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Medicare Revises Conversion Factor to Reflect Physician Fee Hike

Though benefiting from the revised CF, pathology payments are projected to be reduced by 2% due to changes in work and practice expense RVUs in 2008. Nonetheless, technical component fees for flow cytometry will continue to show major gains due to higher overhead RVUs (see table, p. 3).

The Centers for Medicare & Medicaid Services has announced a revised conversion factor for calculating Part B physician fees that reflects the 0.5% increase Congress approved, effective January 1, 2008, and blocks a 10% cut due to take effect this year under the statutory fee update formula. The CF translates a physician service's relative value units (RVUs) into a dollar amount.

Congress, however, approved the fee increase for only the first six months of this year, through June 30. As a result, CMS said, the revised CF for this period is $38.0870. The previously published CF for 2008 reflected a 10% cut under the SGR formula—to $34.0682. In 2007, the CF was $37.8975 (in effect, frozen at the 2005 level).

Absent further legislative changes affecting the last six months of this year, the 10% cut under the Sustainable Growth Rate (SGR) formula will apply to payment for services on or after July 1, 2008, CMS noted. The SGR ties the rate of spending growth for Medicare physician services to a target rate, based on spending growth in the total economy, among other factors. If the actual rate of spending growth exceeds the target, the update is decreased; if it is less, the update is increased. Since 2002, the SGR has *Continued on p. 2*

CMS Uses Crosswalks to Set Fees For New Lab Codes in 2008

Prices for new CPT codes added to the Medicare lab fee schedule in 2008 have been established using the crosswalk method, which matches payment rates to existing codes. There are no new test codes to be gap-filled, a method based on local pricing patterns.

The Centers for Medicare & Medicaid Services announced the crosswalk rates for the new codes in the final Part B lab fee schedule, released December 20, 2007, and effective January 1, 2008.

All other codes on the fee schedule remain frozen at their 2003 levels through 2008, the fifth and final year of the congressionally mandated freeze to the fee update. Also in 2008, the national minimum payment for Pap smears remains frozen at $14.76, the 2003 rate.

The travel allowance in 2008 to collect specimens from nursing home or homebound patients remains at the 2007 rates: P9603, $0.935 per mile (round to $0.94 if necessary) or P9604, $9.35 per flat rate trip basis. For more on changes to the lab fee schedule and other lab payment policies, see the *Focus*, pp. 4-6.

INSIDE *NIR*

Don't miss LabCompete, Feb. 6-8, Tucson, AZ. For info, go to ***g2reports.com/LabCompete08***

Physician Fee Hike, *from p. 1*

triggered fee cuts, but Congress has stepped in repeatedly to block the reductions.

In last-minute action before adjourning at the end of last year, Congress opted for a six-month stop-gap solution after House and Senate negotiators were unable to resolve differences over whether the 0.5% update should be for one or two years and how to pay for it without cutting deeply into Medicare managed care and risking a presidential veto. In the end, lawmakers made smaller managed care cuts and approved them, plus the fee increase and other Medicare payment policy extensions, in the omnibus government spending bill that President Bush has signed into law.

The Medicare compromises are limited to provisions of current law that expire at the end of this year. This bumps repeal of competitive bidding, but "we'll have another shot at it this year," said Alan Mertz, president of the American Clinical Laboratory Association, citing strong support in the Senate from the Finance Committee, including chairman Max Baucus (D-MT) and ranking Republican Charles Grassley (IA).

Certain Pathology TC Fees Continue Fast Rise

Technical component fees for flow cytometry and most in situ hybridization (fish) services continue to increase due to higher transitional practice expense RVUs (*see table*). Flow cytometry TC fees started to climb upward in 2006 after being slashed in 2005—sometimes by as much as 50%—when CMS first priced the new CPT flow cytometry codes that were introduced that year (*NIR 28, 6/Jan 15 '07, p. 3*). The interpretation fee for these codes, however, continues to decline due to reduced work and practice expense RVUs.

Other Payment Policies Get Six-Month Extension

The new spending law includes extensions of other expiring Medicare payment policy through June 30:

- ❑ The "grandfather" protection that allows qualified independent labs to bill Medicare Part B for the technical component of pathology services to hospital patients. The protection expired December 31, 2007.
- ❑ The Physician Quality Reporting Initiative (PQRI). Physicians who voluntarily report on a range of 119 performance measures for 2008 are eligible for a 1.5% bonus on total allowed charges for covered services. Pathologists are eligible for the PQRI for the first time this year, following CMS approval of reporting measures for breast and colorectal cancer (*NIR, 29, 4/Nov 19 '07, p. 6*).

More Time Allowed for Participation Decisions

Since there is a change to the 2008 fee schedule rates, CMS is extending the Participation Decision Period an additional 45 days, through February 15, 2008. All participating status changes will be effective January 1, 2008. To become a participating physician, CMS said, complete the CMS-460 form on the CD that was mailed to physicians in November or request the form from your local contractor. If you are changing your participation status to non-participating, send your request in a letter to your local contractor, postmarked by February 15, 2008.

Claims Processing Notice for Fee Increase

Medicare contractors have been instructed to be ready to process claims with January 2008 dates of service with the new fees, beginning January 7, 2008. The new fees are expected to be posted on local contractors' Web sites no later than January 11, CMS said. The "Medicare Physician Fee Schedule Look-Up" link on the CMS Web

site, which allows you to customize your search, will be updated with the new 2008 fees during the week of January 21. However, the carrier-specific public use files are available now for the new 2008 MPFS rates at the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage*.

Selected Pathology Codes: Final Non-Facility RVUs, Fees for 2008

CPT Code	*Work RVUs*	*PE RVUs (07/08)*	*Malpractice RVUs*	*Total RVUs (07/08)*	*Fee (07/08 scheduled/08 revised thru June 30)**
Flow Cytometry					
88184, 1st marker	0.00	1.60/1.89	0.02	1.62/1.91	$61.39/$65.07/$72.75
88185, add'l marker	0.00	0.85/1.07	0.02	0.87/1.09	$32.97/$37.13/$41.51
88187, read 2-8 markers	1.36	0.44/0.42	0.01	1.81/1.79	$68.59/$60.98/$68.17
88188, read 9-15	1.69/1.69	0.54/0.50	0.01	2.24/2.20	$84.89/$74.95/$83.79
88189, read 16 & more	2.23	0.68/0.61	0.01	2.92/2.85	$110.66/$97.09/$108.55
In Situ Hybridization (fish)					
88365-TC	0.00	1.88/2.33	0.02	1.90/2.35	$72/$80.06/$84.50
88367-TC	0.00	3.85/4.21	0.06	3.91/4.27	$148.18/$145.47/$162.631
88368-TC	0.00	2.46/3.20	0.06	2.52/3.26	$95.50/$111.06/$124.163

Source: Medicare physician fee schedule, 2008. CPT codes © American Medical Assn. *"Pure" fee, rounded up, not adjusted for geographic cost differences, using conversion factor of $37.8975 for 2007, $34.0682 for 2008 (scheduled), and $38.0870 (revised through June 30, 2008).

Senate Bill Introduced to Overhaul CLIA Cytology PT

The Senate now has a companion bill to a House measure that would scrap the current CLIA cytology proficiency testing program and institute a continuing medical education testing alternative for pathologists and others who screen for cervical cancer.

The bipartisan Senate bill—S. 2510, the *Cytology Proficiency Improvement Act of 2007*—was introduced December 19 by Sens. Mary Landrieu (D-LA) and Johnny Isakson (R-GA). Sen. Amy Klobucuhar (D-MN) has also signed on in support of the measure. The bipartisan House counterpart, H.R. 1237, was introduced February 8 of last year and is pending before the Energy & Commerce Committee (*NIR, 28, 10/Mar 12 '07, p. 2*).

For 2008, cytology PT testing continues under the current CLIA program. The College of American Pathologists and the American Society for Clinical Pathology are the two nationally approved PT providers. The Maryland health department runs an approved program for specimens of state residents.

The College of American Pathologists hailed the Senate action, noting that the "current cytology PT requirement, based on regulations written more than a decade ago, does not promote quality and cannot effectively assess the competency of individuals examining Pap tests." In a statement, CAP said that S. 2510 "would provide much needed reform by requiring those who read Pap tests to participate in a rigorous annual CME requirement … This would be an improvement over the PT approach because it would challenge screening and interpretation skills in a constructive learning environment, and over time, keep pace with advances in science and technology."

Continued on p. 7

focus on: *Lab Payment Policy*

Medicare Releases Lab Fee Schedule for 2008: *What the Payment Policies Mean for Your Lab*

The 2008 lab fee schedule is posted at www.cms.hhs.gov/ClinicalLabFeeSched.

In the final 2008 Medicare lab fee schedule released by the Centers for Medicare & Medicaid Services, the agency not only announced crosswalk pay rates for new CPT codes on the Part B schedule, but also reminded providers that payment rates remain in the deep freeze, in accord with the congressionally mandated freeze that ends December 31 of this year.

CMS spelled out lab fee schedule details and lab services subject to reasonable charge payment, effective January 1, in a transmittal to local Medicare contractors (Change Request 5813, December 20, 2007).

Separately, in an omnibus government spending bill that the President signed into law late last year, Congress approved an extension of reasonable cost reimbursement for outpatient clinical laboratory testing by certain small rural hospitals through June 30.

The bill also mandates reduced payment for diabetes lab tests approved for home use. Beginning April 1, 2008, these tests are to be paid at the same rate as other glycated hemoglobin tests. The current national Medicare cap for home-use A1c tests (CPT 83037) is $21.06, while the cap for other A1c tests (CPT 83036) is $13.56.

Summarized below are highlights of payment policies under the 2008 Medicare lab fee schedule, effective January 1.

Freeze on Fee Update Continues Through 2008

In 2008, for the fifth year in a row, Part B lab fees remain frozen at 2003 rates, in accord with the Medicare Modernization Act (Public Law 108-173). The Act imposed a five-year freeze on lab fee updates from January 1, 2004 (canceling a scheduled 2.6% increase) through December 31, 2008. The freeze affects both local fees and national fee caps (also known as national limitation amounts).

Freeze Continues for Pap Smears

For Pap smears, both diagnostic and screening, the national minimum payment remains frozen at the 2003 level of $14.76. These tests are paid at the lesser of the local fee or the national fee cap, but never below the national payment floor and never more than the actual charge. Affected codes include:

88142/G0123	88150	88164	88174/G0144
88143/G0143	88152	88165	88175/G0145
88147/G0147	88153	88166	P3000
88148/G0148	88154	88167	

No Change in National Fee Caps

Medicare's national fee limitation amounts remain set at 74% of the national median for those tests on the lab fee schedule that were capped prior to January 1, 2001. For tests whose national limitation amounts were first established on or after January 1, 2001, the caps are to be set at 100% of the national median, in accord with the

Benefits Improvement & Protection Act of 2000 (BIPA). This BIPA provision has been applied by CMS, since April 1, 2001, to 12 diagnostic/screening Pap smear codes involving thin-layer preparation and manual or automated screening or re-screening: 88142/G0123, 88143/G0143, 88147/G0147, 88148/G0148, 88174/G0144, and 88175/G0145.

2008 Medicare Fees for New CPT Lab Codes

Code	*Descriptor*	*Recommended Crosswalk/Fee**	*Final '08 Crosswalk/Fee**
Organ/Disease-Oriented Panel CPT 80047	Basic metabolic panel (Calcium, ionized): includes Calcium, ionized (82330), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea Nitrogen (BUN) (84520)	80048/$11.83: AACC, ASCP, CAP. ATP07/$11.42 + 82330/$19.09 = $30.51: ACLA, CLMA.	ATP07 + 82330/$30.51**
Chemistry			
CPT 82610	Cystatin C	83883/$19.00: AACC, ACLA, ASCP, CAP, CLMA.	83883 (nephelometry)/$19.00
CPT 83993	Calprotectin, fecal	83631/$27.42: ACLA, ASCP, CAP, CLMA. 83520 + 87015 = $27.42: AACC.	83631 (Lactoferrin, fecal; quantitative)/$27.42
CPT 84704	Gonadotropin, chorionic (hCG); free beta chain	82677/$33.79: AACC, ACLA, ASCP, CAP, CLMA.	84702 (hCG; quantitative)/$21.03
Immunology			
CPT 86356	Mononuclear cell antigen, quantitative, (eg, flow cytometry) not otherwise specified, each antigen	86355/$52.70: ASCP, CAP, CLMA. 86586/$52.70: AACC, ACLA.	86361 (absolute CD4 count)/$37.41
Microbiology			
CPT 87500	Vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique	87641/$49.04: CLMA. 87471/$49.04: AACC, ACLA. 87498/$49.04: ASCP, CAP. 87641/$49.04.	87641 (MRSA amplified probe)/$49.04
CPT 87809	Infectious agent antigen detection by immunoassay with direct optical observation; Adenovirus	87802/$16.76: AACC, ACLA. 87899/$16.76: ASCP, CAP. 87810/$16.76: CLMA.	87802 (Streptococcus B)/$16.76

Source: Final 2008 Medicare Part B lab fee schedule. *National fee cap. **New code 80047 is not capped. It is crosswalked to ATP07, a seven-test automated panel that most carriers pay at $11.42, plus CPT 82330, which is capped at $19.09.

 Acronyms: Amer. Assn. for Clinical Chemistry (AACC), Amer. Clinical Lab Assn. (ACLA), Amer. Society for Clinical Pathology (ASCP), College of American Pathologists (CAP), Clinical Lab Management Assn. (CLMA).

Travel Allowance Held to 2007 Level

In 2008, the Medicare trip fee to perform a specimen collection for nursing home or homebound beneficiaries remains, as in 2007 and 2006, at $0.935 on a per-mile basis (code HCPCS P9603) or $9.35 on a flat-rate basis (P9604). While the personnel portion of the trip fee formula is held to the 2003 level of $0.45, the standard federal mileage rate portion of the formula is $0.485 per mile.

Fee Crosswalks for New CPT Lab Codes

The new CPT codes added to the 2008 Medicare Part B lab fee schedule are payable at the crosswalked rates shown in the table (*p. 5*). The new codes address disease conditions such as kidney dysfunction leading to higher cardiovascular risk, irritable bowel syndrome, pregnancy screening, hospital-acquired resistance to antibiotics, and acute respiratory syndrome in children.

The fees set for chemistry 82610 and 83993 and for microbiology 87500 and 87809 are in line with payment rate recommendations from the national clinical laboratory and pathology groups shown in the table. For chemistry 84704, CMS finalized a lower rate than recommended.

With regard to new code 80047, basic metabolic panel (ionized calcium), CMS adopted the dual crosswalk—and higher pay rate—advocated by the American Clinical Laboratory Association and the Clinical Laboratory Management Association, which argued that separate instrumentation must be used to run the ionized calcium test in addition to the seven tests in the current basic metabolic panel (minus total calcium).

CMS matched 80047 to ATP07 (a seven-test automated panel) plus 82330 for the ionized calcium. The panel is not capped; the highest rate paid by most carriers for it is $11.42. The fee for 82330 is capped at $19.09. So, the highest fee for 80047 is $30.51.

Flow cytometry code 86356 is crosswalked to the rate for 86361 whose national cap is $37.41. Pathology and lab groups advocated payment at $52.70, the rate for 86586, which the new code replaces in 2008.

"G" Code for Hemoglobin A1c Dropped

CMS left out of the fee schedule transmittal any mention of its original proposal to create a new single HCPCS "G" code for hemoglobin A1c testing, replacing two CPT codes now in use, 83036 and 83037. Pathology and lab groups opposed the switch. The American Society for Clinical Pathology, the College of American Pathologists, and the Clinical Laboratory Management Association said it was unwarranted and an added reprogramming burden.

Codes Deleted From the 2008 Lab Fee Schedule

—CPT 86586, Unlisted antigen, each. For skin testing, unlisted antigen, use new code 86486 payable under the physician fee schedule, CMS said. For flow cytometry, quantitative, not otherwise specified, use new code 86356 on the lab fee schedule.
—G0265, Cryopreservation, freeze and storage.
—G0266, Thaw and expansion, frozen cel.

Price Mapping of New CPT Reproductive Medicine Codes

—89322, Semen analysis; volume, count, motility and differential using strict morphologic criteria (eg, Kruger)—89320 + 85007 = $21.65.
—89331, Sperm evaluation; for retrograde ejaculation, urine (sperm concentration, motility and morphology, as indicated)—89320 + 87015 = $26.17.

FDA Okays First Rapid Blood Test For Drug-Resistant Staph

The Food & Drug Administration has cleared for marketing the first rapid blood test for the drug-resistant staph bacterium known as MRSA (methicillin-resistant Staphylococcus aureus), which can cause potentially deadly infections such as blood stream infections, surgical site infections, or pneumonia.

The BD GeneOhm StaphSR Assay is manufactured by BD Diagnostics, a subsidiary of BD of Franklin Lakes, NJ. The test uses molecular methods to identify whether a blood sample contains genetic material from the MRSA bacterium or the more common, less dangerous staph bacterium that can still be treated with methicillin.

Methicillin is an antibiotic that has been used successfully to treat infections from the Staphylococcus aureus bacterium. Over the years, the staph bacterium mutated and spawned MRSA, a strain that is resistant to methicillin and which has a higher rate of being fatal.

The test can identify the MRSA bacterium in two hours, rather than lab personnel having to wait more than two days for test results, the FDA said.

"The BD GeneOhm test is good news for the public health community," said Daniel G. Schultz, MD, director of FDA's Center for Devices & Radiological Health, in a January 2 announcement of test approval. "Rather than waiting more than two days for test results, healthcare personnel will be able to identify the source of a staph infection in only two hours, allowing for more effective diagnosis and treatment."

Staph infections occur most frequently among persons in hospitals, nursing homes, and dialysis centers who have weakened immune systems. Both types of bacteria also can infect healthy people.

The FDA has issued several caveats on approved use of the test. In order to preserve the integrity of positive test results:

—The test should be used only in patients suspected of a staph infection.
—It should not be used to monitor treatment for staph infections because it cannot quantify a patient's response.
—Test results should not be used as the sole basis for diagnosis since they may reflect the bacteria's presence in patients who have been successfully treated for staph infections.

Also, the test will not rule out other complicating conditions or infections, the FDA cautioned.

CLIA Cytology PT, *from p. 3*

CAP is working in concert with a 66-member Cytology Improvement Coalition to gather additional support on Capitol Hill for H.R. 1237 and S. 2510.

The Senate bill further clarifies how CME results would be incorporated into the laboratory's quality assurance activities, CAP noted. "The lab director would utilize CME testing results, along with other CLIA established metrics, to assess individual performance and, if necessary, require remedial training or further continuing medical education. These CME results would be shared with and reviewed by the lab's accrediting organization as part of its inspection and accreditation process."

CMS to Delay Anti-Markup Rules for Certain Diagnostic Tests

The agency says it will issue clarifying guidance sometime over the next 12 months on several issues, including what constitutes the "office of the billing physician or other supplier" (NIR, 29, 4/Nov 19 '07, p. 4).

The Centers for Medicare & Medicaid Services has delayed until January 1, 2009, the applicability of anti-markup provisions under the Stark physician self-referral rules to certain services in certain locations. It does not apply to (1) anatomic pathology not performed in the "same building" in which a group practice generally furnishes services (as defined in the Stark rules) and (2) the technical component of any purchased diagnostic test.

Anatomic pathology now subject to anti-markup rules includes services performed in pod labs, attorney Robert Mazer, with Ober/Kaler (Baltimore, MD), told *NIR*. "It appears CMS concluded that if it eliminated pod labs, most everything else could wait. It's not surprising that pod labs were singled out. CMS has said these arrangements for pathology referrals prompted it to revise Medicare's anti-markup rules."

The anti-markup rules apply to the TC of any purchased diagnostic service (whether or not it is subject to Stark). And except for the PC of anatomic pathology performed by a group practice in a "centralized facility," the PC of diagnostic services would not be subject to anti-markup rules.

Lab Competitive Bidding Update: *Key Target Dates Set for Startup*

In a proposed timeline released this month, the Centers for Medicare & Medicaid Services announced the following key dates in the ramp-up of the Part B lab competitive bidding demonstration in the San Diego-Carlsbad-San Marcos metro area, the first of two sites where the pilot project is to run for three years (*NIR, 29, 5/Dec 17 '07, p. 1*).

- ❑ Bids due—February 15
- ❑ Winners selected—April 11
- ❑ Payments begin to be made under the competitively bid fee schedule, not the current lab fee schedule—July 1

In Washington, DC meantime, lab industry opponents are still lobbying Congress to repeal the demo. Bipartisan bills that would do just that are pending in the House (H.R. 3453) and the Senate (S. 2099).

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