What Labs Can Expect from PAMA in 2019

There are positives and negatives for laboratories as CMS moves forward with PAMA price reporting

CEO SUMMARY: Attendees at the Executive War College learned that CMS has taken steps to expand the number of hospital labs required to report their private payer lab test price data under the Protecting Access to Medicare Act, but the unbundling of certain test panels could be problematic. Problems can occur when labs either did not code panels correctly or their Medicare Administrative Contractor mistakenly overpaid labs for those claims. One expert recommends that labs review these claims.

CLINICAL LABORATORY MANAGERS MAY BE PLEASED TO KNOW that the Medicare program appears to be making a better effort this year to collect accurate and reliable data on what commercial health insurers pay for clinical laboratory testing, according to Lâle White, CEO of **XIFIN** in San Diego. XIFIN contracts with clinical labs to help them boost their revenue.

At the same time, White said lab executives and pathologists still have reasons to be concerned about the deep cuts that the federal **Centers for Medicare and Medicaid Services** made in lab test payments since Congress passed the Protecting Access to Medicare Act (PAMA) in 2014.

White's presentation at the 24th annual *Executive War College* last month offered a mix of positive and negative developments for clinical laboratories. The positive development was that CMS has made more of an effort to collect accurate and thorough data on what private payers pay for clinical lab tests. This is the data CMS uses to set Medicare lab test payments based on actual market rates.

The negative development, however, is that CMS officials appear to believe the agency overpays clinical laboratories for testing for Medicare patients.

On the issue of collecting private payer lab test price data this year, White said, "One question has always been, 'Did we ever have a proper market pricing study of the private payer sector as PAMA intended?'" A goal of the law is to allow CMS to set prices based on what private payers pay for lab tests. Answering her own question, White said, "I think the answer is probably not, since most private payers use the earlier Medicare fee schedule as a pricing guideline."

Lab Price Reporting

This year, CMS is collecting data once again on what private payers pay for lab tests, and more labs are required to report their data. The inclusion of a great number of reporting labs may mean CMS will have the much broader data set needed to set prices accurately based on what private health plans pay, she added.

While basing prices on accurate and comprehensive data could help clinical

labs, White was concerned about the intentions CMS has for its use of the data it collects under PAMA and setting prices based on that data. In the past, it appeared CMS was using the law to set lab test prices lower than what labs might expect if prices were based on accurate market rates, she said.

"We saw with the latest GAO report that CMS and GAO are interested in a price reduction program versus a market-price based program," White said. The GAO is the **Government Accountability Office**, a federal watchdog agency that reports to congress on how tax dollars are spent.

Appropriately enough, White's presentation at the *Executive War College* in New Orleans was titled, "The Ugly Truth about Payers and PAMA: What Labs Can Expect and How to Respond."

Response to GAO Lab Report

In a report to Congress in November titled, "Medicare Laboratory Tests: Implementation of New Rates May Lead to Billions in Excess Payments," the GAO concluded that the way CMS implemented PAMA could result in CMS paying $733 million more than it should pay for clinical lab tests from 2018 through 2020. The GAO report led Senate Finance Committee Chairman Chuck Grassley (R-Iowa) to ask federal officials to explain the potential for excess payments for lab tests. *(See, "Senator Asks: Are Lab Test Payments Too High?" TDR, Feb. 4, 2019.)*

Also, the GAO report may have led CMS officials to believe payments for clinical laboratory tests are too high, White commented. "The GAO report criticized some of the pricing calculations made by CMS because they were not based on average Medicare price, but instead were based on the national limitation amount," she explained. "And, the average price obviously would have been even a further reduction, not to mention a highly-contested methodology based on population distribution.

"In essence the $670 million savings CMS got from PAMA in 2018 versus the $390 million that CMS projected wasn't enough of a decrease for the GAO," she added. "The GAO thinks CMS should have gotten more."

The GAO report also said CMS could be overpaying for unbundled "automated multichannel chemistry" tests, White said.

Labs Responsible for Coding

In its report, the GAO criticized CMS for eliminating bundled prices for these automated tests. It said this one change alone could cause the government to pay $10 billion more for such tests. "In essence, it didn't actually cost Medicare that much, although the GAO made it seem that way when it released that report in November," White commented. "Essentially, panel ordering compared to single test orders did not materially change, and there was really no unbundling by the industry."

White made an important point about bundling, saying that when CMS implemented the PAMA-based fee schedule, it eliminated their edits for panel coding for automated multichannel chemistry tests. Labs running these tests should be aware of changes regarding such edits and should understand that they are responsible for proper coding even when Medicare does not edit for coding accuracy, she added. *(See sidebar, page 9, "To Bundle or Not To Bundle? Labs Get a Solution to a Confusing Medicare Problem.")*

More Labs to Report Data

On the efforts CMS has made to include more labs in its data-collection initiative under PAMA, White said CMS broadened the definition of which labs should submit payment data, which the PAMA statute calls "applicable labs."

"Last year, when CMS published the physician fee schedule, the agency broadened the definition of applicable labs," noted White. "This was very welcome for the clinical lab industry because obviously enough labs didn't participate when CMS

To Bundle or Not to Bundle? Labs Finally Get a Solution to a Confusing Medicare Guideline

CLINICAL LABORATORIES NEED TO BE CAREFUL ABOUT HOW THEY CODE for bundled tests, particularly multi-channel chemistry tests, XIFIN CEO Lâle White told attendees at the *Executive War College* in New Orleans last month.

"As an industry we have to be aware that providers are liable for coding errors and required to code properly for automated multi-channel chemistry tests, regardless of whether payers have the proper edits in place to recognize unbundled coding errors" she said." Also, labs should be aware that congress is considering making changes to the rules that govern how automated tests are paid.

"In November, the Government Accountability Office (GAO) suggested that labs were unbundling tests, but, in fact, labs were not unbundling," explained White. "Instead, labs were following the coding guidance from the **American Medical Association**.

"Clinical laboratories are required to code to the highest procedure code level using the most specific CPT code," she noted. "If a lab does not code properly, it is liable for the incorrect payment that can result from improper coding. None of that changed under PAMA.

"What PAMA stopped was the price bundling for automated chemistries," White added. "In other words, if your lab had a comprehensive metabolic panel, you would bill it as a panel. And, if there was any additional single chemistry test or tests ordered with that panel, Medicare would actually bundle the price and give your lab an incremental payment of maybe $1 more, instead of the actual price of the individual components ordered in addition to the panel.

"What happened was, as part of PAMA implementation, Medicare eliminated that price bundling," she continued. "But also CMS made a mistake by incorrectly eliminating the panel bundling edits that the Medicare Administrative Contractors (MACs) use to ensure that labs were using the right panel codes for those multichannel tests. For example, when a lab bills for another panel that is not an automated multi-channel panel—such as a hepatitis panel—the MAC will bundle it for the lab using its panel-coding edits.

"Accordingly, the MACs would pay the higher fees for the individual components if the provider unbundled, because they eliminated the edit that would automatically bundle the automated multi-channel chemistry tests," added White.

"Therefore, if a lab unbundled such tests or didn't bundle appropriately, the MACs probably overpaid labs for those individually submitted multichannel tests in 2018.

"Today, the MACs and CMS understand what happened, and those edits are being re-instituted in the claims adjudication systems," she warned. "That means that laboratories are responsible for making sure that they did not inappropriately unbundle or did not bundle incorrectly.

"Therefore, labs should confirm that Medicare did not overpay for those tests," she said. "If the MAC did overpay, the lab is responsible for repaying that amount."

The aggregated billing data XIFIN has for its lab clients show that, contrary to what the GAO said, labs were not unbundling tests. "There was no unbundling going on across the lab industry that was of any significance," White added. "Maybe there were one or two mistakes but there was no significant effort to unbundle.

"Nevertheless, if any labs did code tests incorrectly, they are responsible for correcting billing mistakes and repaying overpayments," said White.

collected market-price data in 2016. In that data collection effort, much of the hospital lab industry didn't participate."

Under PAMA's Section 216, labs needed to collect data on what private insurers paid for lab tests between Jan. 1 and June 30, 2016, and report that 2016 payment data in the first quarter of 2017. CMS used that data to set prices for lab tests in 2018, 2019, and 2020. At the time, CMS expected to cut what it paid labs by 10% beginning last year, 10% again this year, and 10% next year.

Second Data Collection

The second-data collection period began Jan. 1 of this year and ends on June 30. Applicable labs required to report will need to submit their data to CMS next year. For this second data-collection period, CMS changed which labs need to report their private payer lab price data.

"CMS changed the majority of revenue thresholds and eliminated Medicare Part C from the calculation for revenues received from the Medicare Advantage programs," White commented.

Also, CMS began using the 1450 14X bill type to define which labs are required to report their private payer lab price data, White explained. Therefore, CMS will require more hospital outreach labs to collect and report their data in this second data-collection period. "Basically, that means most hospital outreach labs will now be included under the definition of 'applicable labs,'" she said.

More Labs Are to Report

"According to CMS data, that means CMS has added about 43% more labs to the number of labs that submitted data last time," she added. "But there are still important questions about how the second data collection will turn out for labs."

In the first data-collection period, CMS excluded most hospital labs from data collection by not defining them as "applicable labs," White said. "If you consider the entire volume of hospital labs as part of the overall lab market, once you exclude hospital inpatient testing, about 44% of lab testing data comes from hospital outreach labs, 28% comes from large labs, and another 28% comes from the rest of the lab industry," she said.

"While these outreach labs are now part of the data collection effort, in a recent clarification, CMS has excluded outpatient private payer data and indicated that data collection for hospital labs should be limited only to non-patient services," White explained. "This limitation of data, however, will greatly reduce the data that hospital labs produce to less than 20% of the entire data set. Since the CMS pricing exercise is required to use a weighted median, how much of a difference that data will make is a question still to be answered." TDR

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Consultant Warns Labs About 'Hurricane PAMA'

IN A NOTICE SENT TO ITS HOSPITAL AND HEALTH SYSTEM CLIENTS, a consulting firm warned about what it called, "Hurricane PAMA."

Mike Kachure, Vice President of Strategic Partnerships for the consulting firm **Accumen** wrote, "Hurricane PAMA—prepare or fall victim to reimbursement damages."

For clinical labs, the Protecting Access to Medicare Act (PAMA) can feel like a hurricane to some health systems, he wrote. "This pending storm impacts a health system's ambulatory laboratory services, financial reimbursement, and hospital outreach profitability," he added. "The impact to an average hospital with Medicare reimbursement for ambulatory outpatient and outreach laboratory services of $5 million annually is projected to lose up to $1.5 million annually in net revenue by 2020, which directly impacts your bottom line."