Who's Watching Your Wallet?

VACHETTE™

vachettepathology.com

Vachette Monthly, October 2020

Follow Vachette on Twitter, or visit our blog at vachettepathology.com for regular updates!

Congress grants Medicare Advance borrowers more time to repay

Now that the federal Continuing Resolution (CR) to fund the government through Dec. 11 has been officially signed, the Medicare Advance and Accelerated Payment Program is being modified to give borrowers a bit more flexibility in repaying their loans.

As part of the CARES Act earlier this year, Medicare expanded access to its advance and accelerated payment program to provide a lifeline to providers struggling with COVID or other shutdown-related expenses. Funds distributed under the program are loans that are eventually paid back to CMS.

While MACs should have started recouping funds at end of August in the form of automatic reductions in new Medicare payments, it quickly became clear Congress was seeking a less punitive option after the recoupment process did not begin as expected. Now, the CR has modified the program in the following ways:

- Borrowers now have 365 days (12 months) from the date of disbursement of the loan before recoupment begins. For most groups, that means it will start on/or about April 2021.
- MACs will recoup 25% of new claims for the first 11 months, then 50% of new claims for up to the following six months until completely recouped.
- This means borrowers have a total of 29 months from the original distribution date to repay the balance before interest is incurred. This extends the recoupment period to as far as September 2022.
- The interest rate applied to outstanding balances after 29 months was lowered to 4%, down from 10.25%.

Recent audit and coding news

- The latest in our string of successes comes from working with Optum Medicare Advantage. It seems they were denying 88342-26 for needing a preauthorization as a molecular code. Tiffany Apthorpe, one of our Client Administrators, noticed these denials in one of the quarterly audits we provide and decided to rectify this issue.

  Tiffany worked to get through the administrative drama at Optum to find the right person and help them understand that 88342-26 is regularly used in instances such as diagnostic surgical pathology and that requirement of a prior authorization was illogical. It took nine phone calls and four hours of her time, followed by additional emails to the Optum contact weekly to get in touch with the Medical Director. Tiffany connected the Medical Director with a pathologist from one of the affected practices. When they talked, they were able to agree this code does not need a prior authorization, resulting in a policy change.

Video: How the election will impact healthcare

In his latest video, Vachette CEO Mick Raich turns his attention to how the upcoming Presidential election between Joe Biden and Donald Trump could impact decisions such as extending the Public Health Emergency, advancing legislation on surprise billing, and whether there's another halt in elective surgeries if COVID-19 ramps up again this fall. VIEW THE DISCUSSION ONLINE.

UHC updates services requiring prior-auth

If you missed it last month, UHC updated its list of procedures that require prior authorization, effective Aug. 1. The update included more than 40 new lab and pathology codes that will be denied outright if the provider fails to obtain authorization. Providers have up to 90 days from the DOS to receive prior authorization. The procedures may be viewed here.

CMS issued an updated Advanced Beneficiary Notice that became effective for use Aug. 31. Any applicable claims submitted without the updated form will be denied.

2020 MIPS:

Don't forget, MIPS participants who have been greatly impacted by COVID-19 may apply to opt-out of 2020 MIPS reporting. The deadline to do so is Dec. 31.

At Vachette, we specialize in consulting and auditing for labs and pathology practices

We have been working with hospitals, laboratories, and hospital-based groups for more than 16 years.

Visit vachettepathology.com, call 517-486-4262, or contact Dustin Suntheimer, vice president of sales and marketing, at 734-972-2693. Our experience and expertise are second to none!

Phase 3 of HHS Provider Relief Fund opens Oct. 5

Providers still reeling financially from the COVID-19 pandemic will have another opportunity to apply for financial assistance through the HHS Provider Relief Fund beginning Monday, Oct. 5 when the program launches its third phase.

An additional $20 billion will be added to the fund, which was initially established as part of the CARES Act funding package. Initially, during phase 1, most Medicare providers received a lump sum payment that was supposed to account for roughly 2 percent of their annual patient revenue. During phase 2, Medicaid providers and those who didn't initially receive a full 2 percent of their revenue were invited to apply for additional payments.

VIEW OUR FULL ARTICLE ONLINE to see the eligibility and payment guidelines offered by CMS. Beginning Oct. 5, those interested may apply using the HHS Provider Relief Portal for providers. HHS is encouraging providers to apply early in hopes of expediting the agency's review process to allow funds to be disbursed in a timely manner.

UHC to require G0416 for prostate biopsies across all products starting Jan. 1, 2020

After making the move to align prostate biopsies with G0416 for Medicare Advantage plans earlier this year, UnitedHealthcare has announced the policy will be put into effect for its commercial products beginning Jan. 1, 2020.

This means that any prostate needle biopsies coded 88305 will be denied, bringing UHC in line with Medicare and Cigna, who instituted an identical policy effective Aug. 18.

In August, several clients informed us UHC was issuing refund requests to recover 88305 payments for prostate biopsies performed on Medicare Advantage members throughout the past six months, despite the payer not previously issuing any communication about this change. When questioned, UHC responded that their policy for prostate biopsies to be billed with G0416 has been in effect since January 2015.

These moves follow a host of aggressive policy changes UHC has instituted during the Public Health Emergency, including moves to limit out-of-network lab services and the implementation of its controversial Lab Test Registry, which is now set to launch Jan. 1 as well.

HHS releases relief fund reporting requirements

After a weeks-long delay, HHS has finally published detailed reporting requirements for Provider Relief Fund (PRF) recipients who accepted one or more payments exceeding $10,000 in total.

Originally scheduled to launch Oct. 1, the HHS Provider Relief website now states the reporting system will be available in early 2021.

According to the guidelines, recipients will report their use of PRF payments by first calculating health care-related expenses attributable to the coronavirus that have not been reimbursed by another source. Those with unused funds at the end of 2020 will also be required to submit a second report next year.

VIEW FULL REQUIREMENTS.

People. Trust. Results.
Since 1960

Pathology & Laboratory Billing Experts

- **Privately-owned & operated**
- **National Presence**
- **Personalized Service**

800.288.8325
www.apsmedbill.com

Watch for limits on genetic testing as CMS looks to rein in spending

The following is a column from Vachette CEO Mick Raich:

A recent edition of *Laboratory Economics* (Volume 15, No. 9, September 2020) featured an article examining the Office of Inspector General's (OIG) recent report detailing how genetic testing is driving an increase in Medicare spending on the Clinical Laboratory Fee Schedule (CLFS).

For those who missed the study, the OIG revealed Medicare lab spending for genetic tests jumped from $473 million in 2017 to $969 million in 2018, despite the introduction of market-based pricing developed through commercial payment rates reported under the Protecting Access to Medicare Act (PAMA). While much of the spending was attributed to an increase in the number of reimbursable tests coupled with an overall increase in utilization, the OIG still said it suspects fraud played a role in the jump as well.

There are a few interesting items to note from the *Laboratory Economics* piece. -- READ THE REST ONLINE

Hospital price transparency starts Jan. 1

Despite push-back from numerous hospital and provider advocacy groups, CMS appears set to move forward with plans to require hospitals to disclose their service pricing beginning Jan. 1, 2020.

This move was first signaled late last year when CMS first published it's plan to require hospitals to publicly post their chargemasters online, beginning in 2020 (which has since been delayed to 2021). At the time, CMS indicated the proposal was intended to benefit consumers by providing them with information that could help them shop around for services and better understand out-of-pocket costs. CMS again stated its intent to move forward with that plan in the 2021 IPPS Final Rule. The rule cemented the new pricing transparency requirements and penalties for failing to comply, which will go into effect Jan. 1.

Under the requirement, hospitals must publicize their standard charges for both gross charges and commercial charges negotiated with specific payers for "shoppable services". This information must be made available online in an easily digestible format and include information on billing codes used by the hospital and their corresponding services.

Hospital advocates, meanwhile, have long contended these rules will strip their ability to negotiate effectively with commercial payers by promoting anticompetitive practices. Additionally, there is concern over potential public relations issues that could be caused by posting standard charges, which don't take into account for potential emergency or acute care scenarios.

VIEW FULL ARTICLE ONLINE

Recent COVID-19 testing rules complicate reimbursement

Throughout the COVID-19 Public Health Emergency, Vachette has served as an invaluable resource to our laboratory clients as we've kept them abreast of and helped successfully navigate the myriad reimbursement issues surrounding reimbursement for this crucial service. However, we've recently seen a host of new rules from CMS that seemed specifically designed to greatly complicate COVID-19 testing reimbursement moving forward.

After initially offering healthy reimbursement rates and lowering most roadblocks to encourage widespread availability of COVID-19 testing, CMS now appears to be tightening the reins on spending with new rules ostensibly designed to prevent fraud and abuse – and you can bet commercial payers will soon gladly follow suit.

In August, CMS released an Interim Final Rule (IFR) that both set limits on the number of COVID-19 tests that could be performed on a patient without a practitioner's order and imposed monetary penalties for failing to report test results to HHS or a local health authority within 24 hours of the results being known.

Monetary penalties for not reporting results: Lab and POC testing providers must report new COVID-19 test results daily to their local or state health authority. Failure to comply with these requirements will subject providers to penalties of $1,000 for the first day/$500 for any additional days of non-compliance.

One test rule: This IFR also imposed a "one-test rule," which explains that Medicare will only cover one COVID-19 diagnostic test and one of each other related diagnostic test (e.g. influenza/respiratory) without a qualified practitioner order. Additional tests will only be covered with a practitioner's order, as medically necessary.

While these rules certainly serve to create new administrative challenges in ensuring you're maximizing and protecting COVID-19 test revenue, it wasn't necessarily hard to envision CMS would eventually seek to implement barriers to reduce what it views as instances of unnecessary testing. But we're even more concerned by the agency now making moves to reduce reimbursement rates, while at the same time creating what we strongly believe will be an administrative nightmare in the process.

On Oct. 15, CMS announced it intends to reduce the payment rate for COVID-19 tests performed using high-throughput technology from $100 to $75. However, labs may receive an additional $25 add-on payment to make itself whole if a lab:

- Completes the test in two calendar days or less, and
- Completes the majority of their COVID-19 diagnostic tests that use high-throughput technology in two calendar days or less for all of their patients (not just their Medicare patients) in the previous month.

It doesn't require expert analysis to deduce this new rule goes hand-in-hand with the requirement to report test results quickly. Now, labs who fail to do so will not only face monetary penalties, but will receive a 25% reduction to their reimbursement rate to boot! And how exactly will CMS administer these add-on payments, which come with a new HCPCS code (U0005)? Your guess is as good as ours, but you can be sure commercial payers are salivating at that opportunity to implement this guidance into their own policies.

In short, now more than ever is the time for labs and other entities performing COVID-19 testing seek out strategic partnerships that can help them both navigate this shifting landscape AND maximize their reimbursements while doing so.