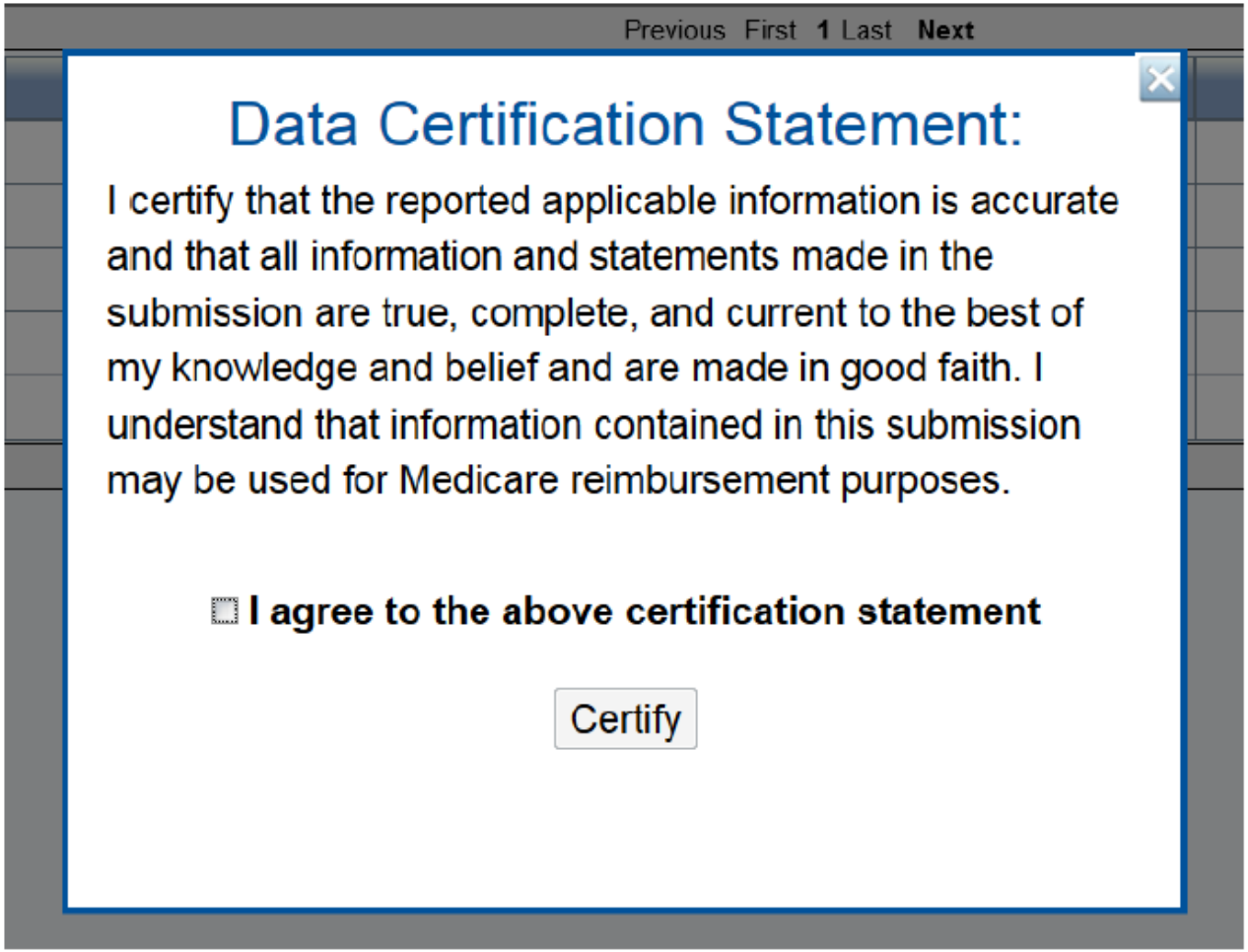
Accuracy Counts

The data collected must be certified by

- a President or Chief Financial Officer (CFO) of the applicable laboratory, or
- an individual appointed as data certifier

who certifies the accuracy and completeness of applicable information submitted to CMS.

Accuracy Counts



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Penalties for Non-Compliance

https://www.federalregister.gov/documents/2016/06/23/2016-14531/medicare-program-medicare-clinical-diagnostic-laboratory-tests-payment-system

“We are revising the certification and CMP [Civil Monetary Penalties] policies in the final rule to require that the accuracy of the data be certified by the President, CEO, or CFO of the reporting entity, or an individual who has been delegated to sign for, and who reports directly to such an officer.

“Similarly, the reporting entity will be subject to CMPs for the failure to report or the misrepresentation or omission in reporting applicable information. “

Current CMP Rate: $10,017 per day.

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CMS Recent Outreach – email 11/2/2021

Tue 11/2/2021 12:13 PM

Centers for Medicare & Medicaid Services <cmslists@su

Clinical Diagnostic Laboratories: Private Payor Rate-Based CLFS Resources

To [redacted]

If there are problems with how this message is displayed, click here to view it in a web browser.

Clinical Diagnostic Laboratories: Private Payor Rate-Based CLFS Resources

Are you an independent laboratory, physician office laboratory, or hospital outreach laboratory that meets the definition of an applicable laboratory under the Clinical Laboratory Fee Schedule (CLFS)? If so, you must report information, including laboratory test HCPCS codes, associated private payor rates, and volume data. CMS recently updated our resources:

- Summary (PDF): Key terms & concepts, whether your laboratory is an applicable laboratory, and timeline
- FAQs (PDF)

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Did you get a letter from your MAC?

WPS | GOVERNMENT HEALTH ADMINISTRATORS

Wisconsin Physicians Service Insurance Corporation
A CMS Medicare Contractor
1717 W. Broadway | P.O. Box 1787 | Madison, WI 53701-1787

September 29, 2021

Dear Clinical Laboratories and Hospitals:

CMS needs your private payor data to set payment rates for clinical diagnostic laboratory tests under the Clinical Laboratory Fee Schedule, effective January 1, 2023. Congress delayed reporting until 2022.

Do I need to report data?
You must report if you meet the definition of an applicable laboratory. This includes:

- Independent laboratories
- Physician's office laboratories
- Hospital outreach laboratories, including those that bill for their non-patient laboratory services using Form CMS-1450 14x type of bill

What do I need to report?
You're required to report:

- Laboratory test HCPCS codes
- Associated private payor rates
- Volume data

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Did you get a letter from your MAC?

(9/29/2021 Letter from WPS, Continued)

When do I need to report?
Between January-March 2022, you must report your January 1-June 30, 2019 data.

Going forward, you must report data every 3 years. Your next reporting period will be in 2025.

How will this affect my payments?
CMS uses the collected private payor data to set Medicare CLFS payment rates.

How can I learn more?

- Visit cms.gov/lab-reporting
- Submit questions to CLFS_Inquiries@cms.hhs.gov

We appreciate your time and effort.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Did you get a letter from your MAC?

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

noridian
Healthcare Solutions
Noridian Healthcare Solutions, LLC

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Did you get a letter from your MAC?

(undated Letter from Noridian, Continued)

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We appreciate your time and effort.

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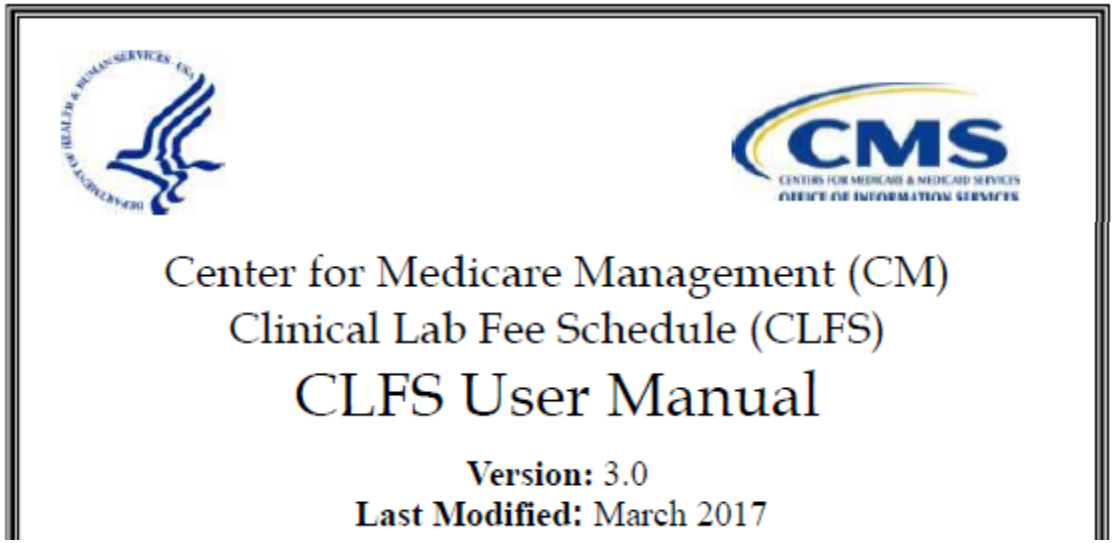
Register as a Submitter in Advance

[CMS removed the User Manual from its website in late October]

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CLFS-Data-Collection-System-User-Guide.pdf



Center for Medicare Management (CM)
Clinical Lab Fee Schedule (CLFS)

CLFS User Manual

Version: 3.0
Last Modified: March 2017

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We're required to report! Now what?

- Hospitals may need to divert staff to find and record a spreadsheet of payment rates made by each "Private Payor" on 14X type of bills for January through June of 2019.

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Have IT mine the data?

- Hospitals can use billing records (i.e. 837 files) to identify their 14X type of bill claims submitted to “private payors”, and
- Match the payment data from 835 remittance files to the full extent possible on each line item, and
- Research the payments that weren’t available in electronic remittances through searching paper remittance records.

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Or … PARA Can Help

PARA offers assistance with generating the data required for reporting private payor rates.

The PARA Data Editor offers the ability to analyze electronic claim files to identify 14X type of bill claim lines, and to match electronic 835 remittance files to efficiently generate a spreadsheet of the allowable rate paid by CPT® codes on 141 bill types.

This data can be configured into the required format for Medicare reporting. However, at this time PARA is not able to research payments submitted on paper remittances.

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PARA Can Help

To learn more about PARA's Lab Payment Reporting Analytical Services, please contact your PARA account executive:

Sandra LaPlace
Phone: 800-999-3332 **ext. 225**
Email: slaplace@para-hcfs.com

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Questions

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www.para-hcfs.com

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