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CMS Uses Crosswalk To Price Most New 2006 CPT Lab Codes

Join in our special November 29 audio conference on keeping ahead of lab and pathology coding and payment changes for 2006. A CD recording of the session will also be available for purchase. Details at www.g2reports.com

In the Medicare clinical laboratory fee schedule for 2006, just released by the Centers for Medicare & Medicaid Services, a series of new CPT lab codes has been added to test for conditions such as coronary heart disease, diabetes, irritable bowel syndrome, and virus resistance. To price the new codes, CMS decided to crosswalk them to codes payable on the current fee schedule (*see table, p. 2*), with one exception.

That exception is for new codes 83037 and 83037QW, hemoglobin, glycosylated (A1c) by a device cleared by the Food & Drug Administration for home use. CMS has opted to price this procedure next year using the gap-fill method, which lets local Medicare contractors set the fee based on local pricing patterns.

In the lab fee schedule that goes into effect January 1, there is no inflation update to fees, marking the third year of the five-year freeze (through 2008) that was imposed by the Medicare Modernization Act of 2003.

The freeze also bars any update to the national minimum payment for a string of Pap smear codes. The minimum remains $14.76 for the following codes: 88142, 88143, 88147, 88148, 88150, 88152, ➥ *p. 2*

INSIDE *NIR*

Lab Vigilance Is Key Defense Against Pandemic

As public health officials keep a wary eye on the H5N1 strain of avian influenza that has quickly spread from Southeast Asia to Europe, President George W. Bush earlier this month unveiled a $7.1 billion plan to prepare for the possibility of a flu pandemic.

The bulk of the money would go to expand vaccine manufacturing capacity and stockpile antiviral drugs to treat those who become infected. Also, more than half a billion dollars would be directed toward both domestic and international surveillance, detection, and response efforts, including support for worldwide and U.S. lab networks that regularly gather data on circulating strains of flu viruses and monitor them for subtypes that are unusual or previously unknown and that might have the potential to trigger a pandemic.

Clinical laboratories are "our front line" for rapid diagnosis of flu strains, says Dr. Mike Pentella, with the State of Iowa's public health lab, and public health labs support local labs by confirming the identification of these strains and sharing the results with clinicians and communities. For more on the role of laboratories in the national anti-pandemic strategy, see the *Focus*, pp. 4-5.

Medicare Lab Fee Schedule 2006: Final Code Crosswalks, Fees

CPT Code	Descriptor	Crosswalk/Fee*
THERAPEUTIC DRUG ASSAY		
80195	Sirolimus	80197/$19.17
CHEMISTRY		
82271, 82271QW**	Fecal occult blood, peroxidase (eg, guaiac); other sources	82270/$4.54
82272, 82272QW	Fecal occult blood, peroxidase (eg, guaiac); single specimen (eg, from digital rectal exam)	82270/$4.54
83631	Lactoferrin, fecal; quantitative	87015/$9.33 + 83520/$18.09
83695	Lipoprotein (a)	83520/$18.09
83700	Lipoprotein, blood; electrophoretic separation and quantitation	83715***/$15.73
83701	high resolution fractionation and quantitation of lipoproteins including subclasses when performed	83716***/$34.68
83704	quantification of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy)	83716***//$34.68 + 85004/$9.04
83721QW	low-density lipoprotein (LDL), direct measurement	83721/$13.33
83880QW	natriuretic peptide	83880/$47.43
83900	amplification of patient nucleic acid, multiplex, first two nucleic acid sequences each	83901/$23.42 x 2
83907	lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue)	87015/$9.33 x 2
83908	signal amplification of patient nucleic acid, each nucleic acid sequence	83898/$23.42
83909	separation and identification by high resolution technique (eg, capillary electrophoresis)	83904/$23.42
83914	Mutation identification by enzymatic ligation or primer extension, single segment, each segment (eg, oligonucleotide ligation assay (OLA), single base chain extension (SBCE) or allele specific primer extension (ASPE)	83904/$23.42
HEMATOLOGY & COAGULATION		
85576QW	Platelet aggregation (in vitro), each agent	85576/$30.01
IMMUNOLOGY		
86200	Cyclic citrullinated peptide (CCP), antibody	83520/$18.09
86355	B cells, total count	86064***/$52.70
86357	Natural killer (NK) cells, total count	86379***/$52.70
86367	Stem cells (i.e., CD34), total count	86587***/$52.70
86480	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	86353/$68.49 + 83520/$18.09
86586	Unlisted antigen, each	86587*** (deleted)/$52.70
86703QW	Antibody, HIV-1 and HIV-2, single assay	86703/$19.17
MICROBIOLOGY		
87209	Smear, primary source with interpretation; complex special stain (eg, trichome, iron hemotoxylin) for ova and parasites	87207/$8.37 x 3
87807QW	Respiratory syncytial virus, DNA or RNA, detection	87807/$16.76
87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics	87904/$182.11 x 5✚

Source: CMS Change Request 4144, November 10, 2005. CPT codes © American Medical Assn.
*Current national fee cap, frozen through 2008. **The QW modifier indicates a CLIA-waived test. ***Code deleted in 2006.
✚ *NIR* asked CMS if the "x 5" is in error; at press time, we are unable to confirm this. CMS officials would not comment since the '06 fee schedule was not yet publicly available.

New 2006 CPT Lab Codes, *from p. 1*

88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

In agreeing to crosswalk all but one of the new codes, CMS said its final fee determinations are consistent with most of the majority opinions of lab industry and professional groups that submitted pricing recommendations (*National Intelligence Report, 26, 19/Jul 25 '05, pp. 1-2*).

But the agency had second thoughts about its previously proposed crosswalk to 83036 ($13.56) for the hand-held A1c device, 83037 and 83037QW. One factor in opting for local pricing of this device may have been a lack of consensus among lab and pathology groups, whose recommendations varied from a low of $8.16 to $13.56 to a high of around $21, as well as diverse input from medical specialty groups. Other factors may have influenced the agency to refrain from setting a maximum allowable at this time, notes Diana Voorhees, president of DV & Associates in Salt Lake City, UT. The new code represents a high-volume procedure, whose utilization could go even higher given the steadily rising number of people being diagnosed with diabetes, while pressures on the Medicare budget are intensifying.

Going the gap-fill route could result in a higher reimbursement level, says Charles Root, who heads CodeMap in Barrington, IL. Advocates of higher payment say this would encourage physicians to use the technology in their offices to obtain real-time measurement of A1c levels and counsel Medicare beneficiaries on glycemic control management. There are many documented studies showing that you get better patient compliance with on-the-spot counseling, Root notes. So, after a year of experience with local pricing patterns, Medicare may be motivated to pay more for such real-time benefits, he adds, because glycemic control is a key item in quality-of-care indicators. But getting higher payment, which would allow doctors some profit on the procedure, will depend on how successful physician advocates and kit manufacturers are in persuading the contractors' medical directors, Root cautions.

Labs Can Collect 'Past Due' Amounts On Medicare Trip Fees

In explaining the retroactive update, CMS said it usually incorporates any mileage rate change in the annual lab fee schedule update each January 1. This year, the Treasury raised the rate well ahead of that time, the agency said.

If your laboratory bills Medicare for the Part B travel allowance, you're entitled to more than you've been getting. But to get the higher allowance, you have to bring your trip fee claims that have already been paid to the attention of your local carrier or intermediary. The Centers for Medicare & Medicaid Services is not requiring them to search past claims and pay retroactively.

CMS announced, in a payment policy memo on the 2006 Part B lab fee schedule, that it is updating the allowable fees for the travel codes, retroactive to September 1 of this year. As of that date, payment for code P9603 went from $0.855 per mile to $0.935 per mile and for P9604 from $8.55 to $9.35. The trip fee is payable when it is necessary for the lab to send personnel to collect a specimen from a homebound or nursing home Medicare beneficiary.

The increase in the trip fees stems from the higher standard mileage rate that the Treasury Department set, $.048 per mile, as of September 1, 2005. The personnel portion of the travel allowance remains frozen at the current level of $0.45 per mile, in accord with the lab fee freeze.

focus on: *Federal Plan For Pandemic Preparedness*

Staying Ahead Of A Potential National Flu Emergency

Pandemics occur when a viral strain to which humans have no immunity mutates and can spread easily from person to person, with the potential to kill millions worldwide. Because these viral strains commonly show up in birds, scientists around the globe are closely tracking one virulent strain, H5N1.

The Bush Administration this month significantly raised the stakes to get the nation ready for the possibility of pandemic influenza. Most worrisome to public health officials here and around the world is the H5N1 strain of the influenza A virus, popularly known as avian or bird flu. It was first identified in 1997 in Hong Kong, and at the time of this writing, 125 human cases of the disease have been documented, with a high mortality rate—64 have died. In all these cases, the victims had contact with infected chickens and other domesticated birds; no cases have been documented to date of H5N1 being spread by wild birds.

The President on November 1 went to the National Institutes of Health to announce a national strategy to counter pandemic influenza. The strategy is a complex plan to prepare, detect, and respond to such a crisis, including the roles that government, industry, citizens, and international bodies should play. In unveiling the plan, Mr. Bush said, "There is no pandemic flu in our country or in the world, but if we wait for it to appear, it will be too late to prepare."

Plan Emphasizes Vaccines, Drug Stockpiles

To carry out the national strategy, the Administration is calling for $7.1 billion, including $6.7 billion in additional 2006 appropriations for the U.S. Department of Health & Human Services. About $4.7 billion would go toward investments in vaccine development and production, $1.4 billion to stockpile antiviral drugs, and $555 million for surveillance, the public health infrastructure, and communications, including $100 million for state and local preparedness.

Several parts of the strategy have already triggered controversy:

- ❑ The plan would shield vaccine manufacturers from liability lawsuits but offer no compensation for people who suffer serious reactions to a vaccine.
- ❑ Overall command of the government's "domestic incident response" would be assigned to the Department of Homeland Security. HHS would handle the medical and public health component.
- ❑ States would have to purchase about 40% of the antiviral stockpile required to protect their residents. White House officials said the Federal Government would subsidize 25% of states' costs to buy the drugs.

Critics say that the $100 million to be slated for state and local preparedness is not enough. States and localities are already struggling with soaring healthcare costs and the growing number of uninsured residents, they argue, and more support is required to bolster the public health infrastructure, including laboratories, personnel training, and communications.

Until new money comes, some state and local officials are tapping existing programs, such as bioterrorism readiness, to underwrite pandemic preparedness. "We do have the ability to use that money to help with pandemic flu" because the two

At present, there is no commercially available vaccine to protect humans against the H5N1 strain seen in Asia and Europe, says CDC in a November 18 fact sheet, but research to test a vaccine began in April 2005 and clinical trials are underway.

require similar responses, Los Angeles County public health director Jonathan Fielding told the *Los Angeles Times*.

Roles For Private, Public Labs

Clinical laboratories are the sentinels for detecting local circulating flu strains, usually via rapid diagnostic assays, then public health labs follow up to "strain-type" the samples and share results with doctors and other clinicians, microbiologist Mike Pentella told *NIR*. Dr. Pentella heads the infectious disease section of the Iowa state public health lab in Iowa City. "We send them the transport media and we do the PCR and culture," he said. By working together, new or novel strains can be quickly identified and measures put in place to control and prevent their spread, he added.

Pentella works with a network of 138 labs in the state, most of them hospital- or clinic-based, to communicate flu updates and conduct various preparedness and response activities. Training personnel is a major and time-consuming activity, including use of "tabletop exercises" that help trainees think through how they and their colleagues should respond to the different phases of a flu outbreak and adjust their work accordingly (for a sample, see *www.hhs.gov/nvpo/pandemics/tabletopex*).

Global, National Lab Surveillance

Two main structures, which now provide lab support for seasonal influenza surveillance, are in place to sound a pandemic alert. One is the World Health Organization network, in which all state and several large local public health labs, plus about 25 tertiary-care hospitals and academic center labs, participate as U.S. collaborating labs. The network collects worldwide data on circulating flu viral strains. The data are used to help formulate each year's flu vaccines, as well as detect novel human flu viruses with pandemic potential. The U.S. collaborating labs provide the Centers for Disease Control & Prevention with weekly reports of lab-confirmed cases of influenza A and B viruses, by age group. These labs typically use virus isolation followed by antigenic testing with IFA staining or HAI—or by molecular testing with RT-PCR—to identify known human flu viral subtypes. If unusual subtypes are detected, or if specimens cannot be subtyped with available techniques, the specimens are sent to the CDC for further testing.

The other alert network is the National Respiratory and Enteric Virus Surveillance System, which includes more than 90 labs throughout the country, including many hospital labs, some state public health labs, and a few private commercial labs (about 40 of the system's labs are also WHO collaborating labs). The network's labs provide the CDC with weekly reports of lab-confirmed cases of influenza A and B viruses. These labs typically test respiratory specimens with commercially available rapid diagnostic tests, but given the known limitations of rapid tests, several also perform virus isolation or antigenic typing by IFA. If viruses cannot be subtyped or unusual subtypes are detected, the specimens are sent to the state public health lab or to the CDC for further testing.

Laboratory Diagnostics & Influenza

Key References

- ❑ HHS Pandemic Influenza Plan, Supplement 2: Covers lab support for disease surveillance and clinicians, biocontainment procedures, occupational health issues for lab workers, and guidelines for reference testing and for collecting and shipping specimens. *www.hhs.gov*
- ❑ FDA cautionary statement on using rapid tests to detect influenza A viruses (issued November 14, 2005). *www.fda.gov/cdrh/oivd/tips/rapidflu.pdf*
- ❑ CDC's Key Facts About Avian Influenza and H5N1; also, weekly influenza summary update. *www.cdc.gov*
- ❑ Association of Public Health Laboratories, Pandemic Influenza Page. *www.aphl.org*

HHS Awards Contracts For Prototype E-Health Networks

With these latest awards, HHS says it has completed contracting for the foundation of a digital, interoperable, standards-based network for secure exchange of e-health information.

The U.S. Department of Health & Human Services has awarded four contracts totaling $18.6 million to create prototype networks linking hospitals, laboratories, physicians, and pharmacists. The prototypes for a National Health Information Network (NHIN) architecture are intended to move the nation away from the current largely paper-based system to a fully electronic health record system for all Americans, a key priority of the Bush Administration.

Key goals of the prototype networks are to reduce medical errors, eliminate unnecessary duplicate medical tests, and link providers to allow real-time transmission of patient-specific data, such as prescriptions and lab test results.

The contracts are going to four consortia, which will work closely with other HHS partners that recently received a total of $17.5 million to harmonize health information standards, certification and evaluation criteria for health IT products, and assure the privacy and security of e-health records (*NIR, 27, 3/Nov 14 '05, p. 8*).

The four consortia are comprised of healthcare and health information technology (HIT) organizations. Each consortium will target its efforts on specific regional and local health markets. The consortia are being led respectively by:

—**Accenture**. The work will concentrate on the following market areas: Eastern Kentucky Regional Health Community, CareSpark (Tennessee), and the West Virginia eHealth Initiative.

—**Computer Science Corp**. Its focus will be the markets served by the Indiana Health Information Exchange, MA-SHARE (Massachusetts), and California's Mendocino Health Regional Exchange.

—**IBM**. This consortium will work in the markets served by New York's Taconic Health Information Network and Community, the North Carolina Healthcare Information and Communications Alliance (Research Triangle), and a similar entity in Rockingham County, NC.

—**Northrop Grumman**. Its focus will be the markets served by California's Santa Cruz Regional Health Information Exchange, and in Ohio, HealthBridge (Cincinnati) and University Hospitals Health System (Cleveland).

The four consortia also will work together to ensure that information can move seamlessly between each of the four networks to be developed. "The prototypes are the key to information portability for American consumers," said David J. Brailer, MD, PhD, HHS's national coordinator for health IT. "This is a critical piece of moving health IT from hope to reality."

The prototypes are to be in working order by the end of 2006, HHS said. They will test patient identification and information locator services; user authentication, access control, and other security protections and specialized network functions as well as test the feasibility of large-scale deployment. Once created and tested, the architecture for each of the networks will be placed in the public domain to stimulate others to develop further innovative approaches to implementing HIT.

The work of the consortia and other partners engaged in building the NHIN will inform the American Health Information Community, the federal advisory committee, which is charged with providing input to HHS and the industry on how to make health records digital and interoperable (*NIR, 26, 22/Sep 26 '05, p. 6)*. More details on these contracts are available at *www.hhs.gov/healthit*.

Change Announced In Billing For Non-Patient Lab Specimens

As of April 3, 2006, Medicare will implement a redefined Type of Bill (TOB) 14x to avoid overpayment for laboratory services furnished to non-patients. According to Change Request 3835 (October 28, 2005), any hospital (including a critical access hospital or CAH) receiving such specimens is to bill for the lab test on TOB 14x.

When lab services are rendered to non-patients by a CAH or a hospital subject to a state of Maryland waiver, the lab tests for these patients are to be paid via the Part B clinical diagnostic lab fee schedule, unlike lab tests for outpatients at these facilities. Lab tests for CAH outpatients are paid based on reasonable cost; those for outpatients of a Maryland waiver hospital are paid under the state's cost containment plan.

Since the definition of 14x was changed in the early 1990s to be for "all referred diagnostic services," Medicare lost the ability to differentiate between the lab specimens of non-patients and outpatients. There was also a need to distinguish between the two for certain pathology tests. So, as of the above implementation date, use of TOB 14x will be reserved for non-patient lab specimens.

♦ QUESTION *of the* M·O·N·T·H

*In the final Medicare physician fee schedule for 2006, the Centers for Medicare & Medicaid Services said it is withdrawing proposed practice expense relative value units (PE RVUs) and is using the 2005 values for most services (*NIR*, 27, 3/Nov 14 '05, pp. 1-2). But CMS did say it would make an exception for codes new in 2006. Does this affect the new surgical pathology codes 88333-34 and 88384-86?*

Yes. The values published for 2006 for new codes CPT 88333 and 88334—intraoperative cytopathology consultation 1 and 2, respectively—are correct. They are:

Code	Work RVUs	PE RVUs	Malpractice RVUs	Total RVUs (non-facility)
88333-26	1.20	0.53	0.04	1.77
88333-TC	0.00	0.55	0.04	0.59
88334-26	0.59	0.26	0.02	0.87
88334-TC	0.00	0.34	0.02	0.36

No values are listed for 88384, evaluation/molecular probes, 11-50, because these are to be carrier-priced next year. However, you can expect a technical correction from CMS about the published global and technical component values for 88385 and 88386—evaluation/molecular probes 51-250 and 251-500, respectively. The College of American Pathologists has confirmed with CMS that the agency erred in saying these values would be carrier-priced in 2006. According to CAP, the agency has accepted the direct practice expense data submitted by the College and approved by the RUC Committee.

CMS Cites Progress In Slashing Medicare Payment Errors

The Medicare payment error rate has been measured since 1996, when 14.2% of all payments were identified as improper.

In fiscal 2005, the rate for improper Medicare payments dropped by 50%, mainly due to improvements in getting documentation for claims, the Centers for Medicare & Medicaid Services has announced.

According to the agency's error rate short report, 5.2% of claims in fiscal 2005 were improperly paid, compared to 10.1% in 2004. That represents a $9.5 billion reduction in erroneously paid claims. The total for improperly paid claims in 2005 was $12.1 billion. Of the total improper payments, about $1 billion was in underpayments, the same as in the previous year.

CMS administrator Mark McClellan said the decline in payment error rates was "unprecedented," noting that the improvement stems from a reduction in errors related to insufficient and missing documentation for claims. He also credited Congress for beefing up financial support for Medicare program integrity initiatives and said CMS wants to achieve similar results in Medicaid, Medicare managed care, and prescription drug plans.

Claims error rates for Medicare fiscal intermediaries fell significantly from 16.4% to 3.4%, while the rates for carriers declined from 11.4% to 6.4%. The contractor category with the highest percentage of errors was durable medical equipment and regional carriers—the error rate dropped from 11.1% to 8.6%. For quality improvement organizations, however, error rates rose from 4.8% to 5.2%.

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