

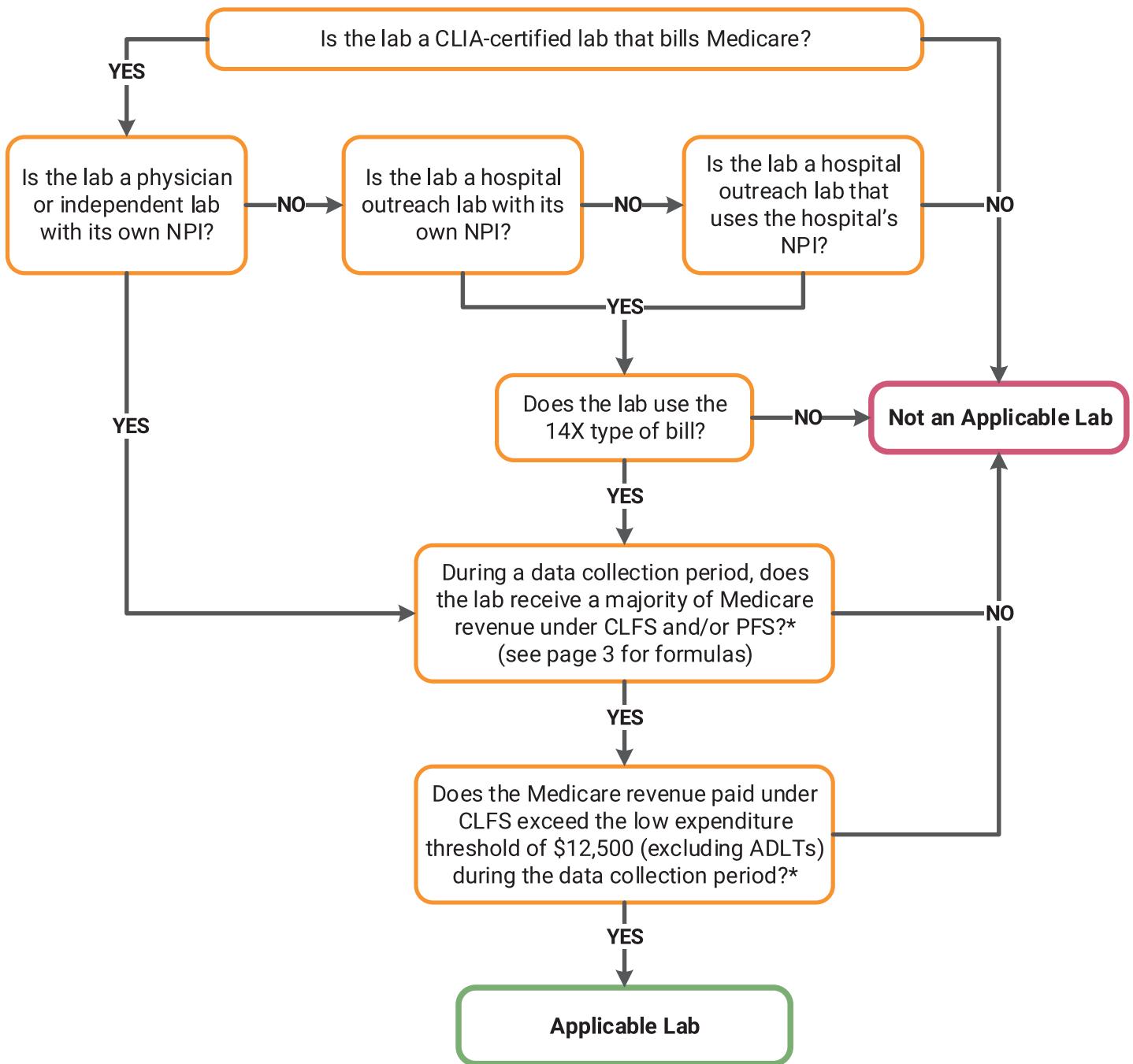
DETERMINING PAMA APPLICABLE LAB STATUS: TOOLS TO ASSIST



For Quadax Laboratory Clients

April, 2020

PAMA Applicable Lab Decision Tree



*The data collection period is January 1 to June 30, 2019.

The Protecting Access to Medicare Act of 2014 (PAMA) requires applicable laboratories to report private payer rate and volume data by March 31, 2022. To be considered an applicable lab, a laboratory must meet the criteria outlined in the PAMA Applicable Lab Decision Tree, which visually depicts the applicable lab determination process. This document supplements the PAMA Applicable Lab Decision Tree by providing HARP strategies that can assist clients in the determination process. Clients must use their own judgment to determine if they are an applicable lab; while Quadax will provide the data to assist, we cannot make that determination for any laboratory organization.

Is the lab a CLIA-certified lab? If so, does it bill Medicare under its own NPI, or is it a hospital outreach laboratory that bills non-patient laboratory tests under either its own NPI or the hospital's NPI?

According to CMS, a facility that receives any CLIA certificate, including a CLIA certificate of waiver, is considered a laboratory as defined under 42 CFR 493. An applicable laboratory is a laboratory that bills Medicare Part B under its own NPI or, for hospital outreach laboratories, bills Medicare Part B on the Form CMS-1450 under the 14X type of bill (TOB) using its own NPI or the hospital's NPI. In HARP, NPIs are stored as provider numbers in the NPI insurance category and are saved in the Provider Numbers section of the Billing Group Maintenance page (Menu > Maintenance > Client > Entities > Billing Group) for each billing group.

Review the Provider Numbers section of the Billing Group Maintenance page for each billing group in the HARP database to determine whether any billing groups bill under different NPIs. If so, note all billing groups that use the same NPI. If there are multiple billing groups with different NPIs, the laboratory may have to report for each NPI. At this time, Quadax is not providing condensed reporting.

As indicated above, in the 2019 Physician Fee Schedule Final Rule, CMS adjusted the applicable lab criteria to include hospital outreach laboratories that bill non-patients for their services. In Transmittal 3425, a non-patient is defined as a beneficiary who has a specimen that is submitted to a hospital for analysis but is not physically present at the hospital for the laboratory service, that is, the patient is neither a registered hospital outpatient nor an admitted hospital inpatient. Non-patients may be identified with the CMS-1450 14X TOB. In HARP, the type of bill is stored on the Billing Group Maintenance page.

Review the Billing Group Maintenance page for each billing group in the HARP database to determine if the 14X TOB is used. If so, note all billing groups that use it.

Clients must use their own judgment to determine if they are an applicable lab; while Quadax will provide the data to assist, we cannot make that determination for any laboratory organization.

During a data collection period, does the lab receive a majority of Medicare revenue (Parts A, B, & D, including any applicable patient liability and excluding Medicare Advantage revenue) under CLFS and/or PFS?

The HARP reports used to assist in applicable lab determination are based on financial categories. Prior to running the reports, financial categories in HARP must be reviewed in order to determine if Medicare payments are adequately grouped in the HARP database. Payments on the CLFS and PFS are under Part B, original Medicare, so all Medicare plans (including Railroad Retirement Medicare and excluding Medicare Advantage) must be grouped under the Medicare financial

category. If insurance plans are not adequately grouped in the Medicare financial category, the reports must be run by insurance plan. If multiple NPIs or TOBs are used, run the report by financial category or insurance plan, and then drill down to the billing group sort level (further details below).

The formula used to calculate the percentage of Medicare revenue paid under the CLFS and PFS varies depending on whether the lab is an independent, physician, or hospital outreach lab with its own NPI, or a hospital outreach lab that uses the hospital's NPI.

If the lab is an independent, physician, or hospital outreach lab with its own NPI, the percentage of Medicare revenue paid under the CLFS and PFS can be calculated using the following formula:

$$\frac{\text{Medicare CLFS revenues (for billing NPI)} + \text{Medicare PFS revenues (for billing NPI)}}{\text{Total Medicare revenues (for billing NPI)}}$$

If the lab is a hospital outreach lab that uses the hospital's NPI, the percentage of Medicare revenue paid under the CLFS and PFS can be calculated using the following formula:

$$\frac{\text{Medicare CLFS revenues (based on 14X TOB)} + \text{Medicare PFS revenues (based on 14X TOB)}}{\text{Total Medicare revenues (based on 14X TOB)}}$$

Note the following:

- The denominator in these formulas, total Medicare revenues, includes Parts A, B, & D and any applicable patient responsibility. In the 2019 final rule, CMS removed Medicare Advantage revenue (Part C) from the formula, so Medicare Advantage revenue is excluded.
- When using the CMS Form-1450 14x TOB for determining applicable laboratory status, the majority of Medicare revenues threshold and low expenditure threshold only applies to the hospital outreach laboratory portion of the hospital's NPI, rather than to the NPI of the entire hospital.
- Any billing done outside of Quadax should be included when calculating the percentage of Medicare revenue paid under the CLFS and PFS.

The web-based Transaction Summary report provides the data used to determine if over 50 percent of Medicare revenue is paid under the CLFS and PFS. The Transaction Summary report in HARP is accessed from Menu > Reports > Transactions > Transaction Summary. The report can be run in the following ways:

1. If financial categories are adequately grouped in the database, sort by financial category first and billing group second.
2. If financial categories are not adequately grouped in the database, sort by insurance plan first and billing group second.
3. If multiple NPIs/TOBs are used, run the report by option 1 or 2, and then drill down to the billing group sort level.

For each of these options, Receipt should be selected as the Transaction Type, June 2019* should be selected as the Billing Period, and Billing Month should be selected as the Date Type. The screen capture below shows the report parameters that should be selected when financial categories are adequately grouped in the database.

The screenshot shows the 'Transaction Summary Report' configuration window. Key settings include:

- Report # New
- Transaction Type: Receipt
- Billing Period: June, 2019
- Date Type: Billing Month
- Sort/Break 1: Financial Category
- Sort/Break 2: Billing Group
- Sort/Break 3: None
- Sort/Break 4: None
- Charge in Error: Include
- Combine Multilink Procedures:
- Report by Expected Amount:
- Exclude Transferred Tickets:
- Include Charges in CRS: No
- Transactions or Units: Units
- Services Heading:
- Report Title:
- Enable Ticket Detail:
- Enable Harp Lookup:
- Enable Parameters:
- Display Chart:
- Reporting Database: Current
- Submit button
- Save Params checkbox

By selecting June 2019* as the billing period, the report shows six months of data, January – June 2019, with totals for the period. If all billing groups bill under the same NPI, you can use the totals for Medicare receipts on the main summary report for the calculation. If multiple NPIs are used, data for billing groups with the same NPI should be combined. If multiple TOBs are used, only include data for billing groups that use the 14X TOB in the calculation. Note that the Transaction Summary report includes all applicable patient responsibility revenue.

**If the yearend for the HARP account is not December, adjust the billing period accordingly.*

Does the Medicare revenue paid under CLFS exceed the low expenditure threshold of \$12,500 (excluding ADLTs) during the data collection period?

The **web-based Reimbursement report** can be used to determine if CLFS Medicare revenue is above or below the low expenditure threshold. Access the Reimbursement report in HARP from Menu > Reports > Financial > Reimbursement, and then select the report parameters shown on the screen shot below. (If all billing groups bill under the same NPI, the sorts can be Financial Category and then Fee Schedule, omitting the Billing Group sort.) Click Submit, and then take the steps outlined on the next page. Data for billing groups with the same NPI should

be combined. If the lab is a hospital outreach lab that uses the hospital's NPI, only include billing groups that use the 14X TOB.

The screenshot shows the 'Reimbursement Report' configuration page. At the top, there is a link to 'Previous Reports'. Below it, the report title is 'Reimbursement Report'. The 'Report #' field is set to 'New'. The 'Transaction Type' dropdown is set to 'Payment'. The 'Billing Period' dropdown is set to 'Selected Dates' with the date range '1/1/2019 - 6/30/2019'. The 'Date Type' dropdown is set to 'Deposit Date'. The 'Insurance Type' dropdown is set to 'Insurance Plan'. The 'Sort/Break 1' dropdown is set to 'Financial Category'. The 'Sort/Break 2' dropdown is set to 'Billing Group'. The 'Sort/Break 3' dropdown is set to 'Medicare Fee Schedule'. The 'Sort/Break 4' dropdown is set to 'None'. There is a 'Number for Top Chart' input field containing '5'. The 'Variance' dropdown is set to 'All'. The 'Dollars' dropdown is set to 'Greater Than'. A 'n/a' button is present. Under 'Enable' checkboxes, 'Enable Ticket Detail', 'Enable Harp Lookup', 'Enable Parameters', and 'Display Chart' are checked. The 'Reporting Database' dropdown is set to 'Current'. A 'Submit' button is at the bottom, along with a 'Save Params' checkbox.

1. On the main report, click the Medicare financial category description to open the billing group sort level.
2. On the report for the Medicare financial category by billing group, click a billing group description to open the fee schedule sort level.
3. On the fee schedule report, if the Total Paid Amount for the Medicare Clinical Fee Schedule is greater than \$12,500, the billing group NPI meets the low expenditure threshold for an applicable lab.
4. Return to the billing group sort level and repeat the process for each billing group with a different NPI, combining totals for any billing groups using the same NPI.

Note the following:

- To best utilize this report, the HARP database must store line item (LIRP) data. If LIRP data is not stored in the HARP database, clients must use their own judgment to determine if they exceed the low expenditure threshold.
- Any billing done outside of Quadax should be included when determining CLFS Medicare revenue.

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questions about
PAMA and your
laboratory?*

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