WASHINGTON G–2 REPORTS

NATIONAL INTELLIGENCE REPORT®

Covering Government Policy For Diagnostic Testing & Related Medical Services

Celebrating Our 27th Year of Publication

Vol. 27, No. 6, January 9, 2006

Medicare Physician Fee Fix Falters In The Homestretch

The physician fee cut is expected to be reversed when Congress clears a final deficit reduction bill, and organized medicine also wants an adjustment retroactive to January 1.

With Congress taking no final action on deficit reduction legislation before adjourning for the holidays last month, the 4.4% cut in Medicare payments for pathologist and other physician services in 2006 has kicked in as of January 1.

The House-Senate conference report on the deficit-cutting bill included a halt to the cut, required under the statutory formula for physician fee updates, and opted for a freeze—or zero update—on Medicare physician fees this year. The report cleared both chambers, but Senate Democrats, objecting to various Medicaid provisions, used a parliamentary procedure to send it back to the House for a second vote. By then, the House had closed shop, and it is not scheduled to get back to business until late January.

But the American Medical Association and other physician groups are already lobbying for a retroactive adjustment to Medicare ➥ *p. 2*

Medicaid Co-Pay: Next Battleground For Labs?

Clinical laboratory groups have been able thus far to thwart attempts to slap a co-payment on Medicare Part B lab services as well as lab testing under Medicaid—most recently, getting the state of Pennsylvania to decide against a lab co-pay for nearly 900,000 adult Medicaid recipients (*NIR, 27, 5/Dec 19 '05, p. 7*).

But a key Medicaid reform provision in the House-Senate compromise on deficit reduction, awaiting final congressional action, could reignite a state-by-state struggle over the issue of lab co-pays. The provision would give states added flexibility to reshape their Medicaid benefits and to increase cost-sharing, including premiums, deductibles, and co-payments. According to House Budget Committee estimates, this would produce $55 million in savings in 2006 and $3.18 billion over five years.

While the original Senate version of deficit reduction achieved much of its Medicaid savings from prescription drug reforms, the final compromise measure hews more toward the House approach, which would achieve savings by higher cost-sharing, tighter controls over access to Medicaid long-term care, and changes in calculating prescription drug prices. The National Governors Association has long backed increased Medicaid cost-sharing.

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Physician Fee Fix, *from p. 1*

payments when the deficit reduction bill is signed into law. They also intend to press hard this year to get Congress to eliminate the Sustainable Growth Rate factor, which drives the physician fee updates. Without this change, AMA warns, physicians face an annual round of fee reductions that could total 26% by 2011. In place of the SGR factor, AMA says pay updates should be based on practice cost increases.

Overall, the conference compromise on deficit reduction calls for $11 billion in Medicaid and Medicare spending reductions over five years as part of a curb of nearly $40 billion on entitlement spending over that period.

- ❑ In terms of Medicaid, the compromise reflects the House approach by wringing most of the $4.7 billion in net savings from recipients through increased cost-sharing and tougher controls on qualifying for long-term care (*related story, p. 1*).
- ❑ In terms of Medicare, the compromise exacts about $6.4 billion in net savings through various mechanisms, such as curbs on bad-debt payments to skilled nursing facilities, reduced payments for certain imaging services, a one-year freeze on home health payment rates (except rural home health agencies would get a 5% add-on), and acceleration of the phase-in, from five years to three years, of higher Part B premiums for the highest income seniors.

In other provisions, the conference report:

- ❑ Drops the Senate Finance Committee plan to eliminate the regional PPO stabilization reserve of $10 billion. The fund, authorized by the Medicare Modernization Act of 2003, is a financial incentive to be used to encourage preferred provider organizations to enter and stay in the Medicare managed care market (the new Medicare Advantage program). Retention of the fund is a victory for the White House, which had threatened to veto any bill that would scrap the reserve.
- ❑ Deletes the Senate Finance language calling for pay-for-performance initiatives for a host of Medicare providers, including hospitals, physicians, home health agencies, Medicare Advantage plans, and end-stage renal disease providers.
- ❑ Extends the current moratorium on new physician-owned specialty hospitals for up to eight months. The moratorium on physician referrals of Medicare and Medicaid patients to these facilities affects hospitals specializing in cardiac care, surgery, or orthopedics that were not in operation or under development as of November 18, 2003 (*NIR, 26, 16/Jun 6 '05, p. 7*). The Senate-passed version of deficit reduction advocated a permanent ban; the House version contained no moratorium.
- ❑ Requires more reporting of performance quality by hospitals. Starting in fiscal 2007, the bill would require them to report on existing complications and co-morbidities upon a Medicare patient's admission and would fine those that fail to report by reducing their market basket update by 2%.
- ❑ Authorizes a gainsharing demonstration under Medicare. The intent is to study the impact of arrangements between hospitals and doctors to share savings from hospital cost reductions achieved by operational efficiencies and quality improvements.

Update On HHS FY '06 Spending Bill

A renegotiated conference report on fiscal 2006 HHS-Labor-Education appropriations (H.R. 3010) cleared Congress on December 22, 2005, and has been signed into law (P.L. 109-149).

The measure provides nearly $142 billion in discretionary funds for health, education, and job training programs, plus an addition $90 million for rural health programs, and $28.6 billion (an increase of $253 million over the FY 2005 level) for the National Institutes of Health.

As expected, the allied health account, which includes funding for training programs for medical technologists and medical laboratory technicians, was drastically cut to $4 million. The Senate had originally approved $11.7 million, the same as the 2005 level, while the House had eliminated the support altogether (*NIR, 27, 5/Dec 19 '05, p. 1*).

The Senate agreed to the revamped conference report on December 21, pending House action to remove drilling in the Arctic wilderness preserve from a Defense Department appropriations measure. The House acceded the following day, clearing the way for the HHS bill to go to the White House.

The bill calls for the HHS Secretary to approve a pilot project by November 2006 and get it up and running in 2007. The HHS Office of Inspector General has been wary of gainsharing's potential to limit or reduce care and has warned that these arrangements, unless properly structured, risk violating various federal statutes, including anti-kickback law and the civil monetary penalties law.

House Approves Suspension Of CLIA Cytology PT

Reminder: Current cytology PT requirements under CLIA remain in effect, and laboratories, pathologists, and cytotechnologists must continue to comply with them. The bill that would suspend the rules for one year must clear the Senate before it can become law.

Shortly before adjourning last month, the House approved and sent to the Senate a bill that would suspend CLIA gynecologic cytology proficiency testing for one year and not allow it to resume until the program has been revamped along the lines advocated by the College of American Pathologists and a host of other national and state pathology societies.

The House acted on December 17 under a suspension of the rules and passed the legislation (H.R. 4568) by voice vote. During the one year that the federal cytology PT program would be shunted to limbo, the HHS Secretary would be required to modify it to:

- "Reflect the collaborative clinical decision-making of laboratory personnel involved in screening or interpreting cytological preparations;
- "Revise grading or scoring criteria to reflect current practice guidelines;
- "Provide for such testing to be conducted no more often than every two years; and
- "Make such other revisions to the standards for such testing as may be necessary to reflect changes in laboratory operations and practices since such standards were promulgated in 1992."

The legislation was introduced by Rep. Nathan Deal (R-GA), chairman of the House Energy & Commerce health subcommittee, which has jurisdiction over the CLIA cytology PT program.

Keeping The Heat On CMS

CAP hailed the House vote as a triumph for a lobbying and grassroots campaign that targeted the HHS Secretary and members of Congress (*NIR, 26, 17/Jun 20 '05, p. 3; 26, 18/Jul 11 '05, p. 6*). The College and other pathology groups launched the campaign after the Centers for Medicare & Medicaid Services began nationwide enforcement, as of January 2005, of the CLIA cytology PT requirements, more than a dozen years after the requirements became final. Despite criticism that the rules had become badly outdated, CLIA officials at CMS said they had no choice but to begin enforcing them on a national scale when an applicant came forth with an acceptable cytology PT program. That applicant was the Midwest Institute for Medical Education in Indianapolis, IN (*NIR, 26, 5/Dec 16 '04, p. 1*).

CAP has since been approved as a national cytology PT provider, beginning this year (*NIR, 26, 22/Sep 26 '05, p. 3*). But the College remains committed to an overhaul of current requirements. CAP president Thomas M. Sodeman, MD, said in a recent statement, "We fail to see how judging pathologists and other lab professionals by standards that lag well behind current best laboratory practices promotes quality care. In fact, it could jeopardize access to care by causing qualified professionals to stop performing Pap tests." CAP takes issue in particular with the focus on individual performance, rather than diagnoses reached through collaboration, as well as the grading criteria that have been "surpassed by new, universally recognized standards in gynecologic cytology."

CMS Says It's Willing To Review Program

For its part, CMS has signaled its willingness to work with CAP and other professional organizations to make improvements in the cytology PT program where appropriate. In response to the letter of June 3, 2005, from a coalition of some 60 national and state pathology societies asking for a review of the current program, Dennis Smith, director of the CMS Center for Medicaid & State Operations, said in an August 16 reply that it "is vital that we fulfill the PT expectations delineated in law by Congress … even as we simultaneously work to ascertain improvements that have merit."

And Smith pointedly noted that "we do not regard the issues you raise as reason to slow the excellent progress that labs are making in ensuring the proficiency of their workers, nor as reason to avoid full conformance with the PT requirements specified in law…." Smith's reply included an attachment presenting the agency's disagreements with several specific points asserted in the pathology coalition's letter.

More recently, CAP reported that in a conference call on December 29, 2005, CMS officials said they were preparing a recommendation to Smith and to his immediate boss, agency administrator Mark B. McClellan, MD, PhD, to hold off from any cytology PT penalties in 2006. This would keep the program as it was last year during its initial rollout when CMS said sanctions would not be imposed on labs, pathologists, or cytotechnologists for testing failures.

CAP also said it was assured that CMS officials would try to resolve scientific and other concerns about the PT program more quickly and would further consult with the Clinical Laboratory Improvement Advisory Committee and other professional societies on appropriate changes. CLIAC has already recommended that the government take a new look at the 1992 rules on which the current cytology PT program is based (*NIR, 26, 10/Mar 7 '05, p. 1*).

Part B Pay Adjustment Rule Finalized

The Medicare program has finalized in regulations its policy on how it will apply its authority to re-price Part B payment up or down for certain services on the basis of "inherent reasonableness."

Under this authority, the Centers for Medicare & Medicaid Services may deviate from certain payment methodologies to adjust the payment amount for a particular item or service if it is determined to be "grossly excessive" or "grossly deficient" and thus not "reasonable."

A payment amount would not be considered "inherently unreasonable," says CMS, if the overall adjustment is less than 15%. However, CMS adds, "This definition does not preclude adjustments of less than 15% in a given year, once it is determined that an overall adjustment of 15% or more is justified."

The "inherent reasonableness" rule does not apply to physician services or to services furnished under prospective payment systems, such as hospital outpatient services and home health services. Nor does it apply to Part B drugs.

The final rule, published in the December 13, 2005 edition of the *Federal Register*, takes effect February 13, 2006. It is basically the same as the interim final rule that has been in effect since February 11, 2003 (*NIR, 24, 9/Feb 24 '03, p. 3*).

Suppliers of medical equipment will most likely feel the impact of the rule in the future, CMS acknowledges, citing various government reports. One found that Medicare may be overpaying between $130 million and $958 million per year for 16 equipment items. Another found that Medicare may be overpaying for medical equipment by more than 20%.

In determining whether to adjust a payment amount that meets the threshold of "grossly excessive" or "grossly deficient," CMS or its local Part B carriers must use valid and reliable data, following a set of 11 criteria spelled out in the final rule. Before CMS or its carriers may make any change in payment, the proposed adjustment must be published for public comment. In addition, after public comment has been considered, carriers may not re-price items or services on their own until CMS tells them it has received notice of the change.

To date, the "inherent reasonableness" authority has not been applied to Part B clinical laboratory services, but it could be. In fact, the HHS Secretary's Advisory Committee on Genetics, Health & Society earlier this year urged the Secretary to direct CMS to "expeditiously" use this authority to raise fees for genetic test CPT codes (*NIR, 26, 19/Jul 25 '05, p. 5*). The panel cited concerns by lab and pathology interests that Medicare payment for genetic testing services was, in many cases, much lower than the cost of providing the services, and the current lab fee freeze is only aggravating this "no win" situation.

From 1984, when the Part B lab fee schedule was established, until the enactment of the Balanced Budget Act of 1997, Medicare was not authorized to apply "inherent reasonableness" to lab tests because payment for these tests was based on the fee schedule, not on "reasonable charges," says attorney Robert Mazer, a shareholder with Ober/Kaler in Baltimore, MD. "BBA 1997 permits 'inherent reasonableness' to be applied to lab tests."

Make Sure You Are Billing Modifier 59 Correctly

"Use of this modifier should be under the control of laboratory management, and how it is assigned should not be left solely to the billing department," says Dettwyler.

With an increasing number of procedures becoming subject to software edits under Medicare's Correct Coding Initiative (CCI), it has become increasingly important to use modifier 59 correctly to avoid automatic claims denials and legal problems, advises laboratory and pathology coding analyst William K. Dettwyler, MT, president of Codus Medicus Inc. (Salem, OR).

In fact, the HHS Office of Inspector General has recently concluded that the Medicare program needs tighter controls to prevent use of the modifier to bypass CCI edits and get paid for improperly coded services. Modifier 59 is one of 35 that, when used, bypass a CCI edit. The OIG has recommended that the Centers for Medicare & Medicaid Services get local carriers to do pre- and post-payment reviews on modifier 59 use and ensure that claims with it are paid correctly. CMS concurred with the recommendations.

CCI edits contain pairs of HCPCS/CPT codes that generally should not be billed together by a provider for a beneficiary on the same date of service. Under certain circumstances, a provider may bill for two services in a code pair and include a modifier on the claim that would bypass the edit and allow both services to be paid. When modifier 59 is used, the provider's documentation must show that the service was distinct from other services performed that day.

In the OIG study, 40% of code pairs billed with modifier 59 in fiscal 2003 did not meet program requirements—they were not distinct from each other, or the services were not documented. The result was $59 million in improper payments. In the study sample, modifier 59 was used inappropriately most often with the CCI

CPT's Definition Of Modifier 59

Distinct Procedural Services: Used to indicate that a procedure or service was distinct or independent from other service(s) performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances (for example, Culture, eye, 87070; culture, ear, 87070-59). This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury) not ordinarily encountered or performed on the same day by the same physician. Modifier 59 should be used only if no more descriptive modifier is available, and its use best describes the circumstances.

code pair for bone marrow biopsy (83221) and bone marrow aspiration (38220). A cytopathology code pair (88108/88104) represented six of the services billed inappropriately with the modifier. In most of these cases, the documentation showed that the services were performed on the same specimen and only one code should have been billed.

The OIG also found a potential high error rate and low frequency code pairs for any combination of the following pathology codes: 88104-88112 (excluding 88108/88104), 88160-88162, 88173, 88174, 88180, 88271-88275, and 88300-88365.

New Correct Coding Edits Proposed For Pathology

The proposed effective date for the 'medically unbelievable edits' is July 1, 2006.

In a client alert last month, attorney Jane Pine Wood noted that among the proposed new edits for pathology and other codes under Medicare's Correct Coding Initiative (CCI), the most significant edit for pathology would restrict the number of units of professional services that would be paid for each site and date of service. Claims for units in excess of the limits would be automatically denied.

According to Wood, who is with McDonald Hopkins (Cleveland, OH), "The proposed edits provide that only two CPT 88305s (Level IV – Surgical Pathology, Gross and Microscopic Exam) would be eligible for Medicare payment per site for a given date of service." The impact of this change could go well beyond Medicare, she added, since many private and commercial payers follow Medicare payment guidelines.

As part of the CCI implementation process, she continued, CCI sent the proposed edits to the American Medical Association, which passed them on to the College of American Pathologists for comment. Meantime, CAP has announced that it is "closely reviewing" the proposed units-of-service limits, called "medically unbelievable edits," and will submit its comments to the AMA by mid-January. The chair of CAP's Economic Affairs Committee, Mark S. Synovec, MD, FCAP, said in a statement, "We will develop clinical evidence of why these unit limitations are clearly inappropriate for pathology and pursue other measures, as appropriate, to fight this process, which appears to be seriously flawed."

How Satisfied Are Medicare Providers With Their Contractors?

That's the question the Centers for Medicare & Medicaid Services will pose this year to 25,000 randomly selected providers in the fee-for-service (FFS) program, including physicians, suppliers, healthcare practitioners, and institutional providers. This first-ever survey of provider satisfaction levels with FFS contractors kicks off this month and will be administered annually, CMS says.

Providers selected to participate will be notified by mail during the first week of January. The survey takes less than 30 minutes to complete, CMS says. Responses will be accepted through January 25. The survey questions will concentrate on seven

The goal is to get quantifiable data on provider satisfaction levels with key services performed by 42 FFS contractors that process and pay more than $280 billion in Medicare claims each year.

main areas of provider-contractor interactions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

CMS says it will use the results to help with its oversight of its Medicare contractors, and the contractors can use the results to improve the services they offer to providers. By early July, survey results should be available online, says CMS.

"We are bringing satisfaction measures and other quality measures to many aspects of Medicare to get the best possible performance for the dollars we spend," said CMS administrator Mark B. McClellan, MD, PhD. Provider satisfaction will be "one of the key considerations" in the agency's move to implement major contractor reforms required by the Medicare Modernization Act of 2003, he said.

McClellan was alluding to the upcoming transition to consolidate Part A and Part B functions into new entities called Medicare Administrative Contractors (MACs), eventually eliminating the current distinction between intermediaries and carriers. Under this new structure, companies other than health insurers will be able to compete, for the first time, to handle claims processing and related administrative functions. The transition to MACs is scheduled to begin this year, CMS has said, and the agency wants to wrap it up by 2009, though by law it has until 2011 to do so (*NIR, 26, 11/Mar 21 '05, p. 6*).

♦CODING A·D·V·I·S·O·R·Y

CMS Corrects RVUs For New Microarray Codes

An emergency update to the Medicare physician fee schedule for 2006 includes changes to status indicators and relative value units (RVUs) for two new microarray codes, 88385 and 88386. The update amends payment files sent to carriers based on the final fee schedule rule for 2006.

In the final rule, 88385 (global and technical component) and 88386 (global and technical component) were listed as carrier-priced, with no RVUs. This was in error, the Centers for Medicare & Medicaid Services acknowledged in response to questions raised by the College of American Pathologists. CMS told CAP it would accept the direct practice expense data prepared by CAP and approved by the RUC for use in this year's physician fee schedule, and would address the error in a fee schedule correction notice (*NIR, 27, 4/Nov 18 '05, p. 7*).

The correction notice, issued on December 30, 2005, designates the codes below as "active," with the following RVUs:

• **88385**, Array-based evaluation of multiple molecular probes, 51 through 250 probes Work RVU = 1.50 Non-Facility Practice Expense RVU = 7.10 Facility Practice Expense RVU = 7.10 Malpractice RVU = 0.12	• **88386**, Array-based evaluation of multiple molecular probes, 251 through 500 probes Work RVU = 1.88 Non-Facility Practice Expense RVU = 7.05 Facility Practice Expense RVU = 7.05 Malpractice RVU = 0.16
• **88385-TC** Non-Facility Practice Expense RVU = 6.45 Facility Practice Expense RVU = 6.45 Malpractice RVU = 0.06	• **88386-TC** Non-Facility Practice Expense RVU = 6.23 Facility Practice Expense RVU = 6.23 Malpractice RVU = 0.16

Source: CMS, Change Request 4268 (December 30, 2005). CPT codes © American Medical Assn.

Infobytes…

Comparing Hospitals On Quality: Thanks to a recent update by the Centers for Medicare & Medicaid Services, consumers can now view, on the Hospital Compare Web site, a full four quarters of data on the quality of healthcare furnished in over 4,000 participating locations. The site, www.hospitalcompare.hhs.gov, reports on 20 measures of hospital quality of care, including treatment of adults for heart attack, heart failure, pneumonia, or for prevention of surgical infections, says CMS (*NIR, 26, 13/Apr 25 '05, p. 5*). Consumers can search for hospitals by state, county, city, zip code, or by name. Hospital Compare displays how selected hospitals rate vs. each other and with hospitals in the state and nationally.

National Quality Reporting System: The Institute of Medicine has recommended that Congress establish a federal panel of experts to devise a national quality performance and measuring system for healthcare providers. The IOM says federal leadership and financial support are needed to produce a "coherent national quality program." While welcoming the pitch to Congress, some outside organizations are wondering to what extent their work will be recognized and continued if the federal government is seen as guiding the helm, according to *Modern Healthcare* interviews with health policy and hospital executives. Meantime, at the request of the Centers for Disease Control & Prevention, the National Quality Forum will hold a workshop on "Defining Quality in Laboratory Medicine" on January 11, 2006 in Arlington, VA. The aim is to define quality and brainstorm about priority-setting, says CDC.

 NATIONAL INTELLIGENCE REPORT (ISSN 0270-6768) is published twice monthly (except August and December which are one-issue months) by Washington G-2 Reports, 3 Park Avenue, 30th Floor, New York, NY 10016-5902. Telephone: (212) 244-0360. Fax: (212) 564-0465. Web site: www.g2reports.com. Order Line: (212) 629-3679.

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