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Hospitals need to be aware of risks resulting from the Protecting Access to Medicare Act

Hospitals and Health Systems that operate Clinical Laboratories are faced with new challenges as a result of federal legislation known as the Protecting Access to Medicare Act of 2014 (PAMA).

PAMA requires most hospital laboratories in the United States to report to CMS the fees they were paid by private insurers. If they do not comply with this new mandate, they are at risk of federal fines totaling $10,000 per day. CMS expects PAMA to save the government $390 M in 2018 and $3.93 billion by 2028.

To determine who should report, PAMA establishes criteria for an "applicable laboratory". Generally, those laboratories that receive more than 50% of its revenues from the Clinical Laboratory Fee Schedule (CLFS) and/or Medicare physician fee schedule (PFS) must report. However, reimbursement from Medicare Advantage plans (Part C) are not included as they are considered private payors under PAMA. This will result in an increase of the number of facilities qualifying as an applicable laboratory.

Moreover, the definition of an applicable laboratory now includes clinical laboratories that receive at least $12,500 in Medicare revenues billed using the CMS 1450 14X claim which is used specifically by outreach laboratories.

The data collection period is from January 1, 2019 through June 30, 2019. Those laboratories that are required to report will do so from during a 3-month window January 1 to March 31, 2020. The revised rates will go into effect January 1, 2021.

This is the second reporting period established by CMS. The first occurred during 2017 and was directed at the big commercial labs which according to many in the industry skewed the data. To put this in perspective, only 1,942 labs submitted PAMA data to CMS in 2017 out of 61,040 labs that received Medicare payments in 2015. Only 1% of the hospitals were required to report in the prior period, whereas now CMS estimates that at least 43% more labs are required to report under the new definition.

Specifically, for each laboratory test reimbursed by an insurance payor, CMS want to know:

1. The HCPCS code for each test
2. Payment Rate: The unique private payor rate for each test
3. The volume of tests paid at each unique private payor rate
4. The National Provider Identification: a 10-digit ID number unique to each provider in the U.S.

Reporting requirements are very specific and problematic for reporting entities. All non-governmental receipts that have a billing month during the collection period of January 1, 2019 to June 30, 2019 must be evaluated. If follow on payments for the same service occur later in the reporting period, the initial results must be eliminated from reporting. Only final payments should be reported. An additional payment received after the data collection period from the same source for the same service means that the initial receipt was not the final payment. Receipts that are not likely final payments are not included in PAMA reporting.

CSS Consulting Group is working with our clients to ensure that hospitals comply with these amendments by establishing programs to properly collect and issue the data to CMS.

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