Illinois Health and Hospital Association

WEBINAR Q&A

MAY 2021

PAMA LAB TEST PRIVATE PAYOR RATE REPORTING

On May 20, 2021 representatives from PARA HealthCare Analytics presented information on the Centers for Medicare & Medicaid Services' (CMS) requirements for certain hospitals to submit claims for non-patient services under the Protecting Access to Medicare Act of 2014 (PAMA). Hospitals that received at least $12,500 in Medicare revenues for clinical laboratory fee schedule (CLFS) claims billed on the 14x Type of Bill between Jan. 1, 2019 and June 30, 2019 are required to report the corresponding private payor rates.

We received several questions throughout the presentation. Our PARA faculty provided answers to these questions below.

Determining Whether You Must Comply

Question: Do we only look at Medicare payments made on TOB 14X, or do all Medicare payments count toward the $12,500 qualification limit, regardless of TOB?

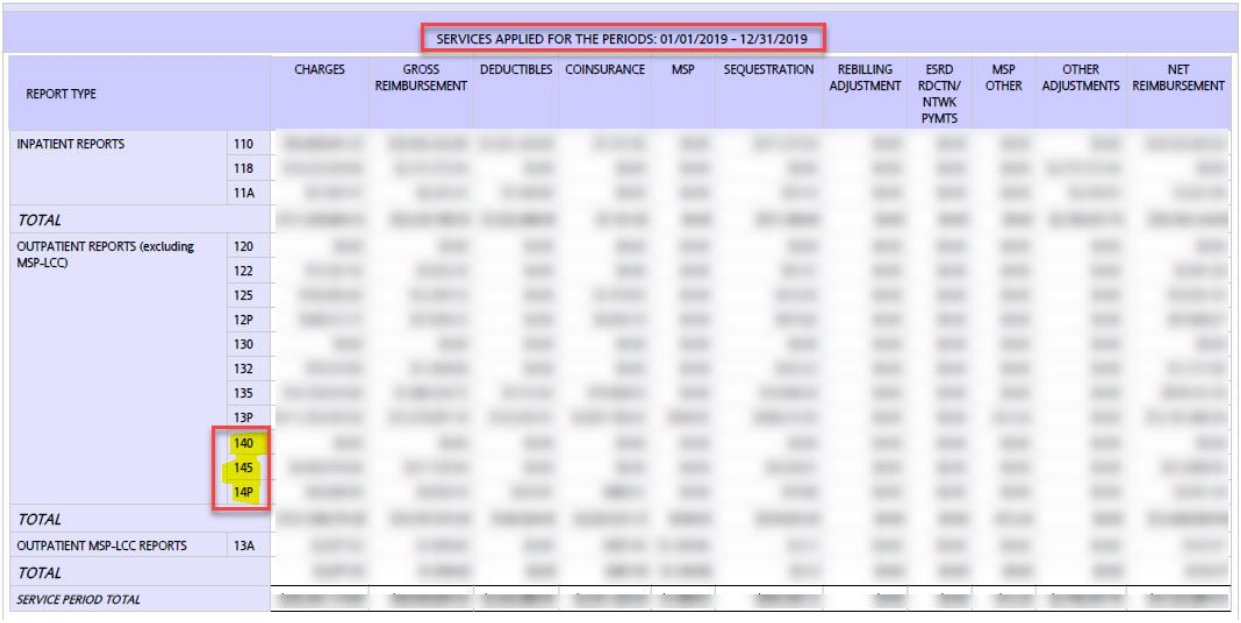
Answer: Only payments made on the TOB 14X. Remember, payments on all variations within the 14 TOB (i.e. 141, 147, 14G, etc.) count toward the $12,500 threshold.

Question: 14X claims are for specimens coming from hospital-owned clinics and patients considered hospital system patients. For this purpose, are they "non-patients"?

Answer: If the claims for lab services arising from encounters at the clinics were submitted to Medicare on the 14X TOB, then the payments received from Medicare count toward the $12,500 threshold.

Question: Could you pull that data from your Medicare PS&R reports to determine the $12,500 threshold?

Answer: Yes, the PS&$ is a reasonable means of determining whether the hospital met the $12,500 threshold. Users may download the summary PS&R for the pertinent period (1/1/2019 – 6/30/2019) and examine the "Outpatient Reports" section, which identifies the 14x type of bill. Here is a screenshot from the summary PS&R for an Illinois hospital:



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												

Reporting Entity

Question: What department(s) typically handle this initiative?

Answer: Internally, Patient Financial Services (PFS) and/or the IT department.

Question: We outsource our billing department. Who should be reporting it?

Answer: You may have your vendor prepare the data, but the hospital receiving the payment is responsible for ensuring data validity, submitting the data, and attesting to the accuracy/completeness of the submission.

Question: Who typically takes on the role of certifying the data?

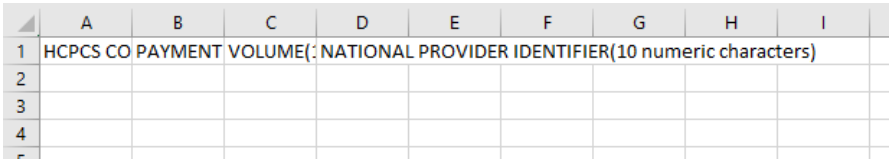
Answer: Medicare requires the certification to be made by the President or CFO, or other designated individual. Here is an excerpt from the *Federal Register* dated Thursday, October 1, 2015, which addresses the certification obligation:

> "…the President, CEO, or CFO of an applicable laboratory or an individual who has been delegated authority to sign for, and who reports directly to, the laboratory's President, CEO, or CFO, must sign a certification statement and be responsible for assuring that the applicable information provided is accurate, complete, and truthful, and meets all the reporting parameters."

Data Requirements

Question: What data elements are hospitals required to submit?

Answer: Required data elements include the HCPCS Code, payment rate, volume, and national provider identifier (NPI). The data submission form is in excel format. CMS provides a template here.



	A	B	C	D	E	F	G	H	I
1	HCPCS CO	PAYMENT	VOLUME(:	NATIONAL PROVIDER IDENTIFIER(10 numeric characters)					
2									
3									
4									

Question: What does CMS consider as a "private payor"? Will we need to include Champus rates, workers compensation claims, or third-party claims?

Answer: The guidance on reporting requirements is very general. PARA recommends either confirming with CMS directly, or erring on the side of caution and submitting more data rather than less.

Here is a link and an excerpt summarizing the definition of a private payor from the CMS document "Summary of Private Payor Rate-Based Medicare Clinical Laboratory Fee Schedule" updated 4/20/2021:

> *Private Payor.* The term "private payor" is defined as any of the following:
>
> - A health insurance issuer as defined in Section 2791(b)(2) of the Public Health Service (PHS) Act);
> - A group health plan as defined in Section 2791(a)(1) of the PHS Act);
> - A Medicare Advantage Plan under Part C as defined in section 1859(b)(1) of the Act; or
> - A Medicaid Managed Care Organization (as defined in Section 1903(m) of the Act).

Following are excerpts from the CMS Frequently Asked Questions document (updated April 2021).

> **Q1.3. What is a private payor?**
>
> A1.3. For purposes of the private payor rate-based CLFS, the term "private payor" is defined as: (1)
> A health insurance issuer as defined in Section 2791(b)(2) of the Public Health Service (PHS) Act); Or (2) A group health plan as defined in Section 2791(a)(1) of the PHS Act); Or (3)A MA Plan under Part C as defined in section 1859(b)(1) of the Social Security Act (the Act); Or (4) A Medicaid Managed Care Organization (MCO) (as defined in Section 1903(m) of the Act).

These are the pertinent excerpts from Section 2791(q)(1) and (b)(2) of the PHS Act referenced in the CMS FAQ document above::

> **(a) GROUP HEALTH PLAN**
>
> **(1) DEFINITION**

> The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).
>
> …
>
> **(b)Definitions relating to health insurance**
>
> …
>
> **(2)Health insurance issuer**
>
> The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1144(b)(2)]). Such term does not include a group health plan.

Question: For Skilled Nursing Facilities, are we required to submit cash-based laboratory testing offered through community-based healthcare settings?

Answer: Please see the definition of private payor as explained above. According to that definition, only payments received from an insurer or group health plan should be reported. It is not appropriate to report cash payments made by patients or organizational clients that are not in the business of providing healthcare coverage or insurance.

Question: If we have a nursing home that reimburses us by contract, are those reportable?

Answer: No, a nursing home is not an insurer or group health plan.

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