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Providers Keep Pressing CMS on Physician Signature Policy

CMS had planned to enforce the new policy as of Jan. 1, but citing "lack of awareness or understanding" of the policy, has postponed the start date to April 1.

Providers have welcomed the three-month delay in implementation of a highly controversial policy change requiring the signature of a physician or nonphysician practitioner (NPP) on clinical laboratory test requisitions.

But a broad-based coalition of providers continues to meet with officials of the Centers for Medicare and Medicaid Services (CMS) and with members of Congress to register strong objections to the new policy.

Large delegations representing the American Medical Association, Medical Group Management Association, nursing homes, and lab groups met recently with Jonathan Blum, director of the CMS Center for Medicare Management, to discuss the impact of the policy change on providers and patients.

Providers want CMS to change its mind on the new policy altogether and consider alternatives or at least postpone implementation through the rest of this year to give the industry time to prepare for the change.

Continued on p. 6

Obama Defends Health Reform Law, Warns More Health Cuts Needed

President Obama in his State of the Union address Jan. 25 made clear he opposes GOP efforts to repeal the health care reform law but is open to working with Congress to improve it, though the law's core protections are off-limits.

In moves to reduce the federal debt, he warned, this will mean "further reducing health care costs, including programs like Medicare and Medicaid, which are the single biggest contributor to our long-term deficit. Health care reform will slow these rising costs. . . . And I am willing to look at other ideas to bring down costs, including one the Republicans suggested last year: medical malpractice reform to rein in frivolous lawsuits."

While the president spoke in general terms, his budget, due out next month, will "tell the story" on what he has in mind for Medicare, Washington observers told *NIR*. The budget is likely to announce stepped-up initiatives to combat fraud and abuse, one source said, "but I would be surprised if it pushed for additional provider cuts beyond those already made by the health care reform law."

INSIDE *NIR*

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CPT 2011 Introduces Four New Pathology Codes

The 2011 edition of the American Medical Association's *Current Procedural Terminology (CPT)* adds four new codes in the 88000 series for pathology: three in cytopathology and one in surgical pathology. The AMA's CPT Editorial Panel maintains and updates the coding system annually.

Cytopathology

- ❏ **88120** Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual

- ❏ **88121** Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology

These two codes replace the use of CPT 88367 and 88368 when the source of the specimen is urinary tract. This will result in a drop of Medicare reimbursement by approximately 52 percent.

The number of probes that can be billed is limited to a maximum of five and a minimum of three. When a lab performs less than three probes, the *CPT 2011* update says to continue to use 88367 and 88368. For more than five probes, use 88399, unlisted procedure. Use of this code could pose problems with various payers that are likely to require additional documentation before deciding to pay the claim, health lawyers caution.

There also is a new cytopathology add-on code (to be used in conjunction with the revised 88172 below).

- ❏ **88177** Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)

When a repeat immediate evaluation episode is required on subsequent cytologic material from the same site, e.g., following determination that the prior sampling was not adequate for diagnosis, use one unit of 88177 for each additional evaluation episode, *CPT 2011* advises.

This code will never likely be used for Medicare and Medicaid patients, health lawyers note, because CMS requires that only one unit of service may be billed for 88172 when the source of the specimen is the same site, regardless of the number of evaluations done on the specimen.

Surgical Pathology

- ❏ **88363** Examination and selection of retrieved archival (i.e., previously diagnosed) tissue(s) for molecular analysis (e.g., KRAS mutational analysis)

Descriptors for new codes in 2010, 88387 and 88388 (representing fresh tissue preparation for molecular diagnostic studies referred to an outside lab for testing), did not include specimens that had previously been processed or diagnosed by the laboratory. This left the lab to eat the cost of preparing those specimens that the treating physician may have requested additional molecular studies on after the initial testing and reports were provided to the physician. The new code is to be used for those previously processed specimens.

Medicare Payment Rates for New and Revised Pathology Codes
Relative Value Units X Conversion Factor for 2011*

CODE	WORK	PRACTICE EXPENSE	MALPRACTICE EXPENSE	TOTAL	GLOBAL FEE**
New					
88120	1.20	12.23	0.06	13.49	$458.34
88121	1.00	10.34	0.04	11.38	$386.65
88177	0.42	0.38	0.02	0.82	$27.86
88363	0.37	0.73	0.03	1.13	$38.39
Revised					
88172	0.06	0.87	0.02	0.95	$32.28
88332	0.59	0.58	0.02	1.19	$40.43
88334	0.73	0.97	0.04	1.74	$59.12

**Conversion factor: $33.9764. **Unadjusted for geographic practice cost variations. Source:* National Intelligence Report, *from 2011 Physician Fee Schedule, Corrections (Jan. 11, 2011). CPT codes © American Medical Association.*

Revised Pathology Codes

The *CPT 2011* update revises the wording of one cytopathology code and two add-on codes for surgical pathology.

- ❑ **88172** Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site
- ❑ **88332** Pathology consult during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)
- ❑ **88334** Pathology consult during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site (List separately in addition to code for primary procedure).

How Pathology Fares in 2011 Under Medicare's Revised Conversion Factor

The revision downward of the conversion factor used to set Medicare physician payments for 2011 has resulted in a dip for Part B spending on pathology services, but most pathology codes will still see gains, though lower than expected.

The conversion factor (CF) translates the relative value units (RVUs) of a Part B physician service—work, practice expense, and malpractice expense—into a dollar amount.

The Centers for Medicare and Medicaid Services (CMS) cut back the CF from $36.8729 in the second half of 2010 to $33.9764 as of Jan. 1, 2011. In explaining the change, CMS noted, "While the physician fee schedule update will be zero percent, other changes to the RVUs (*e.g.*, misvalued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget-neutral. To make them so, CMS must adjust the conversion factor."

Impact of the Change

In 2011, total allowed charges for pathology drop by 1 percent to $1.069 billion. For independent labs, the total charges allowed are up 1 percent to $1.039 billion. But diagnostic testing facilities take a big hit, down 15 percent to $909 million.

Twenty common pathology codes will see an average increase of 4.3 percent, according to analysis in the January issue of *Laboratory Economics*.

The most frequently billed anatomic pathology code, 88305 (tissue exam by pathologist), increases by 2.6 percent to a global fee of $106.35 (unadjusted for geographic practice cost differences). The technical component increases by 5.5 percent to $70, while the professional component declines by 2.4 percent to $36.35.

Flow cytometry codes are seeing gains as well: 88184 is up 6.8 percent to $84.26 and 88185 is up 7.3 percent to $50.62.

CMS to Continue to Delay PECOS Enforcement

The Centers for Medicare and Medicaid Services (CMS) announced this month that, until further notice, it will continue to delay implementation of edits that automatically reject claims from those providers who receive orders for services from ordering or referring practitioners not enrolled in the agency's Provider Enrollment, Chain and Ownership System (PECOS).

This is a welcome reprieve for pathologists and clinical labs who otherwise would be at financial risk for serving Medicare patients referred to them by physicians who do not have a current record in PECOS.

CMS had planned to implement the edits on Jan. 6, 2011. But in an agency transmittal, CMS officials indicated that the "match or scratch" edits would not be "turned on" in the near future. "CMS is working diligently to resolve backlog and other system issues and will provide ample advance notice to the provider and beneficiary communities before beginning any such automatic denials," the transmittal stated.

The new policy requires denial of payment for claims when the ordering or referring practitioner is not enrolled in PECOS or has a valid opt-out record, and when the practitioner is not identified on the claim by his or her legal name and National Provider Identifier (NPI).

CMS originally expected the start deadline for the PECOS requirement to be in early January 2011. This date was moved up six months to July 6, 2010, under changes made by the health care reform law to Medicare and Medicaid enrollment and reimbursement requirements. However, the July start date was delayed amidst enrollment problems and concerns from providers (*NIR 10, 13/July 12, p. 1*).

Despite the most recent announcement, CMS is encouraging physicians to enroll in PECOS "sooner rather than later."

Once PECOS Gets Going

- ❏ If the billed service requires an ordering or referring provider and the ordering or referring provider is not on the claim, the claim will not be paid.
- ❏ If the ordering or referring provider is on the claim, the MultiCarrier System (MCS) will verify that the ordering or referring provider is on the national PECOS file.
- ❏ If the ordering or referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering or referring provider.
- ❏ If the ordering or referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering or referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.
- ❏ Medicare will verify the NPI and the name of the ordering or referring provider reported on the claim against PECOS or, if the ordering or referring provider is not in PECOS, against the claims system. In paper claims, periods or commas are not permitted within the name of the ordering or referring provider. Hyphenated names are permissible.

The health care reform law specifies that the PECOS requirement applies to claims for durable medical equipment, prosthetics, orthotics, and supplies and for home health. In an interim rule implementing the law, CMS added claims for laboratory testing, specialist services, and imaging to the list, using its discretionary authority under the law.

The PECOS-NPI match is intended to weed out fraudulent entities from legitimate health care providers and suppliers, making it harder for the former to bill federal health care programs. Affected providers must document orders and referrals for seven years. Failure to comply could lead to revocation of Medicare enrollment for up to a year (*NIR 10, 10/May 25, p. 2*).

Medicare Fee-For-Service Spending Up 5.5 Percent in 2009

While Medicare spending grew 7.9 percent in 2009 to $502.3 billion, the same rate of growth as in 2008, spending for fee-for-service Medicare accelerated in 2009, increasing 5.5 percent compared to 4.4 percent growth in 2008, said the Office of the Actuary at the Centers for Medicare and Medicaid Services in a report published in the January issue of *Health Affairs*.

Medicare Advantage spending increased 15.8 percent in 2009, following 21.4 percent growth in 2008. This was primarily attributable, the report said, to a continuation of significant increases in enrollment. Total Part D spending (which includes spending for benefits, government administration, and the net cost of health insurance) increased 9.3 percent to $54.5 billion in 2009.

Overall health care spending in the United States decelerated in 2009, increasing 4 percent compared to 4.7 percent in 2008. Total health expenditures reached $2.5 trillion, which translates to $8,086 per person or 17.6 percent of the nation's gross domestic product. This was the slowest rate of growth in the five decades since records have been kept.

The economic recession "profoundly influenced" health spending in 2009, according to the report. "Many consumers decreased their use of health care goods and services partly because they had lost employer-based private health insurance coverage and partly because their household income had declined."

The historically low health spending growth rate, the report said, reflects a deceleration in spending for private health insurance, structures and equipment, as well as slower out-of-pocket expenses. The slowdown was partially offset by other areas, such as increased Medicaid enrollment that fueled higher spending growth and increased prescription drug spending.

Spending on physician and clinical services increased 4 percent in 2009 to $505.9 billion, a drop from 5.2 percent growth in 2008. Slower growth in the use and intensity of services in 2009 was partially offset by increasing prices.

Hospital spending increased 5.1 percent to $759.1 billion in 2009 compared to 5.2 percent growth in 2008. Growth in 2008 and 2009 was much slower than the trend between 1999 and 2007, when spending increased an average of 7.2 percent per year. The slower growth in 2009 was influenced by decelerating private health insurance spending and slower price growth. Partially offsetting these factors was an increase in Medicaid spending, as Medicaid enrollment increased considerably in 2009.

Total Medicaid spending grew 9 percent in 2009 to $373.9 billion, up from 4.9 percent growth in 2008 and driven by a 7.4 percent increase in Medicaid enrollment. Federal Medicaid expenditures increased 22 percent, while state Medicaid expenditures declined 9.8 percent. This difference was due to a significant increase in the Federal Medical Assistance Percentages (FMAP) used to determine federal Medicaid payments to states—a provision of the American Recovery and Reinvestment Act of 2009 (ARRA).

Providers Keep Pressing CMS, *from p. 1*

But an April 1 start date "leaves us with our backs against the wall," Jason DuBois, vice president of government relations at the American Clinical Laboratory Association, told *NIR*.

Making it even more problematic is the fact that promised guidance from CMS on how it intends to apply the policy to specific situations, in particular nursing homes and other settings where a physician or NPP is not on-site, has yet to be issued, noted another industry source at press time. In announcing the three-month delay, CMS said it would devote the first quarter of this year to an education and outreach campaign explaining the new requirement.

CMS announced the signature requirement in the proposed physician fee schedule rule, reversing longstanding policy that while the physician's signature is one way to document who ordered the test, it is not the only permissible way as long as the documentation exists in an alternate format, such as the patient's medical record. This was agreed to in a final 2001 rule developed by a congressionally mandated negotiated rulemaking committee and had been reiterated in CMS issuances as late as March 2010.

Despite a flood of comments opposing the change, CMS adopted without modification the proposed policy in the final physician fee schedule rule.

Policy Under Fire

The physician or NPP signature requirement applies to test requests made on paper forms, not to tests requested electronically or by telephone. If the request is made by telephone, both the treating physician or practitioner, or his or her office, and the testing facility must document the call in their respective copies of the beneficiary's medical records.

A requisition is the actual paperwork, such as a form, provided to a clinical diagnostic laboratory that identifies the test(s) to be performed for a patient.

Physicians are not required to use a requisition. They may use an "order," which CMS defines as "a communication from the treating physician or practitioner requesting that a diagnostic test be performed." This can be an annotated medical record or a documented telephone request.

The policy applies to clinical laboratory services payable under the Part B lab fee schedule. It does not apply to pathology services payable under the Part B physician fee schedule.

Pros and Cons

CMS argues that the new requirement eliminates uncertainty about whether documentation was required, will not increase the burden on physicians because "it is our understanding that physicians are already annotating the medical record or signing the paperwork provided to the laboratory," and would minimize compliance problems for labs during audits.

Opponents counter that most tests are requested via paper requisitions or fax by a nurse or office staff at the direction of the physician, but most are never signed. Under the new policy, the requisition would have to be returned to the physician or

NPP to sign, an especially burdensome added step for nursing homes, home health agencies, and other health facilities where a physician or NPP is not on-site.

Further, labs have no way of enforcing the requirement and are the only provider at financial risk if the requisitions are not signed. Before filing claims based on paper requisitions, labs will have to obtain the missing signatures.

Also on the Horizon

While the physician signature issue is the most immediate priority for the clinical laboratory industry, there are several other key issues ahead in 2011:

- ❏ Extension of the pathology grandfather protection. This allows independent clinical labs to bill Medicare separately for the technical component of pathology services to hospital inpatients and outpatients. The protection expires Dec. 31, 2011.

- ❏ Expanded oversight of lab-developed tests (LDTs) by the Food and Drug Administration (FDA). This would be a "big splash" issue, depending on what the FDA does and when it does it, noted an industry source. At press time, the agency was working on a draft framework to regulate LDTs based on the risk associated with the test. FDA officials said in a recent forum that the agency would continue to seek comment from stakeholders as the document undergoes review and that labs would have ample time to comply (*NIR 10, 22/Dec. 8, p. 1*).

- ❏ Closing the pathology loophole under the Stark in-office ancillary services exception. Pathology and lab groups advocate the removal of anatomic pathology from the exception, saying it has been abused by medical specialty groups to establish in-house labs to boost their Medicare revenue from pathology referrals. The original intent of the exception, the groups note, was to make a service available to the patient during the office visit. But pathology "can't be done in a 24-hour day," said an industry source.

Medicare Claims Advisory

Interest Rate Rises for Medicare Overpayments, Underpayments

Effective Jan. 24, 2011, the rate of interest that Medicare will pay you for claims that were underpaid, or collect from you for claims that were overpaid, has increased to 11.25 percent. This is up from 10.75 percent in effect from Oct. 22, 2010, to Jan. 23, 2011.

Medicare regulations provide for assessing interest at the higher of the current value of funds rate (1 percent for calendar year 2011) or the private consumer rate fixed by the Treasury. Upon notification from the Treasury of the new private consumer rate of 11.25 percent, the Centers for Medicare and Medicaid Services announced the quarterly update to the Medicare interest rate in Transmittal 182, Change Request 7154 (Jan. 14, 2011).

The highest rate in the past decade was in early 2001, 14.125 percent, but for most of the years since, the rate has hovered between 11 percent and 12 percent.

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