Who's Watching Your Wallet?

VACHETTE™

A Lighthouse Lab Services Company

Vachette Monthly, June 2021

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

PAMA data reporting could be simplified under new proposal

Recently, Cigna announced it will no longer pay for the professional component of clinical pathology (PC/CP) beginning July 11. This comes as no surprise; we have seen this coming in recent years as UnitedHealthcare, Humana and Aetna have made similar moves. This trend is not going back.

What will this change mean going forward? First, we have to consider the fact there are several states where Blue Cross still pays PC/CP. If your group is in one of these states, like Texas, you should be working on your revenue strategy going forward. Second, recognize there will be a time when Medicaid does not pay for these services (Medicaid pays for PCCP in several states.) Again, if you're in one of these states, you should build a revenue model that accounts for PC/CP payments being eliminated in the next five years.

It is also time to review your current Cigna contract. Many of the older contracts have a direct payment tied to PC/CP. These contracts will need to be updated, or non-payment may constitute a breach. If you can find your contract, it is imperative to review this document to make sure you have the correct terms going forward.

Another available option is to notify the C-suite at your hospital. Informing them of this pay cut could create leverage you can use for future negotiations. Most importantly, if your Part A/Medical Director contract has a floor for contracted managed care relationships, you will need to raise that point as negotiations move forward.

--Continued on PAMA PAGE

Recent audit and coding news

- CMS announced a systems issue that occurred from April 8-15 caused Medicare to not send Part A and B crossover claims to some supplemental payers. The issue has now been corrected, however, electronic claims finalized through April 25 and paper claims finalized through May 11 may be impacted. CMS recommends that if this issue affected your patients' supplemental payer, bill them using your normal procedures (if Medicare claims weren't crossed over).

- During a recent 250-case audit, we identified nearly $8,000 in lost revenue caused by various coding billing errors! While the biller is now fortunately working diligently to correct this issues, the total amount of lost revenue could have ballooned considerably had they not conducted this review.

Upcoming webinar: The B-S of AR

Join us at 2 p.m., EST, May 18 as we welcome Dr. Stephen Ruby, MD, MBA, to discuss the importance of having a buy-sell agreement in place for your lab or practice and how your accounts receivable factors into that discussion. Vachette VP of RCM Strategy and Growth Josh Yelen, CPFA, MAccy, and VP of RCM Consulting Ann Lambrix will also cover how to effectively collect outstanding AR and report it on your financial statements. Sign up today!

With the **suspension of the 2% Medicare sequester for the remainder of 2021** now approved, sequestration cuts will not resume until Jan. 1, 2022

The **Covid-19 Public Health Emergency has officially been extended another 90 days**. The PHE and related waivers are now set to expire July 19, 2021.

CAP opposes UHC DDP program

Last month, the College of American Pathologists (CAP) officially came out in opposition of UHC's Designated Diagnostic Provider program, which is currently set to launch July 1. CAP stated its opposition primarily concerns consumers who may be affected by surprise bills when they use an in-network provider who is not part of the DDP program.

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 Mick Raich, President of RCM Consulting, at 517-403-0763. Our experience and expertise are second to none!

CMS eliminating Cost category for 2020 MIPS scoring

Last month, CMS announced the agency is not scoring the Cost category for 2020 Merit-based Incentive Payment System (MIPS) participants due to reporting volumes being so heavily affected by the Covid-19 Public Health Emergency and other factors.

For 2020 MIPS, which will impact 2022 Medicare Part B payments with bonuses or penalties of up to +/-9%, Cost was set to comprise 15% of an individual or group's overall score. However, CMS said due to a significant decrease in available data required to calculate scores, the category will be re-weighted to 0% with the 15% being transferred to another MIPS category, such as Quality.

Another factor that likely affected data volumes was CMS's decision to allow most MIPS participants an easy path to opt-out of 2020 reporting through a hardship exception due to the PHE. Any group or individual who only submitted data in one category received an automatic exemption, and there were options for most other participants to apply for the exception.

AHA seeks extension as HHS relief fund spending deadline approaches

The American Hospital Association (AHA) has formally asked HHS to extend the timeframe for providers to spend relief funds past the existing June 30 deadline. Specifically, the advocacy group is asking that recipients be allowed to spend the funds throughout the remainder of the Covid-19 Public Health Emergency (PHE).

The Provider Relief Fund has served as a lifeline for providers throughout the PHE, as most have been barred from billing patients for Covid-19 testing, vaccine administration and related treatment. The agency said that these billing restrictions, along with a still-substantial Covid numbers, have created the need for increased flexibility in spending relief funds.

“The PRF funds have been a lifeline for hospitals and health systems and allowed them to continue to put the health and safety of patients and personnel first, and in many cases, ensured they are able to keep their doors open,” AHA said in its May 5 letter. “While new COVID-19 cases and hospitalizations have slowed since the peak this winter, they are still significant."

Providers will presumably be required to report on the use of these funds later this year, although a deadline to do so has not been established. Currently, HHS is asking providers who received at least $10,000 in aggregate relief fund payments to register for its reporting portal, however, further instruction on next steps has not been updated since January.

A/R collection strategy leads to $120k in recovered payments

Recently, Vachette was hired by a laboratory client under new management to review their outstanding accounts receivable (A/R). The goal was to assess the full scope and realistic collectability of their outstanding payments, while at the same time analyzing the patients into various categories based on outstanding balances, days aged, etc.

With nearly $500,000 in total outstanding A/R, the client initially expected to recover only about 10 percent of the balance. However, we provided three alternative collection options, each taking into account a different focus to produce the most desired outcome, while also enabling us to collect a greater percentage of the outstanding payments.

The root of the issue is that much of the balance was more than 240 days old, and many patients with the highest balances had not previously received a statement for the genetic testing services performed by the lab. With this in mind, we had to assess how to bill these patients without upsetting them with the shock of a statement they may not have been aware of.

After presenting three alternative collection options, we then reviewed the impact of those options on the following areas: Patient experience, physician experience and realistic collectability. Essentially, which collection strategy would allow the lab to collect the largest percentage of its outstanding balances without damaging its reputation with its patients or physicians?

After implementing a hybrid approach preferred by the client, we were able to collect more than $120,000 — nearly 2.5 times what the client and their biller initially thought possible!

People. Trust. Results.
Since 1960

Pathology & Laboratory Billing Experts

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

800.288.8325
www.apsmedbill.com

How does Surveillance Testing work?

While individual diagnostic testing is primarily designed to track and verify Covid-19 positivity in those who have contracted the SARS-CoV-2 coronavirus, surveillance testing instead aims to monitor local infection rates and trends in a population. This method of testing pools samples to conserve supplies, and information is reserved to help inform local health authorities. Surveillance testing takes samples from a percentage of a certain population, regardless of whether or not the sampled persons were exposed to the virus or are symptomatic.

Surveillance testing for Covid-19 is an important public health tool that provides a way to monitor for community or population-level outbreaks. When performed effectively, this testing helps to determine the effects of mitigation measures such as mask-wearing, social distancing, and vaccinations.

Covid-19 surveillance testing is performed by collecting specimens from multiple individuals and then batching those specimens together to create a "pool." Therefore, testing the pool requires only one test on a group of samples, rather than testing each individual sample. If the test comes back negative, the whole group is negative and the organization can feel safe in resuming their activities. If the test comes back positive, the group is referred for individual diagnostic testing. -- **MORE**

--New PAMA proposal, continued

CMS defines an applicable lab as one that bills Medicare Part B under its own NPI and collects more than 50 percent of its Medicare revenue during the data collection period under the CLFS or Medicare Physician Fee Schedule and receives at least $12,500 in CLFS revenue during the data collection period. Hospital outreach labs are included if they meet the volume thresholds and bill Part B on a CMS-1450 under type of bill (TOB) 14x.

Initially, the next round of reporting for payer data collected between January and June 2019 was supposed to take place during the first quarter of 2020. However, legislative and public health emergency-related delays pushed the next round of reporting back two years. Between January and March 2022, labs are required to report data collected between January and June 2019.

Whether this next round of reporting will be as extensive as the first continues to be discussed. A third-party contractor hired by MedPAC to analyze ways to reduce the reporting burden explored different survey methodologies that could be used to collect representative and statistically valid samples of independent, hospital outpatient, and physician office laboratories. MedPAC said it focused on these three types of labs because they furnished "nearly all" laboratory tests from the CLFS, and the prices they received varied.

The study concluded a survey could potentially reduce the number of labs that would be required to report private payer data by up to 70 percent. The idea continues to be explored and final feedback is expected to be included in a June report to Congress.

OIG identifies $3.4 million in Medicare Advantage overpayments to Anthem

The HHS Office of the Inspector General (OIG) recently revealed CMS overpaid Anthem about $3.4 million in Medicare Advantage (MA) payments due to the payer failing to meet federal coding rules.

The overpayments were discovered as part of an audit of MA organizations where OIG focused on seven groups of high-risk diagnosis codes. The goal of the audit was to find whether the diagnosis codes Anthem submitted for use in CMS's risk adjustment program complied with federal requirements.

The OIG sampled 203 unique enrollee-years with the high-risk diagnosis codes for which Anthem received higher payments for 2015 through 2016. The agency limited the review to the portions of the payments that were associated with those codes, which totaled $599,842.

When looking at the seven high-risk groups covered by the audit, most of the selected diagnosis codes that Anthem submitted to CMS for use in its risk adjustment program did not comply with the federal requirements. For 123 of the 203 enrollee-years, the diagnosis codes that Anthem submitted to CMS were not supported in the medical records and resulted in $354,016 of net overpayments for the 203 enrollee-years.

These errors occurred, OIG said, because the policies and procedures that Anthem had to detect and correct noncompliance were not always sufficient. Based on the sample results, OIG estimated that Anthem received at least $3.47 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

The OIG recommended that Anthem refund the $3.47 million in overpayments to the federal government, and identify any similar instances of noncompliance that occurred before or after the audit period. The agency also wants the insurer to enhance its compliance procedures to focus on diagnosis codes that are at high risk of being miscoded.

Meanwhile, Anthem disagreed with OIG's finding and recommendations and questioned the methodology and whether federal requirements were properly executed. Anthem also said the report reflected misunderstandings of the legal and regulatory requirements underlying the MA program.

DOJ charges 14 with Covid-19-related health care fraud

On May 26, Department of Justice today announced criminal charges against 14 defendants, including 11 newly-charged defendants and three who were charged in superseding indictments, in seven federal districts across the U.S. for their alleged participation in various health care fraud schemes that exploited the Covid-19 pandemic and resulted in over $143 million in false billings.

Additionally, the Center for Program Integrity, Centers for Medicare & Medicaid Services (CPI/CMS) separately announced today that it took adverse administrative actions against over 50 medical providers for their involvement in health care fraud schemes relating to COVID-19 or abuse of CMS programs that were designed to encourage access to medical care during the pandemic.

You can read more about the cases here. Remember, as enforcement for improper Covid-19 billing and fraud during the PHE begins to ramp up, it's important to make sure your practices are in compliance with the latest regulations. We're proud to now also be assisting Lighthouse Lab Services clients with these crucial services and would be happy to discuss doing the same for your lab or group.