NATIONAL INTELLIGENCE REPORT™

Covering Government Policy For Diagnostic Testing & Related Medical Services

Celebrating Our 36th Year of Publication

Vol. 15, Iss. 2, January 26, 2015

INSIDE *NIR*

www.G2Intelligence.com

Upcoming Conferences

Lab Revolution
March 11-14, 2015
Loews Portofino Bay Hotel at Universal Orlando®
www.LabRevolution.com

PATH*FORWARD*
How Pathology Can Evolve While Boosting the Bottom Line
March 14, 2015
Loews Portofino Bay Hotel at Universal Orlando®
www.LabRevolution.com/pathforward.html

FDA Holds LDT Workshop Amid Flurry of Debate as Comment Period Nears End

During and surrounding two days of public comment at an FDA-sponsored workshop, various stakeholders sounded off on the LDT regulation debate. As we reported, just prior to the FDA workshop, the American Clinical Laboratory Association issued a white paper with a not-so-veiled threat of litigation (See *NIR*, 1/8/15, p. 1). Additionally, JAMA published two Viewpoints highlighting the issues on each side of the debate, while the Association for Molecular Pathology (AMP) issued its own white paper addressing not only LDTs but genomic testing in general and the regulatory challenges and reimbursement barriers that together AMP asserts are brewing a "perfect storm."

With the period for public comment ending Feb. 2, we'll take a look at the issues being debated with some feedback from the experts on what this all means.

Varied Interests Represented

A broad spectrum of interests were represented at the FDA Workshop including not only laboratories and laboratory-specific associations but other health care organizations such as the American Medical Associa-

Continued on page 2

Daiichi CIA Provides Compliance Guidance for Arrangements with Physicians

Any laboratories that make arrangements with physicians to provide speaking or consulting services should take note of a $39 million settlement of kickback allegations recently announced by the Department of Justice. A pharmaceutical company, Daiichi Sankyo, agreed to settle allegations that it paid kickbacks to induce physicians to prescribe its drugs, according to a Justice Department press release. The company also entered into a Corporate Integrity Agreement that requires specific compliance activities be undertaken.

Daiichi was alleged to have paid kickbacks via speakers fees through its Physician Organization and Discussion programs (called PODs) over at

Continued on page 7

FDA Holds LDT Workshop Amid Flurry of Debate as Comment Period Nears End, *from page 1*

tion, American Heart Association, and organizations representing specific conditions such as Lyme disease, infectious disease, transplantation and cancer. The medical device manufacturing industry, academic institutions and even the venture capital investment sector also weighed in on the issues. Washington, D.C. health care attorney, Barbara Cammarata, of Sidley Austin LLP, sums up the varying stakeholder positions noting "there are so many [stakeholders] in the industry with different needs and everyone is looking for that level playing field."

Many stakeholders also spoke about the interests of physicians and patients, highlighting the potential that regulation could prevent key tests from making it to market. This would hurt patients from a diagnostic and treatment standpoint and "treating physicians won't have access to the same arsenal of tests that they otherwise would have," says attorney Richard S. Cooper, of McDonald Hopkins, in Cleveland. Although Palmetto GBA did present and participate in a panel discussion, Cammarata notes that perhaps the most notably absent party was CMS – whose absence she characterizes as the "elephant in the room" due to the importance of reimbursement to the discussion.

Working Out the Details

The FDA workshop organized public comment and panel discussions around six topics focusing on components and labeling, clinical validity and intended use, categories for continued enforcement discretion, adverse event reporting, classification, and quality system regulation. Throughout those six sessions, repetitive issues and concerns were raised about how this regulation will be implemented and what details are still needed. Beyond whether the FDA has the legal authority to do this or whether they ought to do it from health care quality standpoint there is "just the issue of clarity, how it's really going to work in practice," says Cooper.

Classifications

Many speakers questioned the current proposed framework's classification of LDTs into categories and asked for more detailed guidance from the FDA on how tests would be classified. "They talk about certain factors that are going to be considered but I'm not sure anyone is comfortable looking at their test menu and saying which tier their tests are going to fall into," says Cooper. "There needs to be greater clarity about which tests are going to fit in which category and which elements are going to be used to make that determination," he adds, echoing the sentiment expressed by many of the workshop presenters.

Washington D.C. lawyer, Jeffrey N. Gibbs, of Hyman, Phelps & McNamara P.C., who spoke at the workshop about categories for enforcement discretion, adds: "We are talking about classifying thousands of different tests and we don't know what the criteria will be. … It makes it difficult to comment on this aspect of the proposal." Those details impact financial concerns, explains Cooper, because "the cost structure will be affected by which tier you fall into and that has to get factored into your business

Reimbursement Issues Complicate the Landscape

Health care attorney Barbara Cammarata highlights a critical and related issue that didn't get nearly as consistent attention at the workshop as the issues discussed above: reimbursement. Several reimbursement issues collide with the regulatory burden proposed by the FDA for LDTs. The genetic/genomic testing industry was hit with an unwelcome economic development in the Myriad court decision removing patent protection for genes themselves (while permitting protection for certain synthetic versions of genes), which will have a negative financial impact for test developers who lose the financial opportunities derived from patents, she explains.

At the same time, reimbursement is uncertain as well. "Medicare has been trying to figure out what they are paying for" with respect to genetic and genomic testing, she says, and the lack of clarity also affects commercialization and the financial value of developing such tests.

The impact of PAMA remains to be seen as well, she adds, which will turn reimbursement policy "upside down" because the "private market will be the driver rather than Medicare being the leader as it usually is."

With the loss of patent protection, reimbursement in flux and new regulatory burdens being added, small companies will struggle to finance development and equity investment may be adversely impacted, explains Cammarata.

plan." The uncertainty is due in part, he adds, to the fact that this proposed regulation is "sort of based on what the FDA does in the medical device area" and there is uncertainty as to how that will translate to lab testing. "Not everything will neatly apply to the lab setting," he says.

Continued Enforcement Discretion

Some of the most concrete suggestions raised at the workshop related to categories for continued enforcement discretion and treatment of modifications to approved tests. During his workshop presentation, Gibbs asked the FDA to make the enforcement discretion exemptions "as broad as possible." He explained that doing so would make enforcement more "manageable" given the FDA's limited resources. He also suggested the FDA "scrap" the inclusion of modifications to existing and FDA approved tests, noting the difficulty in deciding when a new 510(k) would need to be submitted for a test modification—which "creates another regulatory burden and quagmire."

Gibbs and others emphasized that modifications to existing tests are essential to patient care and improve existing tests. Summing up the comments made at the workshop, Gibbs advises: "We heard labs say they need to modify tests – they often need to optimize it for their facility. Not allowing them to do this would lock them into a system that may not work so well for them, and that can't be good for patient care."

Many workshop presenters addressed the exemption for tests for rare diseases, asserting that the proposed threshold of 4,000 tests is too low. "4,000 cases would be the minimum that would be reasonable," asserted Gibbs during his presentation. Gibbs and several other speakers referenced the orphan drug definition and 200,000 cases as a preferable alternative.

Timing and Resources

Cooper indicates that the biggest concern he hears from the industry is that the FDA "will lack the resources to practically regulate [LDTs] in the manner that they say they are going to" and "that it will result in very substantial time delays." "If you need a PMA—if it doesn't happen expeditiously—if it takes a year or years to get an approval that could make all the difference in whether the test ever makes it to market or a lab stays in business," says Cooper. Even well funded labs will feel a significant impact, he predicts. "Some of these test are not long lived tests either," he adds. "If your test gets held up, its usable life time gets significantly shortened."

Cammarata indicates she is hearing the same concern. "The perception is that the FDA may not be aware of how many tests are actually out there" and the number of tests they anticipate being subject to the regulation they propose "might be larger than they are thinking."

The potential number of LDT approval applications "will create a logjam at FDA," says Gibbs. "The volume of submissions could swamp the FDA's ability to handle all the submissions" and there's been "no indication how it will increase resources," he adds. Speakers and the experts we spoke with indicate that the device manufacturers are also concerned about this issue and the potential impact on their own submissions for premarket approval.

Laboratory resources were also a concern, with many presenters highlighting the additional staffing and new expertise that will be required for labs to navigate

Industry Impact: Viability of and Investment in Innovation

Innovation was a term used by many on both sides of the debate. The most emphatic objections raised during the workshop involved the impact of this regulation on the viability of labs in general and innovative testing in particular. Many argued that regulation hampers innovation and threatens the very survival of some labs already financially strained by the reimbursement environment in which they operate (see box, p. 2). Echoing the concern about resources, presenters highlighted the cost to laboratories to comply with the regulation. Cleveland attorney Richard S. Cooper explains this "whole new set of regulations and the attendant cost structure" burdens laboratories at "the very time many of them are struggling to remain viable. For some labs it's going to be the tipping point where they may not make it."

The impact on investment in the sector was also highlighted. Cooper notes "molecular and genomic labs are having a difficult time getting investment dollars. It used to be that investors would be putting money in pretty early in the trajectory and now it's coming in much later" because of reimbursement uncertainty. "This [regulation] adds another layer of uncertainty for investors," he adds.

Indeed, one presenter at the FDA workshop, Kelly Slone, speaking on behalf of the National Venture Capital Association, explained that investment in LDT companies has "dried up over the last several years." She attributed the decline to regulatory uncertainty about LDTs and lack of reimbursement.

But it's not all bad news. Cooper notes that some labs that have "financial infrastructure and wherewithal" to handle the approval process "could see this as a way to outpace their competitor." Attorney Jeffrey N. Gibbs agrees that companies that get the FDA approval "may have a better chance of getting reimbursement" and approval "can open doors in other countries," providing some offsetting benefits.

Barbara Cammarata, a Washington, D.C. lawyer, also notes: "Arguably, pharmaceutical and medical device companies who are more familiar with, and who often are already using, the FDA process, and who have greater resources, likely favor greater involvement by the FDA."

this new regulatory process. Gibbs explains that under existing premarket review requirements "companies taking time to get clearances now are often sophisticated companies accustomed to submitting 510(k)s;" labs on the other hand are not accustomed to the process. "Many won't be able to do it," he warns. Cooper agrees, noting that labs "won't necessarily have people on staff adept at these types of regulation, unless they came out of the medical device industry." So he predicts a lot of labs will need to use outside consultants.

Clinical Validity

FDA questioned participants about how to demonstrate clinical validity of IVDs and LDTs. Some participants who objected to regulation asserted that the determination of clinical validity is really part of the practice of medicine. Panelists and public comments discussed the difficulty in determining clinical validity, the fact that doing so may be affected by the individual nature of each test, and the types of evidence that might be relied on—such as clinical trials, case studies, and even literature.

Where we are headed

Many argue that more important than the debate about how this will be implemented, is whether the FDA has the authority to impose this regulation at all. Cooper sums up the debate as involving two legal questions: "Does the FDA have authority to regulate at all; and then, do they have authority to regulate through guidance rather than rulemaking." Cammarata explains that perhaps the most significant difference between pursuing formal rulemaking and issuing guidance is the "economic impact analysis [which] is the key part of the rulemaking process that they won't be getting." Gibbs adds that without rulemaking, the FDA is not required to respond to every major comment or explain why they reject comments.

Cammarata notes that affected stakeholders' options if the proposal isn't modified to their satisfaction are "to sue or try to get Congress to do something. Neither option is easy." Cammarata, Gibbs and Cooper all indicated that litigation is likely. "Who will be behind it and how broadly it will be supported" remains to be seen, says Cooper.

Cammarata suggests that "FDA, CMS and CLIA need to get together" and reach consensus on how to oversee personalized medicine.

Takeaway: The debate about LDT regulation—whether and how it should happen—continues. After the Feb. 2 deadline for public comment, stakeholders with varied interests and needs will be waiting to see how FDA responds. G2

OIG Highlights Sampling Methodology Used in Audits

The OIG recently released a podcast highlighting and explaining use of statistical sampling in audits. Laboratories are under the microscope of OIG scrutiny with this year's Work Plan generically listing independent clinical laboratory billing as an area of concern. So it's wise to understand the OIG's audit techniques.

What is Statistical Sampling?

Statistical sampling is an audit technique the OIG uses when it isn't practical or feasible to review every claim in a universe of suspect claims. Sampling is a lot of times used when you have similarly situated claims with the same CPT Code or the same range of CPT codes for services provided in the same time period and "it would be administratively burdensome to review the records for tens of thousands of claims," explains attorney Kevin R. Miserez, of Wachler & Associates, P.C. in Michigan. "The relevance of this podcast is that the OIG is highlighting a method used more and more frequently when a sustained error rate is found" in initial audits, he adds.

There must be grounds to implement the statistical sampling method, however. "They have to determine a sustained or high level of payment error to even proceed with statistical sampling," Miserez advises. For example, if a probe audit of 40 claims reveals a 100% error rate within those 40 claims, statistical sampling is warranted to project the error rate to a universe of claims within a certain time period.

In the podcast, Lisa Wombles, an OIG senior auditor, interviewed Jared Smith, an office of audit statistician for the OIG, who explains how the sampling is tailored. The four key objectives for statistical sampling are:

1. To yield a "statistically valid" sampling;
2. Provide "efficient" review;
3. Generate a sample "representative of the larger group"; and
4. "[P]roduce a valid estimate of any overpayment."

Medicare Contractors also use statistical sampling in audits or claim reviews. The Medicare Program Integrity Manual lays out requirements and guidelines for CMS contractors to follow in statistical sampling, says Miserez. He also explained the sampling doesn't have to be perfect; it just needs to be statistically valid. "More times than not, the sampling methodology used is determined to be appropriate," he says. The OIG's podcast indicates that to ensure fairness, the agency uses "an estimation method that gives the provider the benefit of the doubt for any uncertainty in the sampling process." Miserez explains that this benefit of the doubt is generally facilitated with a confidence interval (generally 90%) with a high limit and a low limit and the OIG will select the low limit as the amount of overpayment to be demanded to account for the uncertainty in the sample design.

So the resulting overpayment estimate should be less than that which would be found if every claim were reviewed. Smith explained in the podcast that the OIG also reduces an overpayment estimate to account for claims that might have been refunded, not erroneous or canceled. Unfortunately for providers, says Miserez, even with this benefit of the doubt and reduction in the estimate, "when you calculate the overpayment, whether it's $1 million or $1.2 million, either number is significantly high anyways." Smith asserted that sampling benefits the provider by alleviating the need to produce all the supporting documentation for every claim under review.

Appealing Overpayment Estimates Based on Statistical Sampling

The podcast also referenced the right to appeal the results of the statistical sampling through the Medicare appeals process. Miserez explains the provider's recourse following an OIG audit as follows:

First the provider can submit a rebuttal to the OIG's draft audit findings before the OIG releases its final audit findings and provide arguments to refute those findings. Arguments that may be made to refute an audit finding could include that the sample selected wasn't sufficiently random, or the sample selected is not representative of the universe, advises Miserez. When the OIG issues a final audit report and recommends to CMS a recoupment of an overpayment, Medicare appeal rights begin. The provider can seek a redetermination by appealing to the Medicare Administrative Contractor, then a reconsideration to a Qualified Independent Contractor and then a hearing before an administrative law judge (ALJ). Finally, an appeal can be made to the Medicare Appeals Council (MAC) followed by federal district court.

If a provider successfully challenges the statistical sampling at the reconsideration stage, CMS cannot appeal, says Miserez. While this doesn't happen often, when it does, the provider is only liable for the amount of any overpayment relating to sample claims shown to be in error, rather than the much higher projected overpayment demand based on the statistical extrapolation.

After the reconsideration stage, CMS can appeal any decision finding a problem with the statistical sampling methodology. "The MAC doesn't often throw out the statistical methodology," says Miserez; "often times at the MAC and ALJ level, CMS is permitted to correct any errors found in the sampling methodology." The good news is that when you appeal a statistically projected audit—you are appealing the sample claims reviewed and if you get some of those overturned (e.g. deemed medically necessary and appropriately billed), that reduces the error rate applied to the universe of claims. So for every individually sampled claim that you prove accurate, you are reducing the overpayment calculation by more than just the value of that single claim, he explains.

What You Should Do

Generally, such sampling methodology tends to be pretty representative, says Miserez. "Practitioners don't tend to change their documentation habits overnight," he explains. That means errors found in a small sampling of claims are usually a reasonable indicator that the same errors will be found in other claims as well.

In fact, the OIG recently issued an audit report using statistical sampling to review a Louisiana hospital's claims. The OIG conducted an audit covering 1,078 claims considered at risk for billing errors. The audit involved a random sample of 158 claims from an audit period running from January 2011 through September 2012. Of those 158 claims, the OIG found 51 claims were not fully compliant. Using those results, the OIG estimated the hospital received over $1.6 million in overpayments for that audit period.

With significant overpayment liability at stake, it's critical that laboratories and all providers are aware of documentation and billing requirements and rules for Medicare reimbursement to avoid an error rate that justifies statistical sampling. "Providers have to take it upon themselves to ensure their documentation and billing practices align with Medicare reimbursement requirements," advises Miserez.

To listen to or review transcripts of this and other OIG podcasts, visit https://oig.hhs.gov/newsroom/podcasts/reports.asp

Sources

- Medicare Appeal Rights: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/overpaymentbrochure508-09.pdf
- Medicare Program Integrity Manual: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c08.pdf
- OIG Audit Report http://oig.hhs.gov/oas/reports/region6/61300042.pdf

Takeaway: The OIG's podcast spotlighting its statistical sampling methodology is timely and should be of interest to labs given significant scrutiny of laboratory billing.

Daiichi CIA Provides Compliance Guidance, *Continued from bottom of p.1*

least a six year period. The government asserted physicians were paid even when physicians took turns speaking on the same or "duplicative topics" during sponsored meals, when physicians spoke to only their own staff in their own office, or the accompanying dinner was so expensive it exceeded even the company's cost limitations. The case was initiated by a former sales representative of the company in a qui tam (or whistleblower) action under the False Claims Act.

What the CIA Requires

The Daiichi Corporate Integrity Agreement includes some compliance obligations that laboratories should consider if they have any arrangements with physicians who might send specimens to that laboratory for testing. Implementing the compliance strategies that Daiichi is now being required to develop could proactively help laboratories avoid compliance problems.

The Corporate Integrity Agreement requires:

- A sales force monitoring program that requires full-day, ride-along field observation of sales force members interacting with health care providers and review of records regarding sales force interaction with health care providers and a speaker monitoring program.
- The speaker monitoring program must include training for all speakers; written agreements setting forth the scope of work, fee to be paid, and compliance obligations for speakers (e.g., no promotion of off label use); review of all aggregate payments to speakers including fees and expense reimbursement; and a tracking system for all speaker programs to ensure compliance. Speakers must be paid according to a "centrally managed, pre-set rate structure determined based on a fair-market value analysis."
- The speaker monitoring program also requires trained individuals attend 75 speaker programs during the reporting period and audit the programs including a review of slide/presentation materials, the speaker's statements, and sales reps' conduct during the event.
- Oversight of consultant arrangements requiring written agreements with consultants detailing the scope of work and fees to be paid, and an annual engagement plan that addresses business needs for consultants, the number of con-

sultants and activities they will engage in for the year plus a needs assessment to "justify the retention of a consultant" before hiring the consultant. As with speaker fees, consultant fees must be based on a "centrally managed, pre-set rate structure that is determined based on a fair-market value analysis."

- Medical Education Grant monitoring program that requires that sales and marketing staff don't have any involvement in or influence with regard to medical education grants or charitable contributions.

Takeaway: These compliance activities that Daiichi is being required to implement for their CIA are a good guide regarding the compliance efforts that not just pharmaceutical manufacturers but laboratories or any health care company should consider instituting if they make consulting, speaking or other arrangements with referral sources such as physicians. G2

CMS Seeking Advice Regarding Molecular Pathology Tests Estimating Cancer Prognosis

A panel from CMS's Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) will meet in March to review evidence concerning molecular pathology tests used to estimate the prognosis of certain cancers: including adeno carcinoma of the colon and rectum, invasive breast cancer and non small cell lung cancer.

MEDCAC "was established to provide independent guidance and expert advice to CMS on specific clinical topics" giving "unbiased and current deliberation of 'state of the art' technology and science," according to CMS's webpage regarding MEDCAC.

This panel will consider outcomes (good and bad) from anti-tumor treatments that were selected based on specific molecular pathology tests' predictions for the cancer patient's prognosis. That panel will then advise CMS "about the extent to which it may wish to use existing evidence as the basis for any future determinations about coverage for tests that estimate cancer prognosis." These are not coverage determinations but merely advice.

Questions under consideration address whether existing evidence:

- demonstrates the analytical and clinical validity of the test to estimate the prognosis for Medicare patients with the related cancer
- shows whether the estimated prognosis "affects health outcomes" for those patients whose treatment is determined based on the test result
- indicates that the test's estimate of prognosis has a positive effect (avoiding harm or improving health) on patients whose treatment is determined based on the test result

The panel will also discuss how other factors may affect evidence about the tests such as regulation (i.e., FDA approved or LDT), type of laboratory performing the test, characteristics of the patient population and "genomic variations within cancers." G2

National Intelligence Report (ISSN 2332-1466) is published by G2 Intelligence, Plain Language Media, LLC, 15 Shaw Street, New London, CT, 06320. Phone: 1-888-729-2315 • Fax: 1-855-649-1623. Web site: www.G2Intelligence.com.

Kelly A. Briganti, JD, Editorial Director, Kelly@plainlanguagemedia.com; Barbara Manning Grimm, Managing Editor; Stephanie Murg, Managing Director, Conferences & Events;
Kim Punter, Director of Conferences & Events; Myra Langsam, Corporate Licensing Manager; Jim Pearmain, General Manager, Pete Stowe, Managing Partner; Mark T. Ziebarth, Publisher.
Receiving duplicate issues? Have a billing question? Need to have your renewal dates coordinated? We'd be glad to help you. Call customer service at 1-888-729-2315.