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Key Senators Push for Early Action on Health Care Reform

Efforts at a systemic overhaul have been dead since the Clinton plan collapsed in 1994, but prospects for fundamental change this time around are looking better. The issue is no longer being seen in isolated terms, but as an essential part of initiatives to help jump-start the economy.

While proposals for comprehensive health care reform are expected to be introduced early in the 111th Congress, which opens in January, key Senate Democratic health leaders advocate action on some priorities in an anticipated economic stimulus package.

Max Baucus of Montana, who chairs the Senate Finance Committee, said Dec. 10 that he expects a health care reform bill to be ready early in 2009 but supports inclusion of health information technology and a short-term reauthorization of the State Children's Health Insurance Program (SCHIP) in the package.

A short-term renewal of SCHIP would allow time for children's health coverage to be part of comprehensive reform efforts, Baucus said. In his own reform plan, Baucus calls for states to use SCHIP to cover all children in families with incomes up to 250 percent of the federal poverty level and who are not eligible for Medicaid. *Continued on p. 2*

Obama Picks Daschle as HHS Secretary, 'Lead Architect' for Health Reform Plan

President-elect Barack Obama made it official on Dec. 11: As expected, former Sen. Tom Daschle of South Dakota is his choice to become Health and Human Services secretary. Obama said Daschle also will serve as director of the White House office of health reform. "He will be responsible not just for implementing our health care plan. He will also be the lead architect of that plan."

Daschle is widely recognized as a health care expert and an advocate of universal coverage through expanded choices. He also backs comparative effectiveness research to advise on drugs and treatments that should be covered.

Obama's pick of Daschle has been known unofficially for some time, drawing praise from Senate Democratic and GOP health leaders and from business and provider groups, all saying his legislative credentials equip him to work well with Congress on health care reform initiatives.

Daschle represented South Dakota in Congress for 26 years. He was elected to the House in 1978 and to the Senate in 1986. He served as Senate Democratic leader from 1995 until 2004, when he lost his re-election bid.

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Health Care Reform, *from p. 1*

Baucus said health IT is necessary infrastructure spending, with grants and Medicare incentives as possible ways to spur its adoption by providers. This will require big up-front investment, he acknowledged, noting it may be easier to include some of those costs in the stimulus package, avoiding congressional pay-as-you-go rules.

Sen. Tom Harkin of Iowa has called for increased attention to prevention and public health in the health care reform debate, saying that some measures could serve as an economic stimulus, including support for the public health work force.

"A robust emphasis on wellness is about saving lives, saving trips to the hospital, and saving money, and it's the only way we are going to get a grip on skyrocketing health care costs," he said during a Dec. 10 hearing of the Health, Education, Labor, and Pensions (HELP) Committee. Larkin chairs the committee's working group on prevention and public health, one of three formed by HELP chairman Edward Kennedy (Mass.) to craft legislative proposals for health care reform.

Three public health organizations in a Dec. 10 letter urged Harkin to increase federal support for state health departments to allow them to hire an additional 100,000 state and local public health employees. "The increase is consistent with Obama's support for investment in the nation's infrastructure," said the presidents of Partnership for Prevention, the American College of Preventive Medicine, and the Association of State and Territorial Health Officials.

Obama Sees Health IT as Key Investment

In a Dec. 6 radio and Web address, Obama touted health care reform as a way to jump-start the economy and pointed to investment in health IT as a way to create jobs while reducing health care spending in the long term. "We will make sure that every doctor's office and hospital in this country is using cutting-edge technology and electronic medical records so we can cut red tape, prevent medical mistakes, and help save billions of dollars each year."

In previous remarks, Obama has noted, "Somebody's got to help set up those health IT systems. We've got to buy computer systems and so forth. That's an immediate boost to the economy, in some cases working with state and local governments, but it's also laying the groundwork for reducing our health care costs over the long term."

Promoting adoption of health IT is a point on which bipartisan support should be easy to reach. Sen. John McCain (R-Ariz.) agreed with Obama on the campaign trail about the importance of switching to a national system of e-health records for both quality patient care and program savings.

Political Stars Aligning on Health Care Reform

Business, labor, and consumer groups, historically at odds over health care reform plans, have signaled they are united this time in urging Congress to take bold action to overhaul the system. Analysts say there is a consensus among all the players on general principles, such as universal coverage, continuing the employer-based system by which most Americans get health insurance, lowering costs and rewarding quality care. However, some thorny issues are yet to be resolved: Will the uninsured have to buy private coverage or be enrolled in a new government insurance plan similar to the one federal employees already enjoy, and what means would be used to require individuals or businesses to get insurance?

focus on: *Medicare Payment Policy*

What's New in the New Year for Labs, Pathologists?
A Quick Guide to Medicare Changes Effective Jan. 1, 2009

Increase in Lab Fees

Tests payable under the Part B clinical laboratory fee schedule increase 4.5 percent, the first increase allowed since 2003. The five-year freeze on the lab fee update, imposed by Congress starting in 2004, expires at the end of this year. Accordingly, lab fees were slated by law to get the full consumer price index (CPI) update in 2009.

However, in legislation enacted in July (the Medicare Improvements for Patients and Providers Act, MIPPA), Congress reduced the lab fee update by 0.5 percent in each of the next five years, from 2009 through 2013. Protecting the update from any further cuts to pay for other Medicare spending increases is a top legislative priority for the clinical laboratory industry.

Increase in Physician Fees

Congress approved a 1.1 percent increase on average in 2009 reimbursement for services covered by the Part B physician fee schedule. The actual gain will vary by individual physicians, according to specialty, mix, and volume of covered services they provide. The conversion factor for 2009, used to translate a physician service's relative value units into a dollar amount, is $36.0666.

Had lawmakers not stepped in, physician fees were to be cut 15.1 percent on average under the statutory Sustainable Growth Rate (SGR) update formula. For physician groups, repeal of the SGR is a top legislative priority for 2009, since it is due to require another deep cut in 2010. 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 triggered fee cuts, but Congress has stepped in repeatedly to block the reductions. The House last year passed a Medicare provision that repealed the SGR and replaced it with expenditure targets for six categories of physician services, but there was no Senate counterpart language and the provision was not included in final Medicare legislation.

Pathology Payment Changes

❑ ***Total Allowed Charges***

For pathology, the increase in total allowed charges in 2009 is 1 percent versus a cut of 6 percent had the SGR formula update taken effect. For independent laboratories, the increase is 2 percent versus a zero update under the SGR, while diagnostic testing facilities are cut by 6 percent.

Combined 2009 Total Allowed Charges: Impact of Work, Practice Expense and MIPPA* Changes

	Allowed charges (in millions)	*Work, PE changes***	*MIPPA 133(b)*	*MIPPA 131 update*	*Total****
Pathology	$1,007	0%	0%	1%	1%
Independent laboratory	$878	5	-4	1	2
Diagnostic testing facility	$1,186	-2	-5	1	-6

Source: CMS.
*The Medicare Improvements for Patients and Providers Act.
**PE changes are third-year transitional changes.
***Components may not sum due to rounding.

Of the 54 specialties cited in the final 2009 physician fee schedule rule, pathology is one of nine to get an increase of 1 percent in total allowed charges. Eight specialties get no increase, 11 are cut (the steepest are diagnostic testing facilities, down 6 percent, and audiologists, down a whopping 10 percent), and the remainder get increases ranging from 2 percent to 4 percent, while only one, nurse anesthetist, gets a 5 percent gain.

Most pathologists will see a modest increase in 2009 in Medicare reimbursement for frequently performed procedures. For example, the global fee for CPT 88305, the most frequently billed surgical pathology code, will rise by 1 percent, to $103.87. The professional component is being increased by 2.7 percent, to $37.15; the technical component goes up by 0.1 percent, to $66.72.

❑ *Flow Cytometry*

Technical component fees for flow cytometry and most in situ hybridization (fish) services remain on the rise, benefiting from higher transitional practice expense RVUs (*see table*). Flow cytometry TC fees started to climb in 2006 after being slashed in 2005—sometimes by as much as 50 percent—when CMS first priced the new CPT flow cytometry codes that were introduced that year (*NIR 28, 6/Jan 15 '07, p. 3*).

Flow Cytometry, In Situ Hybridization Codes: Final Nonfacility RVUs, Fees for 2009

CPT Code	*Work RVUs*	*PE RVUs (08/09)*	*Malpractice RVUs*	*Total RVUs (08/09)*	*Fee (08/09)**
Flow Cytometry					
88184, 1st marker	0.00	1.89/2.15	0.02	1.91/2.17	$65.07/$78.26
88185, add'l marker	0.00	1.07/1.27	0.02	1.09/1.29	$37.13/$46.53
88187, read 2-8 markers	1.36/1.36	0.42/0.41	0.01	1.79/1.78	$60.98/$64.20
88188, read 9-15	1.69/1.69	0.50/0.49	0.01	2.20/2.19	$74.95/$78.99
88189, read 16 & more	2.23/2.23	0.61/0.55	0.01	2.85/2.79	$97.09/$100.62
In Situ Hybridization (fish)					
88365-TC	0.00	2.33/2.67	0.02	2.35/2.69	$80.06/$97.02
88367-TC	0.00	4.21/4.81	0.06	4.27/4.87	$145.47/$175.64
88368-TC	0.00	3.20/3.93	0.06	3.26/3.99	$111.06/$143.90

Source: Final rule, Medicare physician fee schedule, 2009. CPT codes © American Medical Assn. *"Pure" fee, rounded up, not adjusted for geographic cost differences, using conversion factor of $34.0682 for 2008 and $36.0666 for 2009.

❑ *Reporting on Quality*

Pathologists and other eligible Part B providers are entitled to an incentive payment of 2 percent of total allowed charges for successfully participating in the 2009 Physician Quality Reporting Initiative (PQRI). The final physician fee schedule rule added 52 new PQRI measures for a total of 153. The total includes approved pathology measures for:

—Breast cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade.

—Colorectal cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade.

Anti-Markup Restrictions on Diagnostic Testing

CMS will begin to apply anti-markup rules for diagnostic testing services (other than clinical lab services) billed to Part B. "The rules apply to services ordered by physicians, medical groups, and other suppliers regardless of specialty, including pathologists and radiologists who may order diagnostic tests that were not specifically requested by the referring physician," notes attorney Robert E. Mazer, with Ober/Kaler (Baltimore), in an analysis posted on the G2 Web site (*www.g2reports.com*). "As in the case of tests ordered by other physicians, the payment limits apply only if the billing physician or other supplier (or a party related by common ownership or control) orders the test."

A key criterion in determining whether anti-markup rules apply is "sharing a practice," defined as a situation where the physician performs "substantially all" of his or her professional services for the billing physician or supplier. "Substantially all" means at least 75 percent of a physician's services.

To satisfy this standard, CMS offers two alternatives, Mazer points out. "The first relates to the extent to which the physician supervising the technical component (TC) or performing the professional component (PC) practices as part of the entity billing for the service. If the services generally provided by the performing physician are sufficiently related to those of the billing entity under the CMS criterion, then the physician will be deemed to share a practice with that entity. In that event, none of the services furnished by the physician on behalf of the billing physician or supplier will be subject to the payment limits.

"The second alternative is based on the site of service and whether the performing physician supervised the TC or performed the PC in the same location where the physician or other supplier ordering the service provides patient care services. Unlike under the first alternative, this may be available when the physician performing the diagnostic test has only a limited relationship with the entity billing for the service. The second alternative is applied on a test-by-test basis. Therefore, this analysis is required only when the physician does not share a practice with the billing physician or supplier under the first alternative."

When the payment limits apply, Medicare payment will be the lowest of the following (less any applicable deductible or coinsurance):

—The performing supplier's net charge to the billing physician or other supplier (excluding any charge related to the cost of space or equipment leased from or through such physician or other supplier);

—The billing physician or other supplier's actual charge; or

—The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

New and Revised CPT Lab Codes for 2009

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New Codes

The following new codes are added to the Pathology and Laboratory section of the CPT coding manual, effective Jan. 1, 2009.

Chemistry

83876 Myeloperoxidase (MPO). MPO appears to independently predict early risk of myocardial infarction and other major adverse cardiac events in the ensuing one to six months. In contrast to troponin T, CK-MB and hsCRP MPO levels may identify patients at risk for cardiac events in the absence of myocardial necrosis and assist in stratifying chest pain patients.

83951 Oncoprotein; des-gamma-carboxy prothrombin (DPC). DPC is an important prognostic indicator in patients with small cell hepatic carcinoma. A high preoperative DPC level appears to be indicative for tumor recurrence. Many patients with a high DPC level also develop extra hepatic recurrence; thus, whole body scanning for such patients is advisable.

Hematology and Coagulation

85397 Coagulation and fibrinolysis, functional activity, not otherwise specified (eg, ADAMTS-13), each analyte. This code was created to report functional activity of proteins that affect coagulation and fibrinolysis, such as ADAMTS-13 (also known as von Willebrand factor-cleaving protease). Thrombocytopenia purpura (TTP) and life-threatening microangiopathic hemolytic anemia have been linked to abnormalities of ADAMTS-13.

Microbiology

87905 Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid). This code is used to report measurements of enzymatic activity caused by the presence of infectious agents. For example, sialidase in vaginal fluid is highly correlated with bacterial vaginosis. This code is used to report point-of-care tests such as the BV Blue test by Genzyme that provide rapid diagnosis for bacterial vaginosis.

In Vivo (eg, Transcutaneous) Laboratory Procedures

This is a new subsection in the Pathology and Laboratory section of the CPT 2009, replacing the previous Transcutaneous Laboratory Procedures subsection.

88720 Bilirubin, total, transcutaneous. This code is simply a renumbering of former code 88400, which has been deleted.

88740 Hemoblobin, quantitative, transcutaneous, per day; carboxyhemoglobin. Carboxyhemoglobin is used primarily to diagnose carbon monoxide poisoning. It can now be measured using a simple noninvasive sensor on the finger, eliminating the need to collect and analyze a blood specimen.

88741 Hemoblobin, quantitative, transcutaneous, per day; methemoglobin. Methemoglobin is a form of hemoglobin that does not bind oxygen. When its concentration is elevated in red blood cells, anemia and tissue death can occur. Exposure to oxidizing drugs and their metabolites may accelerate the rate of formation of methemoglobin up to one-thousandfold, overwhelming the protective enzyme systems and acutely increasing methemoglobin levels. Other classical drug causes

of methemoglobinaemia include antibiotics and local anesthetics. Infants under six months of age are particularly susceptible to methemoglobinemia caused by nitrates ingested in drinking water, dehydration caused by diarrhea, sepsis, and topical anesthetics.

0194T Procalcitonin (PCT). Procalcitonin levels can be used to differentiate inflammatory versus infectious disease, especially in such common ailments as chronic obstructive pulmonary disease (COPD). It is presently used extensively in Europe as a means of ruling out bacterial infection in patients presenting in the emergency room. Although given a tracking code this year, the increasing use of this test will probably allow it to be granted a regular category I CPT code in the near future.

Revised Codes

The lists of tests included in the basic metabolic panel (80048), comprehensive metabolic panel (80053), and renal function panel (80069) are revised to clarify that they include total calcium (82310), not ionized calcium.

The codes for albumin (82040), total protein (84155), potassium (84132), and sodium (84295) are revised to include plasma and whole blood in addition to serum as specimen sources to accommodate new CLIA waived point-of-care analyzers that utilize whole blood specimens.

The following molecular diagnostic codes are revised to clarify the units of service to be reported. Also, the introductory language for this section now notes that each nucleic acid preparation may include a "digestate, undigested nucleic acid or other uniquely modified nucleic acid sample such as a newly synthesized oligonucleotide."

—83890 Molecular diagnostics; molecular isolation or extraction, ~~each nuclear acid type (ie, DNA or RNA)~~

—83891 isolation or extraction of highly purified nucleic acid, ~~each nucleic acid type (ie, DNA or RNA)~~

—83892 enzymatic digestion, ~~each nuclear acid preparation~~

—83893 dot/slot blot production, ~~each nucleic acid preparation~~

—83894 separation by gel electrophoresis (eg, agarose, polyacrylamide), ~~each nuclear acid preparation~~

—83897 nuclear acid transfer (eg, Southern, Northern), ~~each nuclear acid preparation~~

—83907 lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue), ~~each specimen~~

—83909 separation and identification by high resolution technique (eg, capillary electrophoresis), ~~each nucleic acid preparation~~

Opiates are now defined as "drug and metabolites, each procedure" to eliminate confusion over how many times the codes can be submitted when multiple opiates or metabolites are determined at the same time.

—83925 Opiate(s), ~~(eg, morphine, meperidine)~~ drug and metabolites, each procedure

Also, the following two codes are revised for added clarity and precision.

—85375 ~~Carbon monoxide~~ **Carboxyhemoglobin**; quantitative

—85376 ~~Carbon monoxide~~ **Carboxyhemoglobin**; qualitative

CMS to Expand Coverage of Prothrombin Time Testing

PT testing (CPT 85610) was third in volume among the top 100 pathology and laboratory codes ranked by Medicare-allowed services in 2006, according to CMS data, totaling 21.457 million in allowed services and nearly $117 million in allowed payments.

The Centers for Medicare and Medicaid Services will add "secondary malignant neoplasm of the liver" to the list of Medicare-covered conditions for prothrombin time (PT) testing. CMS said it has accepted a request to do so from the Ingham Regional Medical Center in Lansing, Mich.

In a Nov. 24 memo, CMS said it will add the ICD-9-CM diagnosis code for this condition, 197.7, to the list of ICD-9 codes covered under Medicare's national coverage decision (NCD) for PT testing, one of the 23 NCDs established under the lab negotiated rulemaking process. The effective date of the revision will be announced in an upcoming update notification, the agency said.

PT testing is frequently used to assess patients with signs of abnormal bleeding or thrombosis, evaluate patients with a history of a condition known to be associated with the risk of bleeding or thrombosis that is related to the extrinsic coagulation pathway, and other conditions, noted the CMS decision memo (*www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=225*).

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