PREPARING FOR PAMA REPORTING: A GUIDE FOR QUADAX CLIENTS

Quadax
Revenue Cycle Optimizers

For Quadax Laboratory Clients

September, 2024

Under the Protecting Access to Medicare Act of 2014 (PAMA), the Centers for Medicare & Medicaid Services (CMS) will base 2024 clinical laboratory fee schedule (CLFS) payment rates on private payer rates as reported by applicable labs. Laboratories must report the volume and final payment amounts from private payers (collected during the first six months of 2019) to CMS during the data reporting period of 1/1/2026– 3/31/2026. As a leading revenue cycle management company servicing the laboratory sector, Quadax will work with our clients on obtaining the requisite data needed to comply with the reporting regulations.

The Quadax PAMA Reporting Committee, an ongoing, cross-functional committee formed to pool the expertise of our staff in areas impacted by PAMA, has been analyzing PAMA reporting information from CMS as it has been released, and then updating our systems in preparation for providing the data to our clients. The committee's first priority was to review the new data collection criteria CMS released in its 2019 Physician Fee Schedule Final Rule and evaluate what changes were needed to assist our clients in their decision on whether they are an applicable lab subject to the reporting requirements.

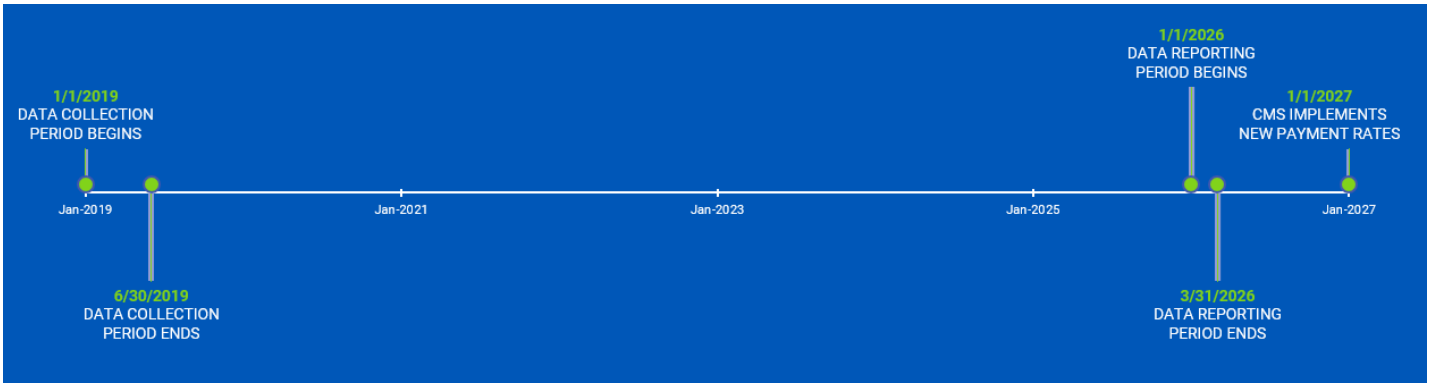
As defined by CMS, an applicable lab is a laboratory that receives more than 50% of its total Medicare revenues from services paid under the CLFS or the physician fee schedule (PFS), with a low expenditure threshold. To meet the low expenditure threshold, a lab must have received $12,500 from final Medicare paid claims for services paid under the CLFS during the data collection period of January 1 to June 30, 2019. Per the 2019 Final Rule, Medicare Advantage revenues are excluded from the total Medicare revenue calculation, and hospital outreach laboratories that bill non-patients for laboratory services are included in the applicable lab determination. Labs that meet these qualifications must then report "applicable information" to CMS.

Upon request, Quadax will provide clients with financial reports that can assist them in making an informed decision on whether they qualify as an applicable lab. Clients who decide they are an applicable lab will receive prototype reporting data from Quadax in mid-November.

For more information on PAMA, refer to the Quadax PAMA Reporting webpage. The webpage includes links to additional Quadax resources as well as a link to CMS guidance and resources. Clients can access the PAMA webpage in the *Getting Ready For…* section of the Quadax Portal.

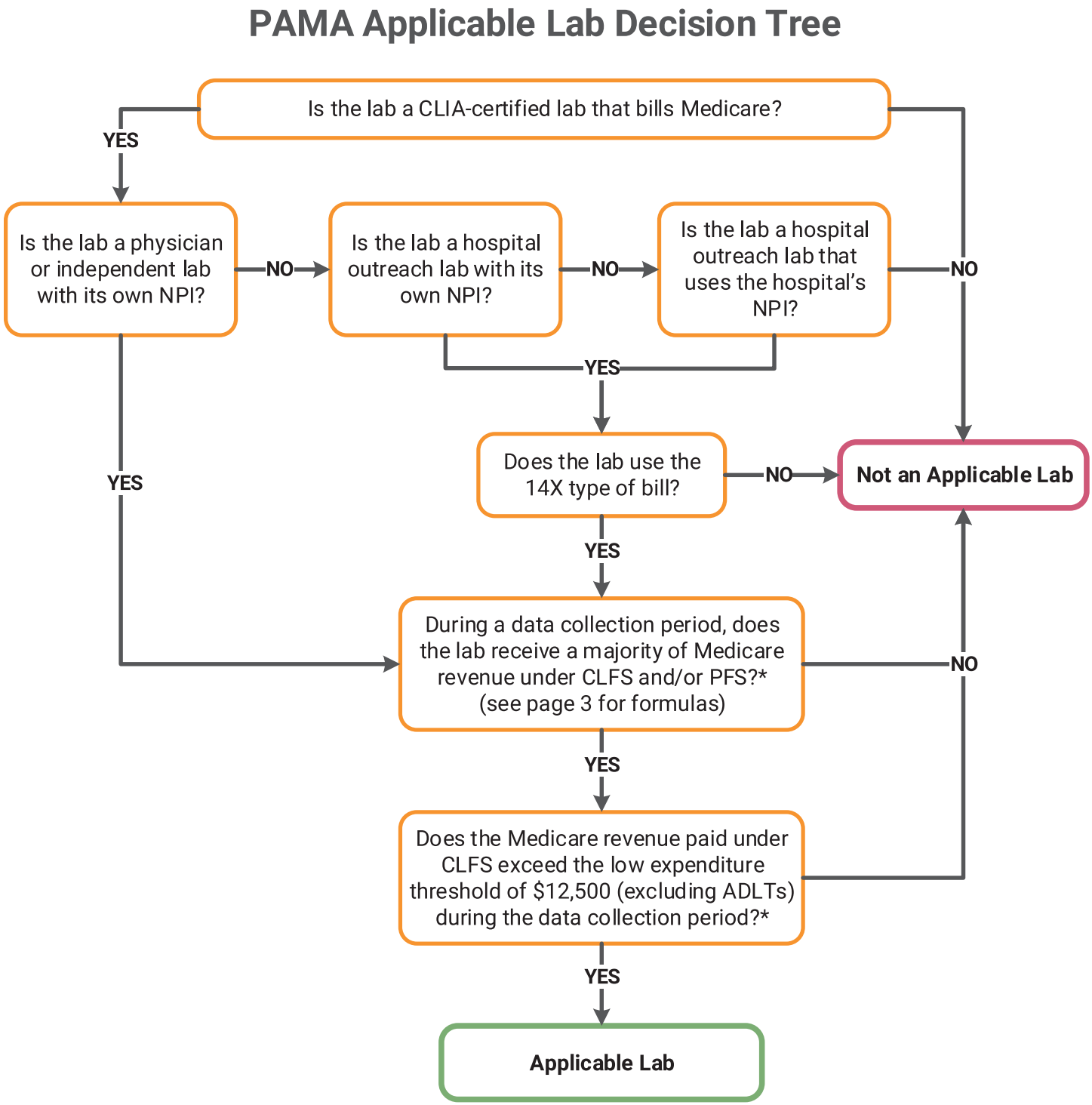
After you've had a chance to review the information in this document and on the PAMA webpage, please feel free to get in touch with your Quadax Account Executive, who will be happy to answer any questions you may have.

CMS Timeline for PAMA Reporting



Applicable Lab Determination

To be considered an applicable lab, a laboratory must meet the criteria outlined in the PAMA Applicable Lab Decision Tree shown below. The PAMA Applicable Lab Decision Tree visually depicts the applicable lab determination process. Clients must use their own judgment to determine if they are an applicable lab; Quadax will not make that determination, although we will provide the data to assist with it.



Tools to Assist in Determination of PAMA Applicable Lab Status

HARP strategies that can assist clients with each step of the determination process are detailed below.

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:

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

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:

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

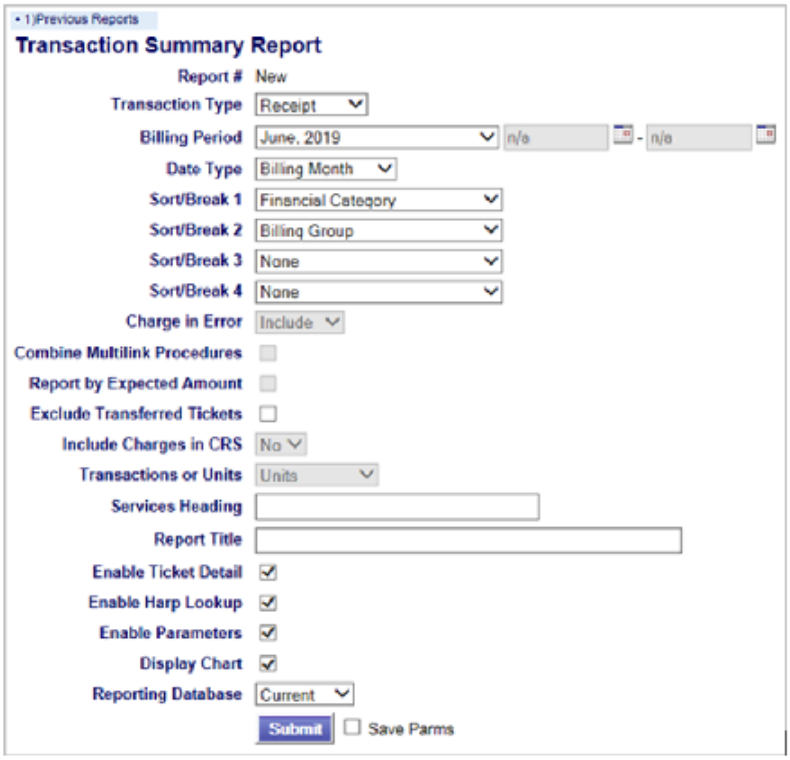
Note the following:

- 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 on the next page shows the report parameters that should be selected when financial categories are adequately grouped in the database.

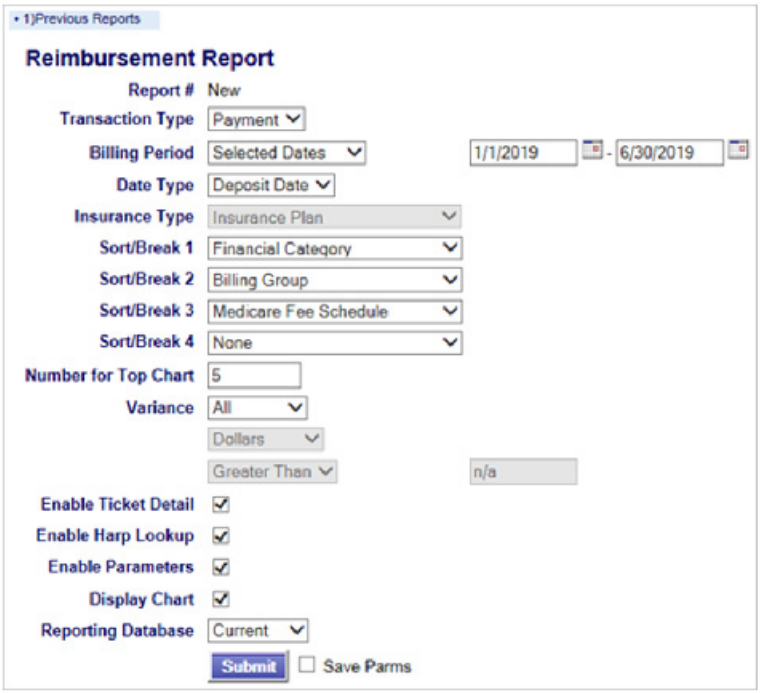


By selecting June 2019* as the billing period, the report shows six months of data, January – June 2019, with totals for the period. If all billing groups bill under the same NPI, you can use the totals for Medicare receipts on the main summary report for the calculation. If multiple NPIs are used, data 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 capture on the next page. (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.



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:

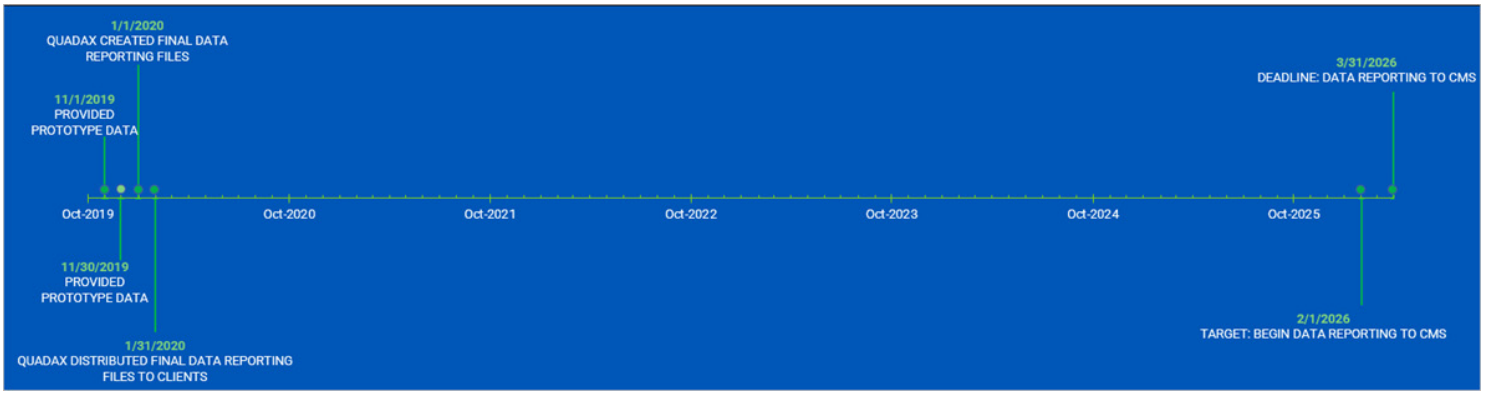
- To best utilize this report, the HARP database must store line item (LIRP) data. If LIRP data is not stored in the HARP database, clients must use their own judgment to determine if they exceed the low expenditure threshold.
- Any billing done outside of Quadax should be included when determining CLFS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

Supplying Data

Quadax will obtain final payment data from our systems and provide that data to clients who have determined they are an applicable lab. Quadax will use 835 remittances as the primary source of final payment data, and HARP LIRP data as the secondary source. Data will be delivered to clients in a CSV file, which is the format required by CMS, with summary and detail data. The detail data will contain final payment information, and the summary data will contain the following fields required by CMS and specified in the CLFS Data Reporting Template.

- **HCPCS Code**. Standardized coding system used to represent medical procedures performed on a patient or non-physician services. Five alphanumeric characters are accepted.
- **Payment Rate**. Each unique private payer rate for each test. Only numeric values are accepted. Formatted as XXXXX.XX.
- **Volume**. Number of lab tests paid at each unique private payer rate. Only positive numeric values including 0 are accepted. Formatted as XXXXX.
- **National Provider Identifier.** A unique 10-digit identification number required by HIPAA for all health care transactions by providers in the United States.

Quadax Timeline for PAMA Reporting



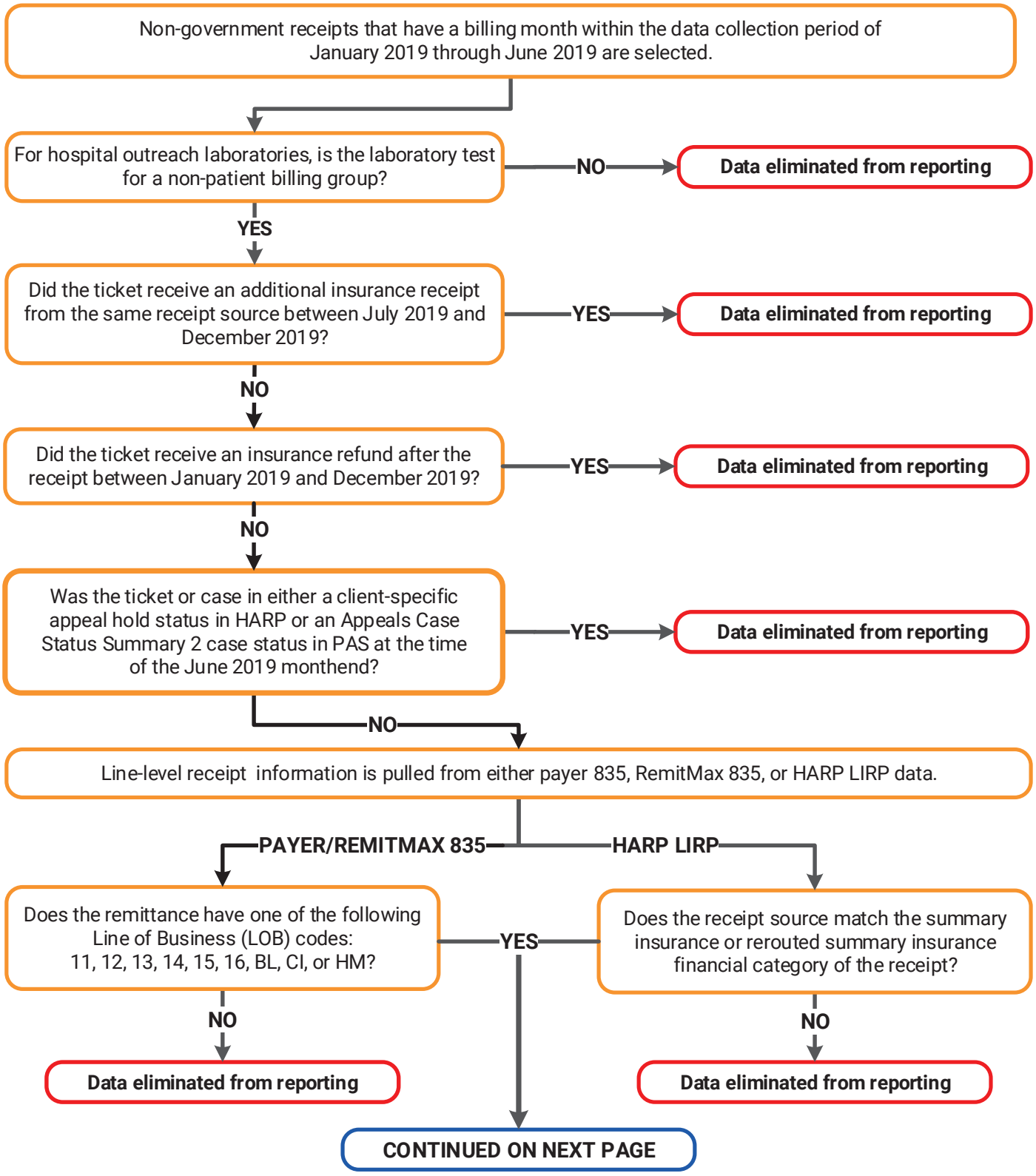
Normalizing Data

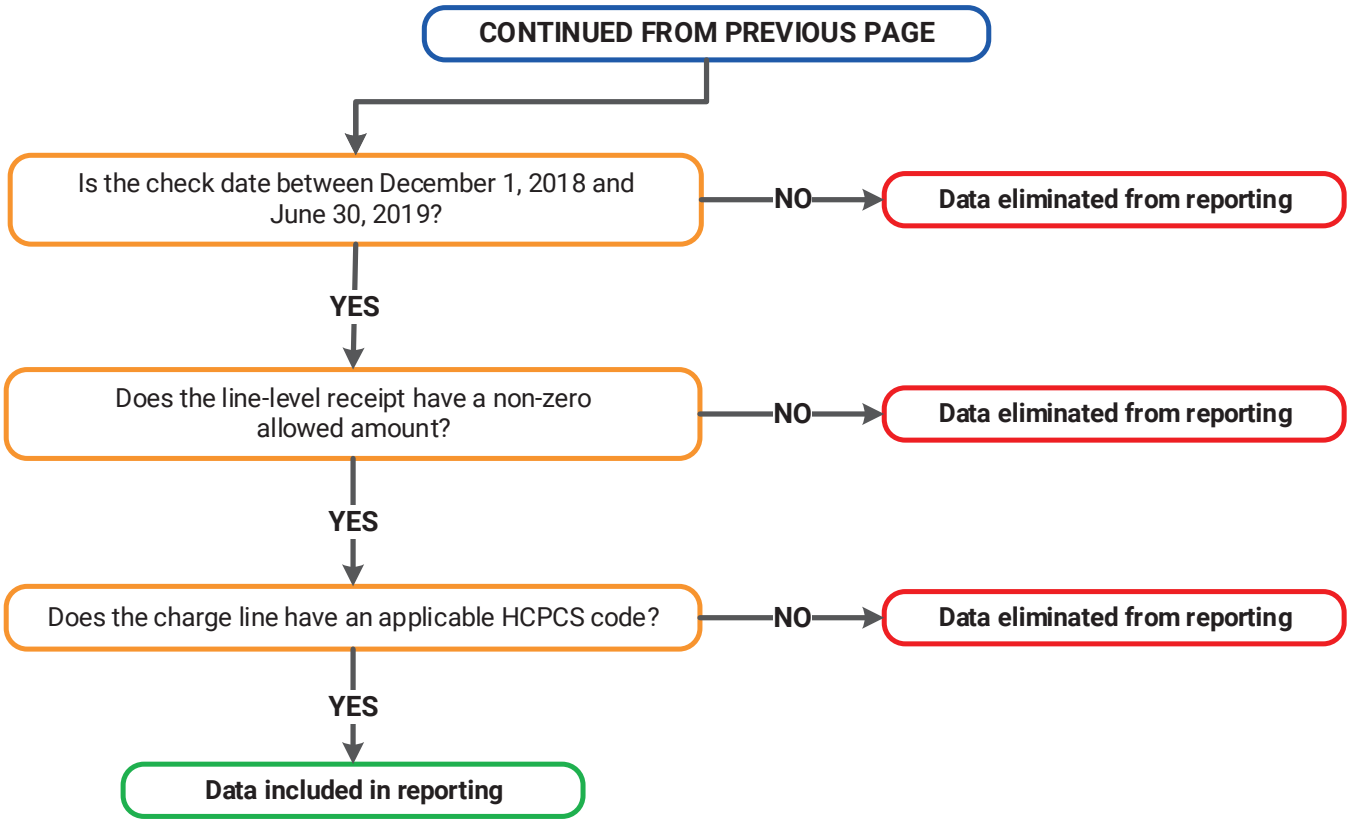
To determine the final payment, Quadax will examine data from January 1, 2019, through December 31, 2019.

- The period of January 1 through June 30, 2019, will be examined because that is the data collection period defined by CMS, and qualifying receipts posted during the data collection period must be reported. Note that when a ticket has multiple payments during the data collection period, Quadax has made the reasonable assumption that final payment is the most recent allowed amount.
- The period of July 1 through December 31, 2019, will be examined because a receipt posted on the ticket six months after the data collection period with the same receipt source as the receipt posted to the ticket during the data collection period indicates that the receipt posted during the data collection period is likely not a final payment.

The PAMA Ticket Selection Tree on the following pages illustrates how Quadax will further select and eliminate data.

PAMA Applicable Ticket Selection Tree





Ticket Selection Details

The reasoning behind each step of Quadax's ticket selection process is detailed below. Please note that the explanations below are reasonable assumptions Quadax has made based on the information CMS has provided and the available data in our system.

Non-government receipts that have a billing month within the data collection period of January 2019 through June 2019 are selected.

The initial selection of the population of tickets that might have final payments within the data collection period is based on receipts posted within that period. Applicable laboratories are only required to report final payment amounts from private payers, so traditional Medicare, Medicaid, and other government receipts are eliminated from PAMA reporting. Using the summary insurance financial category, Quadax will determine which receipts to include/exclude. Note that the financial categories for data collection should include Medicare Advantage. Receipts with billing months outside of the January 2019 through June 2019 data collection period are also eliminated from PAMA reporting. Quadax determined that billing month is the most consistent and reliable date type for selecting tickets because HARP financial reports run by billing month, and billing month is always populated in HARP.

Once the initial population of tickets is selected, subsequent steps will eliminate tickets if the receipt is determined not to be final.

For hospital outreach laboratories, is the laboratory test for a non-patient billing group?

Per CMS's 2019 Physician Fee Schedule Final Rule, hospital laboratories that bill non-patients for their laboratory services are now included in the applicable lab determination, so final payments for these services need to be reported to CMS. Non-patients may be identified by billing groups that are using the CMS-1450 14X bill type.

Did the ticket receive an additional insurance receipt from the same receipt source between July 2019 and December 2019?

The data collection period for PAMA reporting is January 2019 through June 2019, so July 2019 through December 2019 is outside of the data collection period. Quadax has made the reasonable assumption that an additional receipt received after the data collection period from the same receipt source as the qualifying receipt means that the qualifying receipt was likely not the final payment. Receipts that are not likely final payments are not included in PAMA reporting.

Did the ticket receive an insurance refund after the receipt between January 2019 and December 2019?

Insurance refunds could indicate that the payer has not made the final payment, so Quadax has made the reasonable assumption that an insurance refund received on the ticket after the receipt between January 2019 and December 2019 means that the receipt should not be included in PAMA reporting. Receipts that are not likely final payments are not included in PAMA reporting. This reasoning applies to all insurance refunds, including reverse refunds.

Was the ticket or case in a client-specific appeal hold status in HARP or an Appeals Case Status Summary 2 case status in PAS at the time of the June 2019 monthend?

When determining whether a ticket is being appealed, different indicators are used by different clients. Quadax Client Services will determine what indicator is appropriate for each client. For some clients, HARP hold codes will be used to determine whether a ticket is being appealed. For other clients, the PAS case status of Appeals Case Status Summary 2 will be used to make that determination.

A client-specific appeal hold status in HARP or an Appeals Case Status Summary 2 case status in PAS means the ticket or case is in the appeal process. Appeals can result in an additional receipt, and if the ticket is still in the appeal process at the time of June 2019 monthend, that additional receipt would be received after June 2019, which is outside of the data collection period. As stated in the second step of the ticket selection process, Quadax has made the reasonable assumption that an additional receipt received after the data collection period from the same receipt source as the qualifying receipt means that the qualifying receipt was likely not the final payment. Receipts that are not likely final payments are not included in PAMA reporting.

Line-level receipt information is pulled from either payer 835, RemitMax 835, or HARP LIRP data.

Once a ticket has been selected, line-level receipt information will be pulled from either payer 835, RemitMax 835, or HARP LIRP data. To ensure that only payments from private payers are included in the data, payer and RemitMax 835 remittance data is filtered by Line of Business (LOB) code, and HARP LIRP data is filtered by receipt source. Only payer and RemitMax 835 remittances with LOB codes 11, 12, 13, 14, 15, 16, BL, CI, and HM, and HARP LIRP data with receipt sources that match the summary insurance financial category or rerouted summary insurance financial category of the receipt are included in reporting. The LOB codes are defined below.

LOB Code	Description
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk*
BL	Blue Cross/Blue Shield
CI	Commercial Insurance
HM	Health Maintenance Organization

**This is the LOB code for Medicare Advantage, which is included as private payer data.*

Line-level receipts undergo an additional selection process to determine if they are included in PAMA reporting.

Is the check date between December 1, 2018 and June 30, 2019?

The period of December 1, 2018 through December 31, 2018 will be examined because HARP LIRP and 835 remittance data posted in January could have December check dates. The period of January 1, 2019 through June 30, 2019 will be examined because that is the data collection period defined by CMS, and qualifying data posted during the data collection period must be reported.

Does the line-level receipt have a non-zero allowed amount?

Quadax has made the reasonable assumption that the final payment is equal to the allowed amount, and only non-zero final payments need to be reported to CMS.

Does the charge line have an applicable HCPCS code?

A list of applicable HCPCS codes can be found in the CLFS Applicable Information HCPCS Codes spreadsheet file on the CMS website. Charge lines with non-applicable HCPCS codes are eliminated from PAMA reporting.

Data Delivery

In November 2019, Quadax provided clients with prototype final payment data through an FTP location or the Secure File Exchange (SFE). The prototype data contained the final payment rates and volume for tests and was intended to allow applicable labs time to review their final payment data prior to the reporting period. The prototype data can be used for reporting to CMS; however, if clients wish to report the most current data, the final payment data Quadax provided in February/ March 2020 can be used. Clients should review the data files and retain them for submission in 2023.

Submitting Data

Clients can report anytime during the 1/1/2026 – 3/31/2026, data reporting period, but Quadax recommends reporting in early February. Reporting in the middle of the data reporting period will hopefully avoid some of the issues that could occur at the beginning or end of the period. When clients are ready to report, data should be submitted through the CMS Enterprise Portal. Clients are responsible for submitting their data to CMS within the data reporting period; Quadax is not responsible for submitting any data.

Still have questions about PAMA and your laboratory?

Contact your Quadax Account Representative or visit www.quadax.com/PAMA

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