Susan Van Meter
ACLA

Joyce Gresko
ACLA

# Q&A

## Short-Term PAMA Relief Is Here: Next Steps on Required Data Reporting, and the Pathway Passage of the RESULTS Act for Long-Term Reform

Note: The webinar Q&A has been edited for clarity

**Q: What is the difference between "payment amount" and "approved/allowed amount"? Is there a distinction in payment of "insurance payment" vs "patient payment"? Do rates need to be reported if not contracted with a payer? What exactly must be reported?**

A: Laboratories must report the private payer rates for each test with payment received during the data collection period.

Report:

- Private payer rate that includes the total payment. The total payment = insurer payment plus patient cost sharing (copay, coinsurance, deductible). The private payer rate is generally known as the insurance allowed amount.
- This is required whether or not the lab is contracted with the payer.

Do not report:

- Payments still under appeal
- Payments made in error
- Allowed amounts not actually received

Reporting is based on payment date, not date of service.

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**Q: Has CMS acknowledged that many commercial contracts pay labs a percentage of the CLFS—often below Medicare rates?**

A: This concern has been raised consistently for nearly a decade. CMS cannot change this under current law. Any fix must come from Congress, which is why continued advocacy for the RESULTS Act is essential.

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**Q: Do molecular tests, including single-gene or NGS tests, need to be reported?**

A: Yes—if the specific HCPCS/CPT code for the test appears on CMS's list of reportable codes. Tests billed with miscellaneous/unlisted codes are excluded.

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**Q: Does a physician office performing CLIA-waived point-of-care testing need to report?**

A: A physician office qualifies as an "applicable laboratory" only if:

- It holds a CLIA certificate, and
- It receives more than $12,500 in CLFS revenue during Jan–Jun 2025, and
- It meets all other applicable-lab criteria.

Most physician practices do not reach the $12,500 CLFS threshold and therefore are not required to report.

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**Q: Are Medicare Advantage and Medicaid Managed Care payments included?**

A: Yes. Private payers include:

- Commercial insurers
- Medicare Advantage (MA) plans
- Medicaid Managed Care Organizations (MCOs)
- Group health plans

These payments must be reported under current law. The RESULTS Act proposes removing Medicaid MCO data from future reporting cycles.

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**Q: Which CPT codes need to be reported? Do CPT/PLA codes that are unpriced or newly created need to be reported?**

A: Only codes appearing on CMS's official list of reportable HCPCS codes must be reported.

- If a new CPT or PLA code does not appear on the list, it is not reportable.
- Codes not previously priced on the CLFS will undergo crosswalking or gapfilling in the fall following the reporting period.
- Private payer payments using miscellaneous codes (e.g., 81479) are not reportable.

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**Q: When will new CLFS rates be published?**

A: CMS has not set a precise date. Given the tight timeline (data submission closes July 31, 2026), CMS is expected to publish updated rates sometime in Fall 2026. There will be one final set of rates—no preliminary release and no comment period.

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**Q: If a lab is NOT required to report, will it still be subject to future rate cuts?**

A: Yes. Any laboratory that bills Medicare using codes affected by PAMA will be subject to the resulting CLFS rates—even if it is not an applicable laboratory and does not report data.

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**Q: If a patient does not pay their portion, do we still report only what was actually received?**

A: No. Reporting is based on the private payer rate, also known as the insurance allowed amount, which includes patient deductible and coinsurance amounts.

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**Q: Does the new reporting timeline affect ADLTs?**

A: No. The reporting period for Advanced Diagnostic Laboratory Tests (ADLTs) did not change. Only clinical diagnostic laboratory tests are affected by the new 2026 reporting window. ADLTs continue to follow their standard January 1–March 31 annual reporting cycle.

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