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Rival Health Reform Plans Propose Medicare Spending Cuts

But both plans would provide new incentives for prevention, chronic disease management, and coordinated care in the program.

At the second presidential debate held Oct. 7, Republican Sen. John McCain and Democratic Sen. Barack Obama agreed that despite the economic picture, health care reform is a national priority on which action cannot be deferred, though they differ on the course they would take to achieve change.

Left unsaid is the fact that both the McCain and the Obama plans envision paying for the reforms in part by reducing Medicare spending. Neither plan is very specific about payments to be cut, though the Obama plan does single out Medicare managed care plans as a prime target. The McCain campaign says savings will come from eliminating Medicare fraud and by reforming provider payment policies to help lower the cost of care.

With the federal deficit ballooning and Medicare already due for more of a squeeze next year as Congress takes up a long-term physician fee fix in the billions of dollars, clinical laboratory groups are wary. They have already said their top legislative priority is to protect the Part B lab fee update and prevent any raid on lab spending to pay for increases elsewhere. For more on the political climate, see the *Focus*, pp. 4-5.

INSIDE *NIR*

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Are You Due a Trip Fee Adjustment?

That's an important question that clinical laboratory billing personnel should be asking about their per mile travel allowance claims paid by Medicare for dates of service from July 1 to Oct. 6.

Beginning Oct. 6, Medicare contractors are to implement an increase of 80 cents in the per mile trip fee (billing code P9603) payable to clinical laboratories when collecting specimens from nursing home and homebound Medicare beneficiaries.

The increase is effective as of July 1, but contractors are not required to search and adjust claims they have already processed "unless brought to their attention," said the Centers for Medicare and Medicaid Services in Change Request 6195 (*NIR, 29, 21/Sep 15 '08, p. 7*).

The new per mile trip fee is $1.035, up from the $0.955 rate in effect since the start of this year. The increase includes the federal mileage rate of $0.585 per mile, plus $0.45 per mile to cover personnel time and travel costs. Payment on a flat rate basis (P9604) remains unchanged at a minimum of $9.55. *Continued on p. 2*

Trip Fee Adjustment, *from p. 1*

To determine if your lab is entitled to the increase, you should promptly identify Medicare trip fee payments received for dates of service as of July 1 and later, then follow through with a request to your contractor for the fee adjustment.

The per mile travel allowance is used when the average trip to patients' homes is *longer than 20 miles round trip*, and is to be prorated where specimens are drawn or picked up from non-Medicare patients during the same trip.

This marks the second time this year that CMS has increased the per mile trip fee. As of June 30, contractors implemented an increase of 20 cents in that fee as well as the flat rate fee, raising them to $0.955 and $9.55, respectively. The increase was retroactive to Jan. 1, replacing rates of $0.935 and $9.35, in effect since the start of 2006 (*NIR, 29, 16/Jun 9 '08, pp. 1, 4-5*). Then, as now, contractors were not required to search and adjust unless asked to.

Medicare Publishes Edits for 'Medically Unlikely' Services

Reversing its long-held "restricted distribution" policy, the Centers for Medicare and Medicaid Services on Oct. 1 began publishing most of the Medically Unlikely Edits (MUEs) used to weed out improper Medicare payments and improve the program's accuracy in paying claims. CMS is only withholding those edits that are primarily designed to detect fraud.

The MUEs are limits on the units of service that can be billed for a particular CPT/HCPCS code per Medicare beneficiary per day. The MUE program was launched in January 2007, but until now CMS considered most edits to be confidential and said they had to be kept under wraps to prevent providers from "gaming the system."

The College of American Pathologists and the American Clinical Laboratory Association were among the many medical groups that have long urged CMS to disclose the MUEs. This is essential, they have told the agency, if providers are to submit accurate claims and avoid unwarranted denials. Otherwise, providers will not know when to apply an appropriate modifier to bypass the edit, and efforts to educate providers on MUEs and modifier use would be stymied (*NIR, 29, 1/Oct 8 '07, p. 8*).

At the start of the MUE program, there were edits for about 2,600 HCPCS/CPT codes. There have since been quarterly cumulative updates with additional codes. The version posted Oct. 1 contains edits for about 9,700 HCPCS/CPT codes that have been assigned unit values for MUEs, CMS said. They are posted at *www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage*.

The MUE program is designed to detect improbable claims, such as for procedures that could not have been performed on a particular patient (hysterectomies on men, for example) or for units of service that exceeded the likely amounts or could not have been correct under the clinical circumstances (for example, milliliters of a product sold only in liters).

While intended to reduce Medicare overpayments, the program has not shown any savings to date, CMS said. But the agency's acting chief, Kerry N. Weems,

said in a statement that it will help CMS "dramatically reduce costly payment errors."

Prior studies, including one by the HHS Office of Inspector General in May 2006, identified significant Medicare overpayments because provider or supplier claims sometimes reported too many units of service. These errors may be caused by numerous factors, including clerical errors and coding errors, the OIG observed.

In addition to publishing the MUEs, CMS also updated its web posting of "Frequently Asked Questions" about the program. The FAQs address such issues as whether claims denials based on the MUE program can be appealed and how claims are adjudicated using MUEs.

Provider Alert: Medicare Launches New Claims Audit Program

This is the first phase of the rollout to a national RAC program by Jan. 1, 2010, as required by the Tax Relief and Health Care Act of 2006.

Clinical laboratories, pathology practices, and anyone else billing Medicare Parts A and B now have someone else looking over their shoulder—Recovery Audit Contractors (RACs)—to double check whether their claims for services to beneficiaries have been overpaid or underpaid.

Contracts for four permanent RACs have been awarded, the Centers for Medicare and Medicaid Services announced Oct. 6 as part of its program integrity initiative. The four RACs will audit claims from providers in an initial 19 states, and additional states will be added to each RAC region during 2009, CMS said.

The program is an outgrowth of a demonstration project that used RACs to identify improper payments, both over- and underpayments, in six states—California, Florida, New York, Massachusetts, South Carolina, and Arizona. The demo recouped more than $900 million in Medicare overpayments between 2005 and 2008, CMS said, and nearly $38 million in underpayments was returned to providers.

The new RACs are:

- Diversified Collection Services, Inc., of Livermore, Calif.
  Region A: initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York.
- CGI Technologies and Solutions, Inc., of Fairfax, Va.
  Region B: initially working in Michigan, Indiana, and Minnesota.
- Connolly Consulting Associates, Inc., of Wilton, Ct.
  Region C: initially working in South Carolina, Florida, Colorado, and New Mexico.
- HealthDataInsights, Inc., of Las Vegas, Nev.
  Region D: initially working in Montana, Wyoming, North and South Dakota, Utah, and Arizona.

The RACs were selected based on competitive bids. They will be paid on a contingency fee basis on both the overpayments and underpayments they find. CMS also notes that the RAC program will be transparent and will be guided by medical expertise. Each RAC's web site will list the types of issues undergoing review. Each RAC will employ a full-time medical director to help in claims review. *Cont., p. 6*

focus on: Health Care Reform

Competing Remedies for What Ails the Health Care System

Health care reform is a top priority for action in their first year in office, presidential candidates, Republican Sen. John McCain of Arizona and Democratic Sen. Barack Obama of Illinois, told moderator Tom Brokaw at the Oct. 7 town hall debate. McCain said health care in America is a responsibility, and Obama asserted it should be a right (*see p. 5*).

A question from the audience touched on a sensitive nerve. "Selling health care coverage in America as a marketable commodity has become a very profitable industry. Do you believe health care should be treated as a commodity?" But Obama and McCain used the occasion to segue into a discussion of the particulars of their reform plans.

Similar Aims

Reform plans put forth by the McCain and Obama campaigns agree on broad goals:

- ❑ Curb rising costs in health care and lower spending.
- ❑ Expand access to health care coverage. Some 47 million Americans currently lack health insurance, including an estimated 8 million children, and the number is expected to increase as the economy sours and more and more individuals lose their jobs and their coverage or cannot afford to pay for coverage on their own.
- ❑ Ensure quality care at lower cost through adoption of electronic health records and emphasis on preventive services and coordinated care for chronic conditions.

Neither candidate backs an individual mandate requiring all Americans to obtain health insurance coverage, though Obama would require coverage for all children and would allow young people up to age 25 to continue coverage through their parents' plans.

Differing Rx

Despite similar goals, McCain and Obama differ sharply over specific methods to achieve them. McCain advocates an increased role for the private insurance industry where increased competition would lead to wider choice of coverage tailored to different needs among individuals and families.

Crucial to the McCain strategy:

- ❑ Provide individuals and families with tax credits to offset the cost of insurance. For individuals the credit would be $2,500; for families, $5,000. At the same time, the plan would, for the first time, tax workers for employer-paid health insurance premiums and use the money to help finance the tax credit.
- ❑ Provide for portability of health insurance coverage and allow people to purchase health insurance across state lines. McCain says he will work with state governors to develop a model Guaranteed Access Plan for those without prior group coverage and those with pre-existing conditions. There would be limits on premiums and there would be help for those below a certain income level.

Obama, in his bid to expand access and choice, would build on the current system of shared responsibility by employers, individuals, and the government. He would

require insurers to cover pre-existing conditions and would establish a new public insurance entity, as well as a National Health Insurance Exchange, to guarantee coverage to all who seek it, with subsidies for those with low income. The Exchange would offer a comprehensive benefit package similar to the Federal Health Benefits Program through which members of Congress get their coverage. It will cover all essential medical services, including prevention, maternity, and mental health care. Small businesses would get up to a 50 percent tax credit to help them provide coverage for employees.

At What Cost?

What would the plans cost? Obama's would cost an estimated $50 billion to $65 billion a year, his campaign estimates. It would be paid for in part by rolling back tax cuts for those making more than $250,000, by savings from adoption of electronic health information sharing among providers, and by allowing Medicare to negotiate prescription drug prices directly.

The McCain campaign says it has yet to tally the projected costs of the senator's plan. The nonpartisan Tax Policy Center in Washington, D.C., has estimated the tab at $1.3 trillion over 10 years, adding that the plan would enable as many as 5 million more people to have coverage. The center estimates that the Obama plan would cost $1.6 trillion over 10 years and cover 34 million more people.

Medicare to Help Pay the Tab

The Obama plan specifically targets Medicare managed care for cuts. It would pay Medicare Advantage plans the same rate as Medicare fee-for-service. Currently, MA plans receive 12 percent more than it costs to treat comparable beneficiaries through traditional Medicare, contends the Obama campaign.

McCain's senior policy adviser, Douglas Holtz-Eakin, said that the senator's tax credit would be funded in part by savings from Medicare to keep the plan budget-neutral, reported Laura Meckler in the Oct. 6 *Wall Street Journal*. Savings would come from eliminating Medicare fraud and by reforming payment policies to lower the overall cost of care, he said.

Both plans also aim to save on Medicare spending by improvements in prevention, health and wellness programs, chronic disease management, and coordination of care and would reward providers for meeting performance thresholds on clinically validated outcome measures.

Where the Candidates Stand

Moderator Tom Brokaw: *There are new economic realities out there and everyone in this hall and across this country understands some choices will have to be made. Health policies, energy, and entitlement reform … Which will be your highest priority your first year in office and which will follow in sequence?*

McCain: I think you can work on all three at once … As far as health care is concerned, obviously, everyone is struggling to make sure that they can afford their premiums and that they can have affordable and available health care … But we can do them all at once. We have to do them all at once. All three you mentioned are compelling national security requirements.

Obama: We're going to have to prioritize, just like a family has to … The things that have to be at the top of the list … Energy we have to deal with today … Health care is priority number two, because the broken health care system is bad not only for families, but it's making our businesses less competitive. And, number three, we've got to deal with education so that our young people are competitive in a global economy … And so we've got to prioritize both our spending side and our tax policies to make sure that they're working for you.

Brokaw: *Is health care in America a privilege, a right, or a responsibility?*

McCain: I think it's a responsibility, in this respect, in that we should have available and affordable health care for every American citizen, every family member. And the plan I have will do that. But government mandates I'm always a little nervous about. But it is certainly my responsibility. It is certainly small-business people and others, and they understand that responsibility. American citizens understand that. Employers understand that.

Obama: I think it should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can't pay their medical bills—for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying this may be a pre-existing condition and they don't have to pay her treatment, there's something fundamentally wrong about that.

Provider Alert, *from p. 3*

Before work begins, the RACs will hold town hall meetings for providers in affected states during October and November. Providers can get more information about these meetings and the date the program begins in their state, CMS said, by checking the web site, *www.cms.hhs.gov/RAC*.

Soon after this outreach, some health care providers in the states involved in the first phase may begin to receive either requests for medical records or a letter requesting that an overpayment be repaid for their claims submitted to and paid for by Medicare, CMS noted.

To prepare for the start of the program, CMS advises providers to consider conducting an internal assessment to ensure that submitted claims meet the Medicare rules. Other steps include:

- ❑ Identify where improper payments have been persistent by reviewing the RAC web sites and spot any patterns of denied claims within your own practice or facility.
- ❑ Implement procedures to respond promptly to RAC requests for medical records.
- ❑ If you disagree with a RAC determination, file an appeal before the 120-day deadline.
- ❑ Keep track of denied claims and correction of previous errors.
- ❑ Determine corrective action to ensure compliance with Medicare's requirements and avoid submitting incorrect claims in the future.

♦ Medicare Claims *Advisory*

Physician Signature Policy Updated for Lab Test Orders

Following through on its promise months ago to the American Clinical Laboratory Association, the Centers for Medicare and Medicaid Services has instructed its contractors to implement corrections to Medicare's physician signature requirements for lab claims, as of Sept. 30 (Change Request 6100).

CMS has restored language that was contained in Section 15021 of the Medicare Carriers Manual but was inadvertently omitted in the switch to the Internet-Only Manual. The "Definitions" section on diagnostic testing (Pub. 100-02, Chapter 15, Section 80.6.1), now states, "No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services."

The agency also added language to the manual to reflect the fact that while a physician order is not required to be signed, the physician must clearly document in the medical review his or her intent that the test be performed.

ACLA earlier this year alerted CMS that many of its member labs were receiving documentation requests from the CERT contractor for the physician's signature on both paper and electronic claims; without it, the contractor would recommend that the claim be rejected. "When the lab reports that no such document exists—nor is it required—the lab is told the testing is inappropriate. This [has happened] not only when the testing is ordered on paper (where there is no signature requirement), but even when the test is ordered electronically, where, of course, no physician signature would be expected to exist," ACLA said. Unless the situation is corrected, ACLA

said, "virtually every lab in the country is at risk for millions in recoupment," going back as much as five years (*NIR, 29, 15/May 26 '08, p. 5*).

CMS agreed with ACLA that according to national policy established via the congressionally mandated lab negotiated rulemaking, while a signed requisition would be proof of the treating physician's order, there are other permissible ways to document it. CMS instructed the CERT contractor to accept documentation of the treating physician's order in any format that clearly conveys the physician's intent that the test be performed. CMS also told ACLA it would update the Medicare Benefit Policy Manual to correct instructions released earlier this year (Change Request 5743, Jan. 11) which omitted the text stating that requisitions need not be signed.

♦ CLIA *Advisory*

New Waived Tests and Billing Codes Announced

The Centers for Medicare and Medicaid Services on Oct. 1 updated its list of clinical laboratory tests approved by the Food and Drug Administration as waived under CLIA (the Clinical Laboratory Improvement Amendments). The following tests have been added and must be billed with the QW modifier in order to be recognized by local Medicare contractors as a waived test.

New waived tests are approved on a flow basis and are valid as soon as they are approved. The list of CLIA waived tests and billing codes is typically updated quarterly. The Oct. 1 update is presented in CMS Change Request 6179, posted at *www.cms.hhs.gov/transmittals*.

CPT Code/Modifier	*Description*
87880QW	PSS World Medical Select Diagnostics Strep A Twist Jant Pharmacal Accutest Integrated Strep A Rapid Test Device Inverness Medical Biostar Acceava Strep A Twist Diagnostic Test Group Clarity Strep A Rapid Test Strips
80061QW, 82465QW, 83718QW, 84478QW	Abaxis, Piccolo xpress Chemistry Analyzer {Lipid Panel Reagent Disc} (Whole Blood)
82465QW, 82947QW, 82950QW, 82951QW, 82952QW, 83718QW, 84478QW, 84450QW, 84460QW	Abaxis, Piccolo xpress Chemistry Analyzer {Lipid Panel Reagent Disc} (Whole Blood)
82042QW, 82150QW, 82247QW, 82977QW, 84157QW, 84075QW, 84450QW, 84460QW	Abaxis, Piccolo xpress Chemistry Analyzer {Liver Panel Plus} (Whole Blood)
83900QW	SpermCheck Vasectomy
83520QW	HemoCue Albumin 201 System

Lab Test Payments Under the OIG's Microscope

The OIG plans a broad range of studies in lab areas, including Medicare payments for unlisted procedure codes (these are priced by contractors) and appropriate use of the modifier GY on claims for services that Medicare does not cover.

According to its just released work plan for fiscal 2009, the HHS Office of Inspector General will scrutinize whether clinical laboratories have inappropriately unbundled profile or panel tests to maximize Medicare reimbursement, in particular, by submitting claims for multiple dates of service or by drawing specimens on sequential days. The OIG also will see whether contractors have controls in place to detect and prevent such unbundling.

Contractors are required to group together individual lab tests that clinical labs can perform at the same time on the same equipment and then consider the price of the related profile tests. Payment may not exceed the lower of the profile price or the total price of all the individual tests.

Also on the lab "watch" list is the extent of variation in lab test payment rates among Medicare contractors. In 2007, Medicare payments for lab services exceeded $6 billion, the OIG notes. Prior studies by the OIG found that Medicare had paid significantly higher prices than other payers for certain lab tests. In the coming year, the OIG says it will analyze claims data to determine pricing variances among Medicare contractors for the most commonly performed tests.

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