WASHINGTON G–2 REPORTS

NATIONAL INTELLIGENCE REPORT®

Covering Government Policy For Diagnostic Testing & Related Medical Services

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Vol 10, Iss 1, January 11, 2010

Pathologists Spared Fee Cut, But Not Clinical Laboratories

The fate of fundamental changes to the Medicare physician and lab fee schedule systems hinges on how Congress resolves key differences over replacing the current formulae used to determine the annual payment update.

Pathologists and other physicians escaped a cut of 21.2 percent in Medicare payments scheduled for Jan. 1, 2010, but have their fees frozen at 2009 levels for two months, through Feb. 28, giving Congress time to work out differences in changes to the current Medicare physician payment system.

Clinical laboratories were not so lucky. A cut of 1.9 percent in the annual update to the Medicare lab fee schedule took effect Jan. 1 (*see the Focus, pp. 3-5*), even as changes to the update formula are pending in health care reform legislation passed by the House and the Senate and awaiting reconciliation into a single bill.

The reprieve for physicians was approved in the 2010 defense spending bill signed into law by President Obama. Lawmakers opted for a short-term freeze on Medicare physician payments to give House and Senate negotiators time to resolve differences over repealing the current Sustainable Growth Rate (SGR) formula *Continued on p. 2*

CMS Advises Providers on End of Pathology 'Grandfather' Protection

The statutory moratorium protecting certain pathology billings by independent clinical laboratories expired as of Dec. 31, 2009, but provisions to extend it are pending in House and Senate health care reform bills awaiting reconciliation.

Anticipating legislative action, the Centers for Medicare and Medicaid Services (CMS) is advising qualified providers "to hold, to the extent possible, claims for services furnished on or after Jan. 1, 2010."

"If legislation is enacted, claims submission for affected services may resume," CMS said. "Otherwise, claims submitted with dates of service on or after Jan. 1 will not be paid."

The "grandfather" protection allows an independent clinical laboratory to bill Medicare directly for the technical component (TC) of pathology services to hospital inpatients and outpatients. It applies to hospital-lab arrangements in effect as of July 22, 1999, when the Medicare program first proposed to end such billings. Congress has repeatedly stepped in to block this policy change. The TC of pathology services includes anatomic services, cytopathology, and surgical pathology. *Continued on p. 8*

INSIDE *NIR*

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Pathologists Spared Fee Cut, *from p. 1*
used to calculate the annual update. The SGR has triggered negative updates for most of the decade and is projected to force even deeper cuts in the future.

To avoid disruption in Part B physician payments, the Centers for Medicare and Medicaid Services (CMS) has instructed its contractors to hold claims for up to the first 10 business days of January (Jan. 1 through Jan. 15) for 2010 dates of service.

This should have minimum impact on provider cash flow, CMS said, because, by law, clean electronic claims are not paid any sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

Contractors will begin processing claims at the new rates by no later than Jan. 19, 2010. Meanwhile, all claims for services delivered on or before Dec. 31, 2009, will be processed and paid under normal procedures.

CMS also has extended the 2010 Annual Participation Enrollment Program end date from Jan. 31 to March 17. The effective date for any participation status change during the extension, however, remains Jan. 1 and will be in force for the entire year.

Repealing the SGR Physician Payment System

House and Senate bills pending reconciliation differ sharply over whether a physician fee fix should be short term or a permanent overhaul of the SGR system used to calculate the annual Medicare physician fee update.

The Senate health care reform bill blocks the 21.1 percent cut and gives physicians a 0.5 percent increase in 2010 at an estimated cost of $10.9 billion. A House-passed physician fee reform bill cancels the cut and initiates repeal of the SGR. In 2010, the fee update is to be based on the Medicare Economic Index, increasing physician payments by 1.2 percent; thereafter, the update would be tied to the Gross Domestic Product (*NIR 09, 21/Nov. 23, p. 1*).

The House bill faces an uphill battle in the Senate because its cost of nearly $210 billion is not paid for. The Senate rejected a bid to repeal the SGR because it was not paid for (*NIR 09, 19/Oct. 26, p. 1*).

Changes to the Lab Fee Update

House and Senate health care reform bills favor changing the formula used to calculate the annual Medicare lab fee schedule update. Currently, the update is the Consumer Price Index (CPI-U) minus 0.5 percent.

Both bills would replace the 0.5 percent reduction with a productivity adjustment, but differ on when to make the switch. The adjustment has ranged between minus 1.1 percent to minus 1.4 percent and is currently pegged at minus 1.3 percent.

The Senate provision would let the 1.9 percent cut go forward in 2010, and in 2011, replace the 0.5 percent reduction with a productivity adjustment and a guarantee that this would never reduce the update below zero. The House bill would apply the adjustment in 2010, with no protection against the update falling below zero. In 2010, this would translate to a cut of 2.7 percent.

The Senate bill also would make an additional cut of 1.75 percent in the update for years 2011 to 2015. This is projected to reduce the update below zero in each of those years. The House bill has no similar provision.

focus on: Lab Payment Policy

Quick Guide to the 2010 Medicare Lab Fee Schedule

CMS instructions to local Medicare contractors on implementing the 2010 Part B lab fee schedule are found in Change Request 6657 (Dec. 23, 2009) at cms.hhs.gov/transmittals.

Annual Update Triggers Cut of 1.9 Percent Jan. 1

Starting Jan. 1, lab fees are cut by 1.9 percent under the 2010 calendar year Medicare clinical laboratory fee schedule released by the Centers for Medicare and Medicaid Services (CMS). This marks the first time in the fee schedule's 25-year history that the update has dropped into negative territory. In 2009, fees rose 4.5 percent, following a five-year freeze from 2004 through 2008.

The cut results from the formula used to calculate the fee update: the Consumer Price Index (CPI-U) minus 0.5 percent. The 0.5 percent reduction, required by the 2008 Medicare Improvements for Patients and Providers Act (MIPPA), runs through 2013.

Lab tests are payable under local fee schedules and the national limitation amounts (fee caps) for these tests. Payment for a clinical lab test is the lesser of the actual charge billed, the local fee, or the national fee cap. The Part B deductible and coinsurance do not apply to services payable under the lab fee schedule.

The annual update to payments made on a reasonable charge basis for all other laboratory services (blood products, transfusion medicine, and reproductive medicine procedures) is frozen at zero percent.

Pap Smear Minimum Payment

The update for 2010 reduces the minimum national payment for cervical and vaginal smears to $15.13, from $15.42 in 2009. The payment was frozen at $14.76 from 2004 through 2008. These tests are paid at the lesser of the local fee or the national fee cap, but never below the national payment floor and never more than the actual charge. Affected codes include:

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

Final Fees Established for New CPT, G Lab Codes

In setting fees for CPT codes and G codes new to the Part B lab fee schedule in 2010, CMS used the crosswalk method; no new test codes were gap-filled (*see table, p. 4*). Under the crosswalk method, a new test code is matched to a similar code on the fee schedule and is paid at that rate. Payment is the lower of the local fee schedule amount or the national cap. Most lab codes are paid at the cap. The gap-fill alternative is used to set a fee when there is no comparable test and is based on local pricing patterns.

Reconsideration in Pricing the MPO Test

The 2010 lab fee schedule includes the decision by CMS to change the crosswalk for CPT 83876, Myeloperoxidase (MPO), which was added to the fee schedule in 2009.

2010 Medicare Lab Fee Schedule: Pricing of New CPT, G Codes

Code/Descriptor	CMS Final Crosswalk	Natl. Fee Cap
• CHEMISTRY		
83987, pH; exhaled breath condensate	82800, Blood gases, pH only + 87015, Concentration, any type, for infectious agent	$22.74
84145, Procalcitonin (PCT)	84146, Prolactin	$27.76
84431, Thromboxane metabolite(s), including thromboxane if performed, urine	83520, Immunoassay, analyte, quantitative; not otherwise specified	$18.54
• IMMUNOLOGY		
86305, Human epididymis protein 4 (HE4)	86316, Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each	$29.81
86352, Cellular function assay involving stimulation (eg, nitrogen or antigen) and detection of biomarker (eg, ATP)	86353, Leukocyte transformation, mitigen or antigen induced blastogenesis + 82397, Chemiluminescent assay	$97.30
86780, Antibody, Treponema pallidum	86781, Treponema pallidium, confirmatory test (eg, FTA-abs.)	$18.97
• TISSUE TYPING		
86825, Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); first serum sample or dilution	86356 x 3, Monoculear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen	$115.04
86826, Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry; each additional serum sample or dilution (list separately in addition to primary procedure)	86356, Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen	$38.35
• MICROBIOLOGY		
87150, Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed	87798, Infectious agent antigen detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique	$50.27
87153, Culture, typing; identification by nucleic acid sequencing method, each isolate	Molecular diagnostics codes 83891, 83898, 83904, 83912, and 87900 (at ½)	$165.22
87493, Infectious agent antigen detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique	87798, Infectious agent antigen detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique	$50.27
• TRANSCUTANEOUS LAB PROCEDURES		
88738, Hemoglobin (Hgb), quantitative, transcutaneous	88740, Hemoglobin, quantitative, transcutaneous, per day; carboxyhemglobin	$7.19
• DRUG SCREENING		
G0430, Drug screen, qualitative; multiple drug classes, any method, each procedure (eg, multiple drug test kit)	80100, Drug screen, qualitative; multiple drug classes, chromatographic method, each procedure	$20.83
G0431, single drug class method (eg, immunoassay and enzyme assay), each drug test	80101, Drug screen, qualitative; single drug class method, (eg, immunoassay and enzyme assay), each drug class	$19.72

Sources: CMS Final Payment Determinations, 2010 Medicare Lab Fee Schedule. CPT codes © American Medical Assn.

The test is a quantitative marker used to predict myocardial infarction in patients with chest pain. The agency concluded that the test "appears to have the same level of complexity in the action step process as 83880, Natriuretic peptide (BNP)." The crosswalk change means a boost in payment, to a national cap of $48.62.

Deleted Codes

The QW modifier identifies codes and payment rates for tests performed by a laboratory having only a certificate of waiver under CLIA (Clinical Laboratory Improvement Amendments).

Beginning Jan. 1, 2010

82307	Calciferol (Vitamin D)
86781	Treponema pallidum, confirmatory test (e.g., FTA-abs)

Beginning Oct. 1, 2009

83520QW	Immunoassay, analyte, quantitative; not otherwise specified

Beginning July 1, 2009

82042QW	Albumin; urine or other source, quantitative, each specimen

No Change in How Fee Caps Are Set

Medicare's national fee caps remain set at 74 percent of the national median for those tests on the lab fee schedule that were capped prior to Jan. 1, 2001. For tests whose fee caps were first established on or after Jan. 1, 2001, the caps are to be set at 100 percent of the national median, in accordance with the Benefits Improvement and Protection Act of 2000 (BIPA).

This BIPA provision has been applied by CMS, since April 1, 2001, to 12 diagnostic/screening Pap smear codes involving thin-layer preparation and manual or automated screening or rescreening:

88142/G0123
88143/G0143
88147/G0147
88148/G0148
88174/G0144
88175/G0145

Travel Allowance

The travel allowance to collect a specimen from either a nursing home or homebound beneficiary remains the same as it was in 2009:

- ❑ P9603, $1 per mile trip basis
- ❑ P9604, $10 per flat rate trip basis

Reminders

❑ **Coding for Blood Draws**

You should no longer bill G0001 for venous blood collection by venipuncture. Medicare has retired that code and replaced it with CPT 36415, Collection of venous blood by venipuncture. The draw fee remains at $3.

❑ **No Grace Period for Adopting 2010 Coding Changes**

Medicare no longer allows a three-month grace period (Jan. 1-March 31) for processing lab claims with CPT/HCPCS codes active in 2009, but deleted in 2010. As of Jan. 1, 2010, only active codes will be accepted.

Medicare to Cover Kidney Disease Patient Education

Effective Jan. 1, 2010, kidney disease patient education services will be added as a Part B covered benefit for Medicare beneficiaries diagnosed with Stage IV chronic kidney disease (severe decrease in GFR; GFR value of 15 to 29 ml/min/1.73 m2), who have received a referral from the physician managing the beneficiary's kidney condition. Congress approved the new benefit in the 2008 Medicare Improvements for Patients and Providers Act (MIPPA), Section 152(b).

The covered services are to be tailored to meet the needs of the individual beneficiary, to enable him or her to actively participate in the choice of therapy, and to provide comprehensive information regarding:

- ❑ Management of comorbidities, including delaying the need for dialysis;
- ❑ Prevention of uremic complications; and
- ❑ Each option for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-facility, dialysis access options, and transplantation).

Contractors will pay for services that meet the following conditions:

- ❑ No more than six sessions are provided in a beneficiary's lifetime.
- ❑ Sessions are billed in increments of one hour (a session must last at least 31 minutes, but if it runs less than one hour, it still constitutes one session).
- ❑ Sessions are furnished either individually or in a group setting of two to 20 individuals (though all in the group need not be Medicare beneficiaries).
- ❑ The services are furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person.

The term "qualified person" is defined as:

- ❑ A physician, physician's assistant, nurse practitioner, or clinical nurse specialist;
- ❑ A hospital, critical access hospital (CAH), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice that is located in a rural area; or
- ❑ A hospital or CAH that is paid as if it were located in a rural area (hospitals and CAHs reclassified as rural under section 42 CFR 412.103).

Note: A CAH is designated as a qualified person for furnishing kidney disease education services irrespective of the provider's geographic location. Renal dialysis facilities, however, are precluded from providing these services irrespective of the provider's geographic location.

The covered services will be payable under the Medicare physician fee schedule using two new HCPCS codes:

- ❑ G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour.
- ❑ G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour.

Meanwhile, the American Clinical Laboratory Association notes that clinical laboratories are reporting additional data to help detect kidney disease at an early stage and thus delay the onset of end stage renal disease (ESRD) and the need for chronic dialysis treatments. Chronic kidney disease is a silent killer affecting some 26 million Americans.

While the coverage is effective at the start of this year, the implementation date for Medicare contractors is April 5 (CMS Change Request 6557, Dec. 18, 2009). Contractors are not required to search their files for claims with dates of service between Jan. 1 and April 5, but may adjust claims brought to their attention.

The ACLA board of directors and general membership have agreed to voluntarily and routinely report a patient's estimated glomerular filtration rate (eGFR) with physician test orders for serum creatinine. The initiative has been endorsed by the National Kidney Foundation and the Renal Physicians Association. According to ACLA, "The reporting of a patient's estimated eGFR is widely accepted as a more accurate indicator of kidney function than a serum creatinine test alone. The calculation of eGFR accounts for a patient's age, height, weight, and gender, along with the serum creatinine results. The creatinine test itself measures how well the patient's kidneys process a waste product released by muscles when they burn energy. The eGFR calculation provides a more complete picture of how well the patient's kidneys are performing."

A number of subspecialty societies and organizations have emphasized that automatic eGFR reporting is the most desirable method of identification of patients with chronic kidney disease, ACLA said. At least six states mandate that clinical labs in their state report eGFR when creatinine is ordered (Louisiana, Michigan, Connecticut, Pennsylvania, New Jersey, and Tennessee) and several additional states have similar legislation pending.

Medicare Finalizes Decision to Cover HIV Screening

The full coverage decision memo is available at www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=229.

The Centers for Medicare and Medicaid Services (CMS) has expanded the Medicare preventive services benefit by adding coverage of voluntary HIV screening for beneficiaries. In a final coverage decision memo released Dec. 8, 2009 and effective immediately, the agency said, "The evidence is adequate to conclude that screening for HIV infection, which is recommended with a grade of A by the U.S. Preventive Services Task Force (USPSTF) for certain individuals, is reasonable and necessary for early detection of HIV."

CMS will cover HIV screening with an FDA-approved enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA), or rapid HIV antibody test, as follows:

1. Annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection under guidelines of the USPSTF:

- ❑ Men who have had sex with men after 1975
- ❑ Men and women having unprotected sex with multiple (more than one) partners
- ❑ Past or present injection drug users
- ❑ Men and women who exchange sex for money or drugs or have sex partners who do
- ❑ Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- ❑ Persons being treated for sexually transmitted diseases
- ❑ Persons with a history of blood transfusion between 1978 and 1985
- ❑ Persons who request an HIV test despite reporting no risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors

2. Voluntary HIV screening of pregnant Medicare beneficiaries.

Medicare coverage of HIV screening marks the first time CMS has exercised its new authority to expand the Part B benefit without first obtaining congressional approval. Since Jan. 1, 2009, CMS has had this power, if certain requisites are met, under provisions of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

Pathology 'Grandfather' Protection, *from p. 1*

House and Senate health care reform bills extend the "grandfather" protection, but differ over its length. The House extends it for two years, the Senate for one year. The original Senate Finance bill did authorize a two-year extension, but the Democratic leadership scaled it back to help keep down the bill's total cost. Both the House and Senate aim to keep the cost of health care reform below the $900 billion benchmark set by the Obama administration.

In light of the political pressure to rein in the cost of overhauling U.S. health care, industry sources speculate that if the protection survives in the final reform bill, it is likely to be extended for one year.

CMS has repeatedly sought to end the "grandfathered" pathology TC billings, contending that the TC is paid through the hospital's inpatient DRG payment and labs should seek reimbursement from the hospital, not the Part B program.

The protection applies to the hospital, not the lab, CMS has ruled. Hospitals may switch labs without forfeiting the protection; however, independent labs cannot switch hospitals and still be protected.

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Times: 2:00 p.m. – 3:30 p.m. (Eastern)

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 NATIONAL INTELLIGENCE REPORT (ISSN 0270-6768) is published twice monthly (except August and December, which are one-issue months) by Washington G-2 Reports, 1 Washington Park, Suite 1300, Newark, NJ 07102-3130. Telephone: (973) 718-4700. Fax: (973) 718-0595. Web site: www.g2reports.com. Order Line: (212) 629-3679.

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