

WHAT'S AHEAD FOR LABORATORY REIMBURSEMENT

PAMA, Payer Scrutiny, and Compliance Risk in 2027

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Danielle H. Tangorre is a Partner in the Health Law Group and Co-Chair of the Enforcement, Investigation and Litigation in Health Care Group at Robinson+Cole. With extensive experience advising clinical and pathology laboratories, healthcare providers, and healthcare entities, Danielle focuses her practice on regulatory compliance, investigations, enforcement and litigation, audit responses, and healthcare transactions. She is recognized for her practical, business-focused approach to solving complex legal challenges and her commitment to helping clients navigate the evolving healthcare landscape. Danielle is a frequent speaker and author on healthcare law topics, and is dedicated to supporting clients in achieving their strategic goals.

Darla Wanitschke: Vice President, Customer Success, TELCOR



Darla joined TELCOR in January 2010 and has held multiple roles across sales, implementation, and special projects. She also managed the Claim Resolution team for TELCOR Revenue Cycle Services, further strengthening her expertise in laboratory billing and reimbursement. Darla brings a strong leadership presence and a strategic mindset to revenue cycle management in the laboratory industry. Her expertise includes:

- **Revenue Cycle Optimization:** Driving efficiencies and innovation to enhance financial performance across a diverse range of laboratories.
- **Strategic Leadership:** Providing guidance and solutions that improve operational workflows and reimbursement outcomes.
- **Industry Experience:** Serving as a Senior Director of Revenue Cycle Management for two molecular diagnostic laboratories, demonstrating a deep understanding of laboratory billing complexities.
- **Cross-Functional Expertise:** Applying experience in sales, implementation, and special projects to deliver comprehensive RCM solutions.

The 2027 reimbursement question

Three forces are converging: lower Medicare rates, tighter payer controls, and higher proof expectations.

1 PAMA reset

Preliminary CY 2027 rates translate a new private-payor data cycle into Medicare payment pressure.

2 Payer scrutiny

Audits, prior authorization, edits, denials, and recoupments are increasingly data-driven.

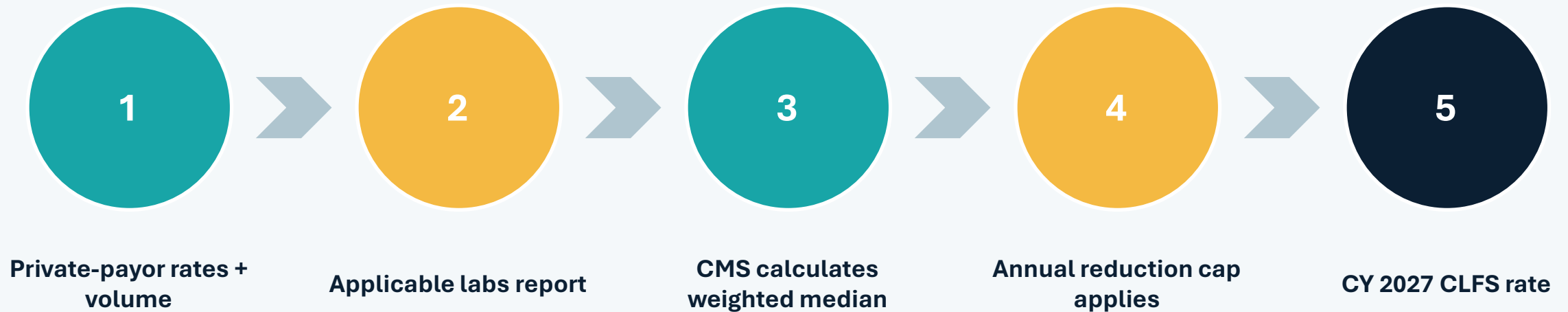
3 Compliance risk

The claim must have documentation from clinical need and order through performance, coding, and payment.

Protecting revenue in 2027 requires an integrated response across finance, revenue cycle, operations, compliance, and legal.

PAMA in one slide

How private-payor data becomes Medicare pricing.



PAMA is a rate-setting mechanism with direct strategic consequences for service lines, contracting, and margin.

What CMS released for CY 2027

The preliminary data points to broad downward pressure, with uneven effects by test category.

1,528 codes with calculated weighted medians

1,171 below the 2026 CLFS amount

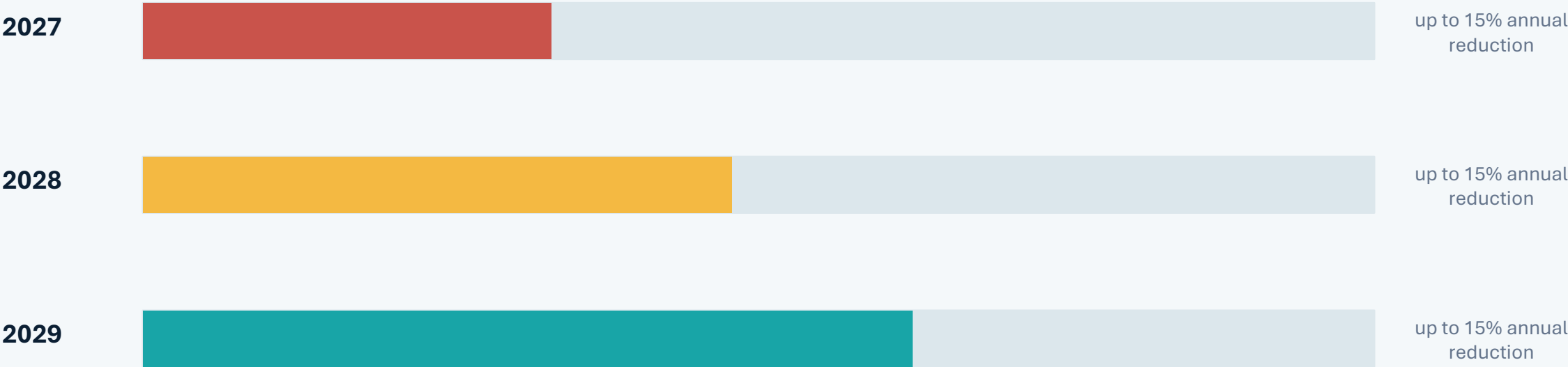
≈16% average potential change lower, before phase-in

\$1B estimated annual Medicare savings



The 15% cap is a phase-in, not a uniform cut

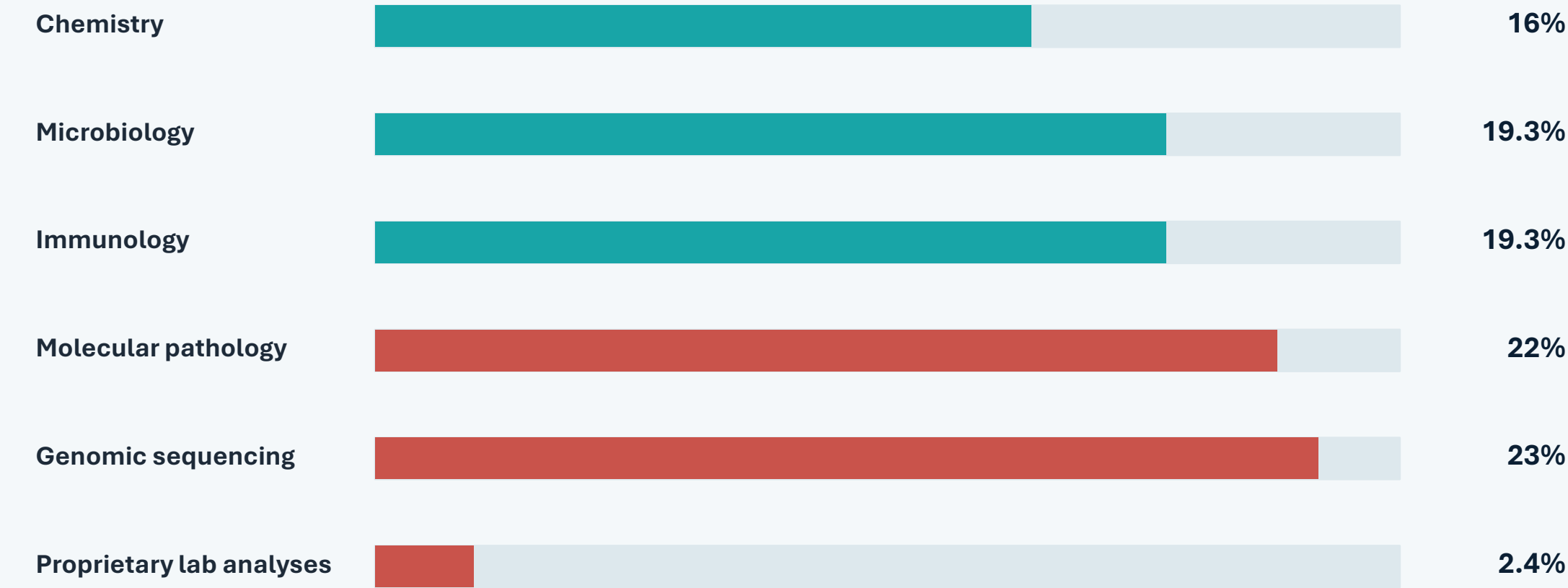
A test may not decrease by more than 15% per year in 2027, 2028, or 2029 compared with the preceding year.



Implication: A code whose weighted median is materially below its 2026 rate can experience multi-year pressure. Labs need to think about all years, not just January 1, 2027.

Where the pressure is concentrated

Category averages are directional; laboratories need code-level modeling.



The legal and policy debate is not over

The rate release makes the methodological dispute operational.

CMS position

PAMA aligns Medicare payment with private-payor rates and CMS estimates meaningful program savings.

Industry concern

Hospital and laboratory groups argue the data are incomplete or unrepresentative and could threaten access or innovation.

RESULTS Act

Proposed reform would change the data source and rate-setting approach, reduce reporting burden, and mitigate reductions.

Takeaway: track both the final rate process and potential legislation, but do not defer operational planning.

Payer scrutiny is broader than PAMA

Revenue risk now emerges before, during, and after claim submission.

Before testing

Network status • prior authorization •
Z-codes • panel design • documentation

At claim

Edits • coding • medical necessity •
frequency • documentation

After payment

Audit • recoupment • extrapolation •
suspension • referral • documentation

A denial-management issue can become a compliance issue when a pattern reveals unsupported billing, weak controls, or ignored warnings.

Data analytics are changing the intervention point

Payers and regulators can identify patterns before a traditional retrospective audit concludes.

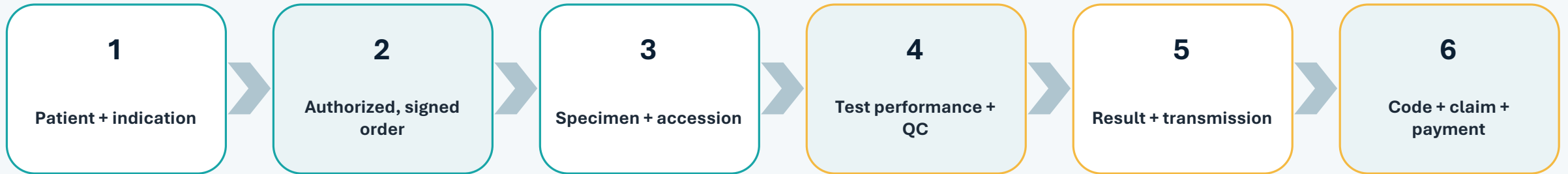


- Abrupt changes in volume, test mix, ordering, coding, or reimbursement
- Concentration by ordering provider, marketer, geography, or specimen source
- Mismatch between test utilization and diagnosis, policy, or documented clinical need
- Repeated denials, edits, or exceptions that are not escalated
- Entity, enrollment, location, or ownership inconsistencies

Know your own outliers before the payer explains them to you.

The claim must tell one coherent story

Audit readiness is the ability to reconstruct the service, not simply retrieve a requisition.



Clinical proof

Symptoms, history, risk, treatment rationale, provider relationship.

Operational proof

Specimen integrity, personnel, platform, QC, audit trail.

Billing proof

Coverage policy, code, units, modifiers, edits, remittance.

From audit to enforcement: understand the escalation path

Not every audit becomes an investigation, but the same facts can support multiple remedies.

Denial / records request

Prepayment or postpayment review

Overpayment + extrapolation

Payment suspension / revocation

Referral / investigation / FCA exposure

From “pay and chase” to prevention

The immediate compliance risk is not only repayment. It is interruption of cash flow and enrollment.

\$1.6B

in potentially improper laboratory payments stopped

157	enrollment revocations	\$732M
185	payment suspensions	>\$500M
442	identified overpayments	>\$276M
85	law-enforcement referrals	\$127M



2027 readiness: a practical workplan

Start with the codes and controls that matter most to your organization.

Financial impact

Model code-level 2027 rates, multi-year phase-in, volume, margin, and service-line sensitivity.

Payer intelligence

Map contracts, policies, prior authorization, Z-code requirements, denial trends, and appeal rights.

Documentation

Define test-specific minimums and ownership for missing records, exceptions, and retrieval.

Audit testing

Sample claims from payment back to encounter, order, specimen, performance, result, and remittance.

Outlier governance

Monitor volume, mix, ordering, coding, denial, payment, geography, and third-party concentration.

Response playbook

Prepare protocols for holds, audits, recoupments, suspensions, overpayments, and referrals.

Key takeaways

- 1 PAMA is now an operational issue** The preliminary 2027 rates require code-level financial planning.
- 2 The pressure is multi-year** The 15% annual cap can phase larger reductions across 2027–2029.
- 3 Payer controls are converging** Authorization, edits, denials, audits, and analytics form one risk system.
- 4 Documentation is distributed** The laboratory still needs a documentation chain that withstands payer review.
- 5 Readiness must be cross-functional** Finance, revenue cycle, operations, compliance, and legal need one workplan.

Questions & discussion

Questions



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