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Medicare Pulls The Plug On Pathology TC Code Increases

Citing errors in its practice expense calculations and confusion over its PE methodology, CMS says it's falling back on the lower 2005 values to allow more time for public comment.

In its recently released final 2006 physician fee schedule, effective January 1, Medicare has yanked the higher reimbursement it had proposed for flow cytometry and for the most frequently billed surgical pathology code, CPT 88305. The reversal is part of a bigger problem Medicare officials said they found in calculating practice expense relative value units (PE RVUs). So, they decided to value all physician services next year at current 2005 RVUs, a move that cancels fee hikes expected for a number of key pathology codes (*see table, p. 2*).

In its August 8 proposed fee schedule rule, the Centers for Medicare & Medicaid Services increased the PE RVUs for the technical component flow cytometry codes 88184-88185 and for the TC of 88305 (*National Intelligence Report, 26, 20/Aug 17 '05, pp. 1-2*). For 88184 and 88185 the boost was substantial, up about 22% and 33%, respectively. For the per-marker codes 88187-89, however, CMS proposed decreases ranging from 1.6% to 2%. ➥ *p. 2*

INSIDE *NIR*

'Vigilance' Remains Watchword For Lab Groups

As Congress continues to work on 2006 budget reconciliation legislation at press time, the clinical laboratory industry has thus far dodged being targeted for Medicare savings via the return of a 20% copay, further extension of the five-year freeze (now effective through 2008), or additional reductions in payment amounts.

But lab lobbyists say they can't rest until a final budget bill is enacted. The versions in Congress differ significantly over where to make spending cuts in entitlements. The Senate-passed bill requires $35 billion in savings, with $10 billion split between Medicare and Medicaid and the bulk of it coming from pharmacies and drug manufacturers. The bill also would eliminate the stabilization fund to encourage private health plans to participate in Medicare Advantage. The White House has threatened to veto any such move. Further, the bill prevents a scheduled 4.4% physician fee cut and approves a 1% update.

The House version being considered at press time would spare Medicare, but slash federal Medicaid spending by $11 billion, with the savings to come from various reforms, including higher copays for beneficiaries. Hill watchers predict a long and difficult House-Senate conference to resolve differences between the bills.

Pathology TC Coding, *from p. 1*

CMS said it decided to withdraw its entire practice expense methodology after concluding that "due to an error in our indirect PE program, the indirect costs were not calculated as intended. As a result, almost all of the PE RVUs published in the August 8, 2005, proposed rule were incorrect." PE RVUs make up an average 45% of physician payments, the agency noted. Another reason for the withdrawal, CMS said, was that its PE methodology was not widely understood and needs more time for public comment. In January the agency said it will begin to ensure that the data and methodology are better understood prior to the 2007 proposed rule next summer.

But leading pathology and laboratory groups want CMS to go ahead with the proposed payment adjustments, noting that the agency has already accepted their PE supportive data and recommendations for flow cytometry and other pathology values. "It's in the CMS database already," said Alan Mertz, president of the American Clinical Laboratory Association, urging CMS to make a quick correction and grant the higher payments. "We shouldn't have to wait another year to get this fixed," he added. The College of American Pathologists also expressed concern that the PE calculation error will derail the changes that CMS has agreed to. CAP has asked CMS to immediately implement the PE adjustments.

Fee Cut Expected To Be Stopped

As required by law, Medicare fees will be cut by 4.4% in 2006, CMS said in meeting a deadline for publishing its final 2006 physician fee schedule rule.

At press time, however, it's widely anticipated in Washington circles that Congress will block any cut and approve an update of at least 1% instead. The Senate-passed budget reconciliation bill would do just that, at a cost of $10.8 billion.

Under the 4.4% cut, the conversion factor would fall to $36.1770 from $37.8975 in 2005. The American Medical Association has warned that physicians may leave Medicare if fees are cut. In a national survey of its members, 38% said they would no longer take new Medicare patients. Pathology groups and other medical specialties want Congress to overhaul Medicare's Sustainable Growth Rate formula to prevent projected future fee cuts and assure reasonable annual updates.

Selected Pathology Codes, Medicare Physician Fee Schedule: Final Non-Facility RVUs For 2006

CPT Code	Work RVUs	PE RVUs (final/proposed)	Malpractice RVUs	Total RVUs (final/proposed)
Lab Pathology Consultation				
80500	0.37	0.21/0.20	0.01	0.59/0.58
80502	1.33	0.54/0.53	0.04/0.06	1.91/1.92
Surgical Pathology, Tissue Exam by Pathologist				
88305-26	0.75	0.33	0.03	1.11
88305-TC	0.00	1.58/1.76	0.04	1.62/1.80
Flow Cytometry				
88184, lst marker	0.00	1.32/1.62	0.02	1.34/1.64
88185, add'l marker	0.00	0.64/0.86	.02	0.66/0.88
88187, read 2-8 markers	1.36	0.45/0.42	0.01	1.81/1.78
88188, read 9-15	1.69	0.57/0.53	0.01	0.58/0.54
88189, read 16 & more	2.23	0.75/0.69	0.01	2.98/2.92
Cytopathology				
88141	0.42	0.15/0.23	0.02	0.59/0.67
In Situ Hybridization				
88365-TC	0.00	1.62/1.83	0.02	1.64/1.85
88367-TC	0.00	3.50/4.23	0.06	3.56/4.29
88368-TC	0.00	1.80/3.37	0.06	1.86/3.42

Source: Final and proposed rules, 2006 Medicare physician fee schedule. CPT codes copyright American Medical Assn.

The PE RVU adjustments in the proposed rule gave big increases to pathology and independent clinical laboratories, said Matthew Schulze, senior manager for federal and state affairs at the American Society for Clinical Pathology. The PE for pathologists would have gone up by 5.3% over a four-year period, while independent clinical laboratories would have received a 28% update, also over four years.

The organizations have lobbied long and hard for higher reimbursement for flow cytometry. In 2005, when CMS first priced the new CPT system of flow cytometry codes introduced that year, fees for both the TC and the professional component fell by as much as 50%. The new CPT system replaced the old per-marker code 88180 with two new codes for the TC (88184-85) and three for the physician's interpretation (88187-89), but not until after CMS had published its proposed rule for the 2005 fee schedule.

Stark Ban, Screening Benefit Expanded; Imaging Fees Cut

In addition to the controversial negative update factor and the pullback from higher payments for certain pathology services (*related story, p. 1*), the final 2006 Medicare physician fee schedule makes a series of other payment policy changes, including:

- Adding diagnostic and therapeutic nuclear medicine services to the list of designated health services subject to the Stark ban that prohibits a physician from referring Medicare/Medicaid patients to facilities with which the physician has a financial relationship through ownership interest or compensation arrangements or both. Recognizing that this change may require the restructuring of some financial arrangements, the effective date for placing diagnostic and therapeutic nuclear medicine under the ban is January 2007.
- Expanding the glaucoma screening benefit to include Hispanic-Americans age 65 and older because they are identified as an ethnic group at high risk for the disease. Currently, this benefit is limited to individuals with diabetes, those with a family history of glaucoma, and African-Americans age 50 and older, another group with a propensity to develop glaucoma.
- Expanding Medicare telehealth services to include certain individual medical nutrition therapy to help rural beneficiaries. Also, the payment for the Medicare telehealth originating site facility fee is updated by 2.8%, based on the Medicare Economic Index. In 2006, the payment for HCPCS code "Q3014, telehealth originating site facility fee" is 80% of the lesser of the actual charge or $22.47. The MEI increase for 2005 was 3.1% and for 2004, 2.9%.
- Providing supplemental payments to federally qualified health centers that contract with Medicare Advantage (managed care) plans. The payments will cover the difference, if any, between the amount the center gets for treating MA enrollees and for treating beneficiaries in traditional fee-for-service. The aim is to encourage these centers to participate in the MA program that debuts in 2006.

The final rule also inaugurates a two-year phase-in of reduced payments for multiple diagnostic imaging procedures in the same session when performed in the physician office. While the first procedure will be paid in full, subsequent procedures will be cut by 25% in 2006 and 50% in 2007. The reduction applies only to the technical component of the service. CMS has put off, for now, similar reductions for these services to hospital outpatients, pending further study.

Medicare Outpatient PPS Rates To Rise In 2006

In 2006, Medicare payments for outpatient PPS to over 4,200 hospitals are projected to total $27.6 billion, up 5.2% from this year's $26.2 billion.

Acute care hospitals will get a 3.7% inflation update in Medicare prospective payments for outpatient department services as of January 1, 2006, under a final rule just released by the Centers for Medicare & Medicaid Services. The rule also lowers the co-insurance rates that beneficiaries have to pay for outpatient services.

The update for 2006 is higher than earlier proposed (*NIR, 26, 19/Jul 25 '05, p. 1*). With the 3.7% increase, plus other required adjustments, the 2006 conversion factor is $59.511.

Sole community hospitals will receive an additional 7.1% payment adjustment, CMS said, up from the 6.6% previously proposed. The pay hike will benefit about 400 sole community hospitals.

Medicare also is increasing payment for the "Welcome to Medicare" baseline physical examination when furnished in a hospital outpatient department by 7% in 2006, as part of the emphasis on prevention and early detection of disease.

Beneficiaries will continue to see lower co-pay rates. Rates have declined since peaking at 50%, down to 40% and eventually 20%. Under the final rule, the co-pay for 31 additional Ambulatory Payment Classifications (APCs) will decline to the 20% minimum. This is a 21% increase in the number of APCs at the 20% level over calendar 2005, CMS said.

CMS will begin paying for most Part B drugs and biologicals administered in hospital outpatient departments based on 106% of the manufacturer's average sales price (ASP). Also, the outlier threshold is set at $1,250. To receive outlier payments, the estimated cost for a service must be more than 1.75 times the average payment for the service.

Blood & Blood Products

Blood and blood products will continue to be paid under a separate methodology based on blood-specific cost-to-charge ratios (CCRs). In 2005, Medicare began paying some 25% more for blood and blood products provided to hospital outpatients, after two years of declining or frozen reimbursement, and the increase was even higher for the most frequently billed blood product, HCPCS P9016 (*NIR, 26, 5/Dec 16 '04, pp. 6-7*). CMS agreed to boost payments in response to blood organizations after concluding that hospitals' true costs for blood and blood products had been underestimated.

In 2006, CMS will set the final median costs for blood and blood products at the greater of: (1) the simulated median costs calculated from calendar 2004 hospital claims data, or (2) 95% of the calendar 2005 adjusted median costs for these products (the previously proposed decrease was 90%).

Also next year, CMS will discontinue outpatient PPS payment for CPT 85060 by changing its status from "X" to "B". The code is for "Blood smear, interpretation by physician with written report." The interpretation of an abnormal peripheral blood smear is considered a routine part of the ordered hematology lab service, such as CPT 85007 and 85008 paid under the clinical lab fee schedule. So, hospitals would get duplicate payment for the facility resources associated with the interpretation if Medicare were to continue to pay separately for 85060 under outpatient PPS, CMS said.

Multiple Imaging Procedures

CMS has postponed proposed pay cuts of up to 50% for multiple diagnostic imaging procedures performed in one session for hospital outpatients, pending further study. But the agency is going ahead with the cuts when the multiple imaging services are provided in the physician office setting. Under the 2006 physician fee schedule, the first procedure will be paid at the full rate, but subsequent procedures will be reduced by 25% in 2006 and 50% in 2007. The reduction applies only to the technical component of the service.

Lab Tests Included In Physician Quality Reporting Effort

Beginning January 1, 2006, Medicare is launching an initiative under which physicians may voluntarily report quality measures on the services they provide to Medicare beneficiaries, including data on clinical laboratory testing for diabetes, coronary heart conditions, and kidney disease. To capture such data on physicians' Part B claims, a series of new HCPCS G-codes has been created.

The voluntary reporting initiative was announced by the Centers for Medicare & Medicaid Services on October 28. Doctors are encouraged to report on 36 quality indicators that CMS developed in collaboration with physicians, physician organizations, and others such as the National Quality Forum, the National Committee for Quality Assurance, and RAND. Additional quality measures are under development and may be phased in during the year, CMS said.

G-Codes & Quality Indicators For Selected Lab Testing

Hemoglobin A1c control in patient with Types I or II diabetes mellitus

G8016: Diabetic patient with most recent A1c level (within the last six months) documented as less than or equal to 9%
G8015: Diabetic patient with most recent A1c level (within the last six months) documented as greater than 9%
G8017: Clinician documented that diabetic patient was not eligible candidate for A1c measure
G8018: Clinician has not provided care to the diabetic patient for the required time for A1c measure (six months)

LDL control in patient with Types I or II diabetes mellitus

G8020: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl
G8019: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl
G8021: Clinician documented that diabetic patient was not eligible candidate for LDL measure
G8022: Clinician has not provided care to the diabetic patient for the required time for LDL measure (12 months)

Antiplatelet therapy for patient with coronary artery disease

G8036: Coronary artery disease patient documented to be on antiplatelet therapy
G8037: Coronary artery disease patient not documented to be on antiplatelet therapy
G8038: Clinician documented that coronary artery disease patient was not eligible candidate for antiplatelet therapy measure

LDL control in patient with coronary artery disease

G8040: Coronary artery disease patient with LDL documented to be less than or equal to 100 mg/dl
G8039: Coronary artery disease patient with LDL documented to be greater than 100 mg/dl
G8041: Clinician documented that coronary artery disease patient was not eligible candidate for LDL measure (six months)
G8182: Clinician has not provided care for the cardiac patient for the required time for LDL measure (six months)

Hematocrit level in ESRD patient

G8078: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)
G8079: ESRD patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)
G8077: Clinician documented that ESRD patient was not eligible candidate for URR or Kt/V measure

The American Medical Association has told CMS it has "strong objections" to the program due to "excessive administrative requirements," especially on primary care, and says it should be "rescinded." A more pressing problem is the need for a Medicare physician fee fix, AMA said.

New G-Codes To Report Data

To report the data, physicians will use new G-codes which will supplement, not substitute for, the CPT and ICD-9 coding requirements for claims, CMS emphasized, and there will be no payment for the G-codes. While Congress has authorized higher Medicare payments to hospitals that voluntarily report certain quality measures, there is as yet no similar pay-for-performance (P4P) program for physicians' Medicare services. So, the immediate physician incentive to report is to get additional feedback about the care they provide, said CMS administrator Mark McClellan. The agency anticipates that the G-codes will serve as an interim step until data are exchanged via electronic health records.

Prelude To Physician P4P

McClellan has been an enthusiastic backer of P4P-type initiatives in Medicare, and the voluntary reporting initiative, CMS notes, is a way to "better position" Medicare and physicians for some form of P4P. The agency currently is running its first-ever Medicare demonstration of physician P4P, a three-year project involving 10 large group practices and coordination of care for chronically ill and high-cost beneficiaries (*NIR, 26, 8/Feb 7 '05, p. 8*).

On Capitol Hill meantime, the Senate, in passing its budget reconciliation bill for 2006, approved Finance Committee provisions to extend P4P—referred to as value-based purchasing programs—to physicians, Medicare Advantage plans, ESRD providers, and home health agencies. The HHS Secretary is directed to establish such programs; in addition, the Medicare Payment Advisory Commission will conduct studies to evaluate the impact. Value-based payments would begin in 2009. At press time, the House was working on its version of budget reconciliation, with a conference committee as the next stop to resolve differences with the Senate's measure.

Annual Medicare Enrollment Period Begins This Month

November 15 is the start date for eligible physicians, practitioners, and suppliers to enroll in, or terminate their enrollment in, the Medicare participation program. Providers and suppliers have until December 31 to make their decision for the coming year. Those who currently participate and wish to continue doing so need take no action.

By signing a participation agreement, providers and suppliers agree to accept assignment for all covered services provided to Medicare beneficiaries (that is, they accept the Medicare payment as payment in full and agree not to bill others for any balance).

Participating physicians get 5% higher fee schedule amounts. Also, they have "one-stop" billing for beneficiaries who assign both their Medicare and Medigap payments to participants.

The majority of physicians and other providers have chosen to participate in Medicare. During 2005, 91.6% of all physicians, practitioners, and suppliers billed under Medicare participation agreements.

Those enrolled with Medicare but choosing not to accept assignment for every covered service they furnish do not have to sign a participation agreement in order to bill Medicare and receive payment.

♦CODING A·D·V·I·S·O·R·Y

Carriers Told To Process All Diagnosis Codes Reported

In welcome news for many clinical laboratories, the Centers for Medicare & Medicaid Services has instructed local Medicare Part B carriers to prepare to process all ICD-9 diagnosis codes reported on a claim up to the maximum eight codes allowed by the ANSI 837P 4010A1 claim format vs. carriers' current limit of four codes.

CMS will implement the change in multiple phases, according to Change Request 4097 (October 31, 2005). The first phase (design and analysis) begins April 1, 2006, and for claims processed as of October 1, 2006, the carrier standard system is to capture and process the maximum number of ICD-9 codes reported. The new policy carries out an agreement with the lab negotiated rulemaking committee to automatically consider all diagnosis codes reported, the agency said.

It also addresses a big concern among clinical laboratories. Currently, in processing the HIPAA format claim, carriers handle only the first four diagnosis codes on the claim. The remaining diagnosis codes are not used in determining Medicare payment. Labs now typically use a work-around to get paid for a proper diagnosis, submitting claims with more than four diagnosis codes twice—initially with the first four codes, then with any additional codes (*NIR, 26, 13/Apr 25 '05, p. 1*).

Medicare earlier this year scrapped its plan to require carriers to conduct only one medical review of lab and other Part B claims while rejecting as duplicates those resubmitted after denial or awaiting further documentation. The American Clinical Laboratory Association lobbied against the plan, saying it would force many labs to file paper appeals for claims denied as medically unnecessary when more than four diagnosis codes were reported (*NIR, 26, 18/Jul 11 '05, p. 1*). This could have meant thousands of claims going to appeal per month per lab, noted ACLA senior vice president JoAnne Glisson.

Infobytes...

Utah Gets New Medicare Contractor: By December 1 of this year, Noridian Administrative Services (NAS-Fargo, ND) will take over as the new Medicare Part A fiscal intermediary and Part B carrier for the state of Utah, the Centers for Medicare & Medicaid Services has announced. The current Utah carrier and intermediary, Regence BlueCross BlueShield of Utah, is not renewing its contract, CMS said.

NAS already is the Part A intermediary for four states—Alaska, Minnesota, North Dakota, and Washington—and the Part B carrier for 11 states, including Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North and South Dakota, Oregon, Washington, and Wyoming. With the addition of Utah, the company's total Medicare claims processing volume is projected to be over 73 million annually. NAS is a subsidiary of Noridian Mutual Insurance Company, also in Fargo.

Medicare Interest Rate Rises: The interest rate for Medicare overpayments and underpayments increased to 12.25% as of November 3, the Centers for Medicare & Medicaid Services announced. The rate had been 12% since April 25 of this year. It peaked in this decade at 14.125% in early 2001 and since has fluctuated in the range of 11%-12% since early 2002. Under Medicare regulations, interest may be assessed at the higher of the current value of funds rate (one percent for calendar 2005) or the private consumer rate as fixed by the Treasury Department.

Lab, Radiology Work In Forefront Of Hospital Health HIT

Hospitals tend to add HIT functions incrementally, the AHA survey found, due to initial investment costs and the need to test and train personnel.

Electronic order entry and review of results for clinical laboratory and radiology services are the most common health information technology (HIT) functions in hospitals today, according to a recent survey by the American Hospital Association. Sixty-two percent of hospital respondents had such functions in place for these services, and just under half (48%) said they have electronic pharmacy order entry.

Overall, 53% of the hospitals said they share electronic patient health records with at least one outside party, including laboratories (21% of hospitals), health care payers (21%), public health departments (15%), and long-term care facilities (14%). One-third of the hospitals said they share electronic patient clinical information with private practice physicians. The survey did not ask how hospitals did so, but one popular way is to give doctors Web portal access to patients' records. AHA conducted the survey of hospital CEOs from April to June of this year.

Meantime, three contracts totaling $17.5 million have been awarded by the U.S. Department of Health & Human Services to private standards and certification groups to help build an infrastructure for the national system of electronic health records for all Americans, a priority of the Bush Administration. The groups include the American National Standards Institute (ANSI), the Certification Commission for HIT, and the Health Information Security and Privacy Collaboration.

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