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Senate Set for Showdown on Medicare Physician Fee Fix

Though a 10.6 percent cut in fees took effect July 1, Medicare is delaying payment on physician claims, anticipating congressional action to reverse the cut.

At press time, as Congress reconvenes after the Independence Day recess, the Senate is set to consider Medicare legislation that would roll back the July 1 cut of 10.6 percent in pathology and other physician fees and grant payment increases through 2009, extend the pathology "grandfather" protection for independent clinical laboratories, and repeal the lab competitive bidding demonstration.

The House, before recessing last month, passed its Medicare legislation containing these provisions (H.R. 6331) by a wide bipartisan margin (355-59). The bill would pay for the physician fee increase by reducing payments for Medicare managed care, a move opposed by the president who has said he would veto it.

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CMS Proposes 2009 Physician Fee Schedule Rule

Pathologists and other physicians face a negative update of 5.4 percent under the proposed 2009 Medicare physician fee schedule rule just released by the Centers for Medicare and Medicaid Services. The figure could be revised, CMS noted, in the final rule to be published in November.

Though Congress is expected to override the cut and grant a fee increase instead, CMS is required by current law to calculate and propose the update using the SGR (Sustainable Growth Rate) formula. The SGR system, which physician groups want repealed, has triggered negative updates through most of this decade, but Congress has repeatedly intervened to block them.

Under the proposed rule, total allowed charges for pathology in calendar year 2009 would be $833 million, or a scheduled cut of six percent. For independent labs, the total charges would be $754 million, no gain or loss since increases in work and practice expense values would be canceled by the negative update.

Of the 53 specialties listed in Table 28 in the rule, pathology was among the 23 scheduled for a cut of 6 percent, while four others are slated for a 7 percent reduction. Audiology would take the most severe hit, down 16 percent.

Payment for the most frequently billed pathology code, CPT 88305, Level IV, Surgical pathology, gross and

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Medicare Physician Fee Fix, *from p. 1*

Senate Finance Committee chairman Max Baucus (D-Mont.) told reporters July 7 he is optimistic that there will be enough votes to block a GOP filibuster and get a Medicare bill to the floor for a vote. A bid to pass H.R. 6331 before the recess failed to garner the 60 votes needed for cloture. Meantime, unable to reach a compromise, Baucus and the ranking Republican on Finance, Charles Grassley (Iowa) introduced rival Medicare bills (*NIR, 29, 17/June 23 '08, p. 1*).

The good news for pathologists and clinical labs is that all the bills before the Senate incorporate their key legislative priorities this year:

- Blocking the July 1 cut of 10.6 percent in pathologist and other physician fees under the SGR formula, continuing the 0.5 percent increase in effect since the start of this year through Dec. 31, and granting an additional 1.1 percent increase for 2009.
- Extending for 18 months the "grandfather" protection that allows independent clinical labs to bill Medicare Part B directly for the technical component of anatomic pathology services to hospital inpatients and outpatients. This protection, which expired June 30, applies to hospital-lab arrangements in effect as of July 22, 1999, the date when the Centers for Medicare and Medicaid Services first proposed to end such billings on grounds that the technical component is reimbursed as part of the hospital's Part A inpatient payment.
- Repealing the Part B competitive bidding demonstration for independent laboratory services. The planned launch of the demo in San Diego on July 1 is on hold following a court order in a lawsuit filed by local labs.

But for labs, the bills also would reduce their fee schedule update for 2009—the first update in five years—by 0.5 percent. The CPI update for next year is currently projected at 2 percent. The five-year freeze on lab fee updates, which kept the rates at their 2003 level, expires at the end of this year.

CMS Puts Hold on Physician Claims Payment

With Congress expected to act soon to restore physician fees, CMS is holding Medicare payment of physician fee-for-service claims as of July 1. The hold is designed to avoid disruption in the delivery of services and claims processing, CMS said. "This should have minimum impact on provider cash flow because, under current law, electronic claims are not paid any sooner than 14 days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before June 30 will be processed and paid under normal procedures."

After 10 business days, contractors will begin releasing claims with a date of service of July 1 and later for processing, and this could result in payments reflecting the 10.6 percent cut, CMS cautioned. But if a new law is enacted reversing the cut retroactive to July 1, CMS said it is prepared to automatically reprocess most of those claims that have already been processed.

Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the Jan. 1-June 30, 2008 fee schedule will be automatically reprocessed if Congress retroactively reinstates the update that was in effect for that time period. Any lesser amount will likely require providers to resubmit a revised claim.

"To the extent possible, providers may hold claims in-house until it becomes clearer as to whether new legislation will be enacted or until cash flow becomes problematic," CMS said. This will reduce the need to reconcile two payments (the initial claim and the reprocessed claim) and will simplify provider billings of beneficiary coinsurance and payment calculations for payers that are secondary to Medicare.

No Delay on Pathology 'Grandfather' Protection

Though legislation pending in the Senate and already approved by the House would extend the pathology "grandfather" protection, which expired June 30, for 18 months, through 2009, CMS was prompt in notifying Medicare contractors that the provision had expired.

In Change Request 6088 (July 7, 2008), CMS said independent labs that had qualified to bill for the technical component of anatomic pathology to hospital inpatients and outpatients may no longer bill for these services with a date of service on or after July 1.

CMS Invites Input on Pricing New Lab Codes for 2009

The Centers for Medicare and Medicaid Services will hold a July 14 public meeting to receive recommendations on assigning payment rates for CPT codes new to next year's Part B clinical laboratory fee schedule.

The new codes are as follow (numbering has not yet been finalized):

Chemistry

8372X	Myeloperoxidase (MPO)
8395X	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)

Hematology and Coagulation

85XXX	Coagulation and fibrinolysis, functional activity, not otherwise specified (e.g., ADAMTS-13), each analyte

Microbiology

879XX	Infectious agent enzymatic activity other than virus (e.g., sialidase activity in vaginal fluid)

In Vivo (e.g., Transcutaneous) Laboratory Procedures

8872X	Bilirubin, total, transcutaneous
8874X1	Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin (For in vitro carboxyhemoglobin measurement, use 82375.)
8874X2	Hemoglobin, quantitative, transcutaneous, per day; methemoglobin (For in vitro quantitative methemoglobin determination, use 83050.)
88400	Bilirubin, total, transcutaneous, has been deleted. To report, use 8872X.

Laboratory and pathology groups, test manufacturers, and other interested parties are invited to submit their recommendations on whether a new test should be priced using one of two approved methods—crosswalk or gap-fill.

The crosswalk is used to match a new test code to a similar existing code and pay at that code's rate. Payment for the new test is made at the lower of the crosswalk to the local fee schedule amount or the national cap. Most lab fee schedule codes are paid at the national cap.

The CMS public meeting kicks off the annual fee-setting process for new and revised lab tests on the Part B fee schedule, as required by statute and regulations.

The gap-fill method is used when there is no comparable existing test. In this case, local carriers set the fee for the first year, based on local pricing patterns such as charges for the test, routine discounts, resources needed for the test, and what other payers pay. CMS then taps these local amounts to set a fee cap for following years.

Timetable for 2009 Lab Fee Schedule

CMS typically makes public its tentative fee decisions for new lab codes in September, followed by a short time for additional comments before the fee decisions are released in the final 2009 lab fee schedule, usually in November.

'You Still Have Time to Sign Up for 2008 Quality Reporting'

That's the message to pathologists and other physicians from a top official at the Centers for Medicare and Medicaid Services, explaining new options to make it easier to participate in the voluntary Physician Quality Reporting Initiative (PQRI) for 2008 and qualify for a bonus payment of 1.5 percent on total allowed charges payable under the physician fee schedule during the approved reporting period. Participants also receive confidential feedback on their performance relative to all other professionals who successfully reported the same measures.

In 2008, pathologists are, for the first time, eligible to enroll in the PQRI, which began the previous year. The program includes two approved pathology reporting measures (*see box*).

In an open letter to physicians and other eligible providers on what is new in the 2008 PQRI, Michael Rapp, MD, JD, FACEP, director of the quality measurement and health assessment group in the CMS office of clinical standards and quality, noted:

- There are two alternative reporting periods: Jan. 1 through Dec. 31, or July 1 through Dec. 31.
- There is a new option to starting reporting measures groups as of July 1, in addition to the option to report individual measures. Measures groups combine quality measures applicable to clinical conditions common among Medicare beneficiaries. For 2008, there are four such groups covering diabetes mellitus, end-stage renal disease, chronic kidney disease, and preventive care. Each group contains at least four PQRI measures. The diabetes and chronic kidney disease groups include specific lab testing elements.

- There is a new option to submit quality measures data to CMS through a qualified, established clinical registry, in which eligible professionals may already be participating. CMS expects to post online a list of approved registries in the late summer this year.
- Some participants may receive a higher incentive payment for successful participation, since a new law removes the limit (cap) on the incentive payment.

Approved Pathology PQRI Measures, 2008

The following were developed by the College of American Pathologists, approved by the American Medical Association, and introduced to the Physician Quality Reporting Initiative as of the start of this year:

- 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.

The PQRI for 2008 encompasses new and revised measures and now comprises 119 unique quality measures, including two structural measures, said Rapp. The structural measures focus on whether a professional uses electronic health records and/or electronic prescribing technology. Structural measures may be reported by any eligible professional on any Medicare patient, regardless of whether any other 2008 PQRI measures apply to the services furnished by that professional.

The PQRI is an important step toward purchasing based on the value rather than just the volume of services furnished, Rapp concluded. For more on the program and how to register, go to *www.cms.hhs.gov/PQRI*.

CMS Finalizes Rule on Hepatitis C and Transfusion Safety

The Centers for Medicare and Medicaid Services published a final rule in the June 27 *Federal Register* aimed at preventing hepatitis C virus (HCV) infections among patients in hospitals that receive Medicare and Medicaid funding. The rule also aims to "create opportunities for disease prevention that, in most cases, can occur many years after recipient exposure to a donor," CMS noted.

The final rule spells out what hospitals must do when they receive and transfuse blood and blood components with an increased risk for transmitting HCV:

- Prepare and follow written procedures for appropriate action;
- Quarantine prior collections from a donor who is at increased risk for transmitting HCV;
- Notify transfusion recipients, as appropriate, of the need for HCV testing and counseling; and
- Extend the records retention period for transfusion-related data to 10 years.

The final rule adopts the provisions in the interim final rule published Aug. 24, 2007 and effective Feb. 20, 2008. CMS estimates it will require a one-time cost of $41.6 million and an annual cost of $1.7 million.

Approximately 7 percent of the estimated 3.9 million Americans ever infected with HCV were infected as a result of blood transfusion before the availability of donor screening tests, according to CMS.

Physician Fee Schedule Rule, *from p. 1*

microscopic, would decline even more, by 7 percent, under the proposed rule. In 2008, the fee (unadjusted for geographic variation) is $32.36. In 2009, it would drop to $29.97.

Pathology Quality Reporting Measures

For 2009, CMS is proposing a final set of 175 measures under the voluntary Physician Quality Reporting Initiative (PQRI). Of these, 64 are new and 111 are current measures. Pathology measures for breast and colorectal cancer, developed by the College of American Pathologists and introduced to the PQRI list as of Jan. 1, 2008, are included on the list for 2009, but no new ones, CAP sources confirm.

Total Medicare spending under the 2009 physician fee schedule is projected at $54 billion, CMS said, down 5 percent from the $57 billion projected for 2008. More than 980,000 physicians and nonphysician practitioners are paid under the fee schedule. Nearly 95 percent of physicians enrolled in Medicare accept the fee schedule rate as payment in full.

In other PQRI changes, CMS plans to:

- Increase the number of conditions covered by measures groups to nine, adding coronary artery disease, HIV/AIDS, coronary artery bypass surgery, rheumatoid arthritis, care during surgery, and back pain to the original measures groups for diabetes, chronic kidney disease, and preventive care.
- Allow claims-based reporting for either individual quality measures or a set of related measures. For individual measures, three would have to be reported (or less if only one or two are applicable to eligible professionals) for 80 percent of applicable cases during the calendar year. For a set of related measures, reporting would be required for the full calendar year for 30 consecutive patients for whom all measures of one group apply, or 80 percent of patients to whom all measures of one group apply, with a minimum of 30 patients.
- Include two new reporting periods (Jan. 1 to Dec. 31, 2009, or July 1 to Dec. 31). For the latter period, reporting would be required on 80 percent of applicable patients, with a minimum of 15 patients.
- Accept PQRI data via clinical registries and electronic health records systems.

Prostate Saturation Biopsies

CMS is proposing four new G codes for prostate saturation biopsies that would be carrier-priced while the agency gathers information on the lab and clinical staff resources required to value these services. Prostate saturation biopsy is a technique currently described by Category III, CPT code 0137T, and typically entails 40 to 80 core samples taken from the prostate prior to anesthesia. The biopsies are reviewed by a pathologist and captured under CPT 88305, which is separately billed by the physician for each core sample taken.

CMS says that paying individually for each core sample submitted "grossly overpays for the pathologist interpretation and report for this service." The agency proposes the following replacement codes (digits to be finalized):

- GXXX1, Surgical pathology, gross and microscopic exam for prostate needle saturation biopsy sampling, 1-20 specimens.
- GXXX2, 21-40 specimens.
- GXXX3, 41-60 specimens.
- GXXX4, greater than 60 specimens.

CMS Lowers Fee for Metabolic Panel Code 80047

In a steep reduction in reimbursement for CPT 80047—Basic metabolic panel (ionized calcium)—Medicare began paying for the panel at the rate for 80048, Basic metabolic panel (total calcium), effective July 1. CPT 80047 was added to the 2008 Part B lab fee schedule that took effect Jan. 1.

From then until July 1, Medicare reimbursed 80047 as the sum of the rate for a seven-test panel (paid by most contractors at $11.42) and the separate rate for 82330, ionized calcium (capped at $19.09), or a maximum of $30.51. Now the fee will be pegged to the rate for an eight-panel code, which translates to $11.83 in most regions of the country and in some areas as low as $9 to $10.

In making the fee crosswalk to 80048, the Centers for Medicare and Medicaid Services is considering 82330, ionized calcium, as an automated chemistry test when performed as part of the 80047 panel and is including it in the composite rate payment for end-stage renal disease testing.

The American Clinical Laboratory Association contends that this decision is problematic and advocates keeping the previous payment policy. ACLA earlier this year asked CMS to rethink the fee change (*NIR, 29, 12/Apr 14 '08, p. 7*). The July 14 public meeting on pricing new 2009 lab codes provides ACLA with another opportunity to ask CMS to reconsider 80047 pricing, association president Alan Mertz told *NIR*. "The only instrument capable of performing all tests in 80047 is a point-of-care handheld device. It is not suitable for the centralized lab. When the specimen is sent to the hospital and independent lab, it must be collected in two separate tubes and run separately on two separate instruments."

Medicare Preventive Service Update

Citing misleading information in the Medicare manual, the Centers for Medicare and Medicaid Services has issued the following clarification of coverage rules for a screening pelvic exam (including a clinical breast exam):

[The] exam with or without specimen collection for smears and cultures should include at least seven of the following 11 elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal exam including sphincter tone, presence of hemorrhoids, and rectal masses;
- External genitalia (e.g., general appearance, hair distribution, or lesions);
- Urethral meatus (e.g., size, location, lesions, or prolapse);
- Urethra (e.g., masses, tenderness, or scarring);
- Bladder (e.g., fullness, masses, or tenderness);
- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (e.g., general appearance, lesions, or discharge);
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, or nodularity); and
- Anus and perineum.

The exam is covered once every two years for beneficiaries at low risk for cervical or vaginal cancer and once a year for those at high risk or who are of childbearing age and have had an exam during the previous three years indicating the presence of cervical or vaginal cancer or other abnormality.

Protest Halts MAC Contract to National Heritage Insurance

The contract in dispute has a total estimated value of approximately $148 million over five years, CMS said.

The recent award of a Medicare A/B MAC contract to National Heritage Insurance Corp. is on hold, following a protest filed with the Government Accountability Office. The GAO is reviewing the issue and is due to rule in early September, CMS announced. The dispute affects clinical labs, pathologists, and other providers in Alaska, Washington, Oregon, and Idaho (Jurisdiction 2).

The award to NHIC on May 8 was the seventh in the rollout of the Medicare Administrative Contractor (MAC) program that combines A/B claims processing with one entity and replaces the current system that channels Part A work to fiscal intermediaries and Part B work to carriers (*NIR, 29, 15/May 26 '08, p. 1*). NHIC, a subsidiary of EDS, is headquartered in Hingham, Mass.

This is not the first challenge to a CMS award of an A/B MAC contract. Palmetto GBA protested against the MAC award to Highmark Medicare Services Inc. (Camp Hill, Pa.) for Jurisdiction 12, including Delaware, Maryland, New Jersey, Pennsylvania, and the District of Columbia. The GAO dismissed the protest after CMS took corrective action, restoring the award to Highmark. CMS plans to award 15 A/B MACs nationwide by 2009 under the new claims processing system authorized by the Medicare Modernization Act of 2003.

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