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Opening Salvos Fired Over Medicare Physician Fee Fix

The current freeze on the physician fee update expires Dec. 31, and a cut of nearly 30 percent is due to take effect Jan. 1, unless Congress decrees otherwise.

Unless Congress intervenes, Medicare physician payments are scheduled for a drastic cut as of Jan. 1, 2012, under the statutory sustainable growth rate (SGR) update formula.

The Centers for Medicare and Medicaid Services (CMS) has told the Medicare Payment Advisory Commission (MedPAC) that under the SGR, the conversion factor used to calculate physician fees will drop from $33.9764 to $23.9396, a plunge of 29.5 percent. Short-term relief provided by Congress to block SGR cuts has been critical, but a long-term solution is needed, CMS said.

MedPAC, in its March 2011 report to Congress, called for a 1 percent update to the Medicare physician fee schedule in 2012. But the panel made no recommendation for any SGR fix, saying it will continue to discuss the issue at meetings throughout the year.

Also this month, a broad alliance of physician interests sent a letter to House and Senate leaders urging them to scuttle the SGR formula and build a new payment system, rather than enact yet another temporary fix.

Continued on p. 6

INSIDE *NIR*

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Briefing Highlights Genetic Testing's Impact on Quality Care and Costs

As federal regulators plan to expand oversight of genetic tests and lab-developed tests, a March 17 briefing was held on Capitol Hill to discuss the role of genetic testing innovations in tailoring prevention, treatment, and therapy to the patient's genetic profile and reducing or avoiding costly hospitalization and disease complications.

The policy breakfast briefing, hosted by *The Hill*, was sponsored by Results for Life, the educational arm of the American Clinical Laboratory Association.

In his remarks, Rep. Charles Gonzalez (D-Texas) noted that genetic testing is rapidly transforming the diagnostics industry and clinical practice. Gonzalez, a member of the House Energy and Commerce health subcommittee, said innovations in this technology can save money now spent on ineffective or less effective care. Personalized medicine can help cut the $136 billion spent each year on adverse drug reactions alone, he added.

The genetic testing industry further helps advance the economy, he said, fostering jobs in this country and keeping the United States competitive in this fast-growing worldwide market.

Continued on p. 2

Genetic Testing's Impact, *from p. 1*

Gonzalez said the mandate in the health care reform law requiring everyone to obtain health care coverage will be a key factor in improving the access of patients to genetic testing innovations. If insurers are going to profitably cover personalized medicine, they will need a risk pool to support that, he said, adding that he would likely support including genetic tests in the essential benefits package that, under terms of the health care reform law, insurers will have to offer in state health insurance exchanges, starting in 2014.

Rep. Michael Burgess (R-Texas), a physician and vice chairman of the health subcommittee, cited his experience with his genetic profile, suggesting that it can lead to advantageous behavioral changes. While his report cited some risks of "borderline utility," it also provided useful information on his risk for cardiovascular disease that prompted him to add the recommended low-dose aspirin to his daily regimen.

Kenneth Sisco, M.D., Ph.D., medical director at Quest Diagnostics Nichols Institute, emphasized that research continues to be a key driver of the genetic testing revolution. In the shift from the traditional model of trial-and-error medicine to the new model of personalized medicine, he said, the practice of getting the right drug to the right patient has resulted in better warfarin dosing and gains against childhood leukemia, breast cancer, metastatic colon cancer, and HIV among others. It also saves billions by reducing spending on the wrong drug for the wrong patient.

Cynthia Kimball, a patient whose life was transformed by having the BRCA genetic test for breast cancer, shared her story and that of her sisters in dealing with their family history of cancers and a host of treatments, while energizing them to reach out to others and educate the community. The Kimball sisters' story has been featured in *People* magazine and on billboards in prevention and care campaigns. More on their activities is posted at *www.every1counts.net*.

President's Pick for Permanent CMS Head in Trouble

President Obama's nomination of Donald M. Berwick, M.D., as permanent chief of the Centers for Medicare and Medicaid Services (CMS) appears dead in the water for now. The post, vacant since 2006, requires Senate confirmation.

The head of the Senate Finance Committee said March 10 that he will not call up the nomination because there are not enough votes to confirm. Max Baucus (D-Mont.) said, "Republicans have made it clear to me that he will not be confirmed. It is up to the president to determine what he wants to do about that."

Forty-two of the 47 GOP senators wrote to Obama on March 3 urging him to withdraw Berwick's nomination. White House spokesman Reid Cherlin responded that the administration has no intention of doing so. "The president nominated Don Berwick because he's far and away the best person for the job, and he's already doing stellar work at CMS: saving taxpayer dollars by cracking down on fraud and implementing delivery system reforms that will save billions in excess costs and save millions of lives."

Berwick is currently serving as head of CMS under a recess appointment made by Obama in July 2010, allowing him to serve through 2011 without Senate confirmation. Such appointments can be made only when Congress is not in session. He was nominated to lead CMS in April 2010 but drew strong opposition from Republicans on the Finance panel, though a wide range of health care stakeholders, including

leading hospital groups, endorsed him. He was renominated as permanent agency head by Obama on Jan. 26 of this year (*NIR 11, 3/Feb. 10, p. 5*).

Republicans on the Finance panel have been hostile to Berwick from the start, despite his widespread support among health care stakeholders. They questioned him over his views on health care reform, a major new undertaking with CMS in the lead, and alleged that his statements indicate support for health care rationing and the British National Health Service. But the senators were angered even more by the recess appointment, which they regard as a "short circuit" of the process, denying them the right to confront Berwick.

In the latest barrage, they note, "Enactment of the 2010 partisan health care law placed more authority in the hands of the CMS administrator than ever before. As CMS now has the responsibility for restructuring insurance markets across the country, Dr. Berwick's lack of experience in the areas of health plan operations and insurance regulation raises serious concerns about his qualifications for this position."

According to the Department of Health and Human Services Web site, before assuming leadership of CMS, Berwick was president and chief executive officer of the Institute for Healthcare Improvement, clinical professor of pediatrics and health care policy at the Harvard Medical School, and professor of health policy and management at the Harvard School of Public Health. Berwick also is a pediatrician and a consultant in pediatrics at Massachusetts General Hospital.

For the Record

Lab Test Payment Demo: Official guidance to contractors on the implementation of this project has been moved to a new source. Transmittal 2144, dated Jan. 28, 2011, has been replaced with Transmittal 2173, dated March 10, 2011, which corrects compatibility errors in the Internet-Only Manual revisions. All other information remains the same.

Beginning July 1, 2011, the Centers for Medicare and Medicaid Services (CMS) will launch the demonstration, establishing a separate Medicare payment method for certain complex diagnostic tests. These are tests with a date of service that under standard Medicare rules would be bundled into the payment for an associated hospital inpatient stay. The project is to run for two years or until a $100 million payment ceiling has been reached (*NIR 11, 3/Feb. 10, p. 2*).

PECOS Claim Edits: CMS notes an editorial oversight in the Compendium of Unimplemented Recommendations (March 2011 Edition) from the Office of Inspector General (OIG). The report states that CMS will delay until July 5, 2011, the implementation of claim edits to identify ordering or referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). This is incorrect. As previously stated, CMS will give providers ample notice before these edits are applied and claims not in compliance are rejected (*NIR 11, 2/Jan. 27, p. 4*).

Correction: In the March 10 issue of *NIR* (*p. 5*), the descriptor for code 88112 was incorrectly cited as "Cytopathology, cervical or vaginal, requiring interpretation by physician." It should read: "Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical and vaginal."

Caution Advised in Billing New Drug Screening Codes

Clinical laboratories should take extra care when billing Medicare for drug screening codes this year due to changes made by the government in these codes, advises coding expert William K. Dettwyler, M.T., in the forthcoming updated *Medicare Reimbursement Manual 2011* from G2 Intelligence. He is president of Codus Medicus Inc., in Salem, Ore., and a senior coding consultant for Health Systems Concepts in Longwood, Fla.

For starters, Dettwyler notes in the book's section on "Coding for Medicare Services" there is a new CPT code—80104, Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure—but Medicare has declined to cover it in 2011 along with existing code CPT 80100, Drug screen, qualitative; multiple drug classes chromatographic method, each procedure.

Instead, the Centers for Medicare and Medicaid Services (CMS) has created a new set of HCPCS G codes for drug screening, depending on the complexity of the test method assigned under the Clinical Laboratory Improvement Amendments (CLIA)—waived, moderate, or high.

Changeover to New and Revised G Codes

While acknowledging that 80104 was created by the CPT Editorial Panel to take the place of G0430, CMS said that neither of these codes is properly described in order to control improper payment, billing, and utilization. Accordingly, neither should be priced under Medicare "because the descriptor does not accurately reflect the types of tests that need to be captured for accurate billing and payment."

Drug Screening Codes: Medicare Changes in 2011

CPT CODES NOT RECOGNIZED	
NEW	*EXISTING*
80104, Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	**80100,** Drug screen, qualitative; multiple drug classes chromatographic method, each procedure
ACTIVE HCPCS LEVEL II CODES	
NEW	*REVISED*
G0434 Drug screen, other than chromatographic; any number of drug classes, by CLIA-waived or moderate-complexity test, per patient encounter. Maximum Medicare allowance, $20.47.	**G0431** Drug screen, qualitative; multiple drug classes by high-complexity test method (e.g., immunoassay, enzyme assay), per patient encounter. Maximum Medicare allowance, $102.33.

However, 80104 is now an active code in the CPT 2011 update, Dettwyler points out. "If laboratories are using a multiple drug class testing methodology (*e.g.*, paddle, stick, cup, etc.), they will be expected to utilize this new code for non-governmental billings, as the code 80101 that many were using in the past is for single drug class methods. In addition, this new code also indicates 'each procedure' which severely limits most billings to one unit of service, where in the past many were billing up to 12 units with code 80101."

CMS has deleted G0430, Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure. This code is no longer active for Medicare now that G0434 is in play. This substitution is being made, CMS said, to limit the billing to one time per patient encounter.

But be cautious here, Dettwyler advises, because while "Medicare contractors have been instructed to not pay for code 80100, the code is still listed on the 2011 lab fee schedule with a national payment limit of $20.47."

The new code G0434 uses the new terminology of moderate-complexity not previously used for drug screens and limits this test to one unit per patient encounter,

regardless of the number of drug classes tested and regardless of the use or presence of the QW modifier indicating the test device is waived, he notes. Labs with a CLIA waiver must bill this code with the QW modifier. Labs with a CLIA certificate of compliance or accreditation do not append the QW to claims.

Another point of caution, he notes, concerns the revised G0431. An article from the Medicare Learning Network (MLN) says this code is for "CLIA high complexity tests only and the QW modifier is not used." However, the 2011 lab fee schedule includes a listed code, G0431QW, with a national fee cap of $102.33. This may well have been remedied later, but take note, the MLN article did not state correctly what is actually listed.

Screening for a Single Drug Class

Dettwyler further points out that "for 2011 CMS has not developed a code that appears useable for a single drug screen test performed by chromatography, because G0434 states 'other than chromatographic' and G0431 now limits this test to 'multiple drug classes' and to once per patient encounter."

Note: Based on more recent communication with personnel from CMS, Dettwyler told *NIR*, "I have been advised that laboratories performing testing by chromatography will be allowed to use code G0431. It may be that this is partly because CMS did not allow payment for any chromatography testing for single drug classes, based on the 2011 terminology descriptions in codes G0431 or G0434, while codes 80101 or 80100 are not payable."

Chromatography by description for code 80100 is limited to "multiple drug classes." Code 80101 allows the "single drug class method" that can be by any methodology.

Lab National Coverage Policies: Coding Change in April

The next quarterly update to contractor edits of claims for tests subject to Medicare's clinical laboratory national coverage determinations (NCDs), effective April 1, 2011, makes one change to the NCD for Blood Counts.

Diagnosis code ICD-9-CM V49.87, Physical restraints status, is added to the list of ICD-9-CM codes that "Do Not Support Medical Necessity."

This NCD differs from the other 22 in that it takes an exclusionary approach. It does not list diagnosis codes presumed to demonstrate medical necessity as do the 22 others, but rather only those codes that are not covered as "not supporting medical necessity." Thus, the Blood Counts NCD simply states that any code not listed is covered.

The change results from coding analysis decisions and biannual updates to the diagnosis codes, said the Centers for Medicare and Medicaid Services in Transmittal 2133. Contractors are to adjust claims brought to their attention but are not required to search their files to either retract payment for claims already paid or to retroactively pay claims.

The NCDs affect frequently ordered clinical laboratory procedures and stipulate requirements for uniform coverage, claims processing, and medical necessity documentation. They specify the circumstances under which Medicare will pay for a test, the appropriate CPT and ICD-9-CM codes to use, coverage limitations (such as frequency limits), and other guidelines. The NCDs were developed by a negotiated rulemaking required by the 1997 Balanced Budget Act and were published in a final rule on Nov. 23, 2001. Lab claims for each of the NCDs have been processed uniformly nationwide since April 1, 2003. Details for each NCD are posted at *www.cms.hhs.gov/CoverageGenInfo.*

Opening Salvos Fired, *from p. 1*

"It is our hope that Congress can again work together this year to end the cycle of temporary patches once and for all and develop a long-term and meaningful solution to this issue," the American Medical Association (AMA) and 130 other organizations representing doctors said in the letter.

President Obama, in his budget request for fiscal 2012, proposed a two-year patch that would cancel SGR cuts and freeze the fee update at current rates from Jan. 1, 2012, to Jan. 1, 2014. The budget blueprint lays out the cost of a 10-year fix but proposes savings offsets only for the first two years. The fix would cost $18.6 billion for 2012 and $54.4 billion over 10 years. A 10-year fix would cost around $370 billion, according to the U.S. Department of Health and Human Services.

Medicare Physician Service Stats

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings.

- ❒ In 2009, fee-for-service (FFS) Medicare spent about $64 billion on physician and other health professional services, accounting for 13 percent of total Medicare spending and 20 percent of Medicare's FFS spending.
- ❒ Among the 1 million clinicians in Medicare's registry, about half are physicians who actively bill Medicare. The remainder includes other health professionals, such as nurse practitioners, chiropractors, and physical therapists. These health professionals may bill Medicare independently (accounting for 10 percent of physician fee schedule spending) or provide services under physician supervision.
- ❒ Almost all FFS Medicare beneficiaries (98 percent) received at least one physician service in 2009.

Source: MedPAC Report to Congress, March 2011 Edition

The president urged Congress to use the two years in his proposed fix "to work on putting in place a plan to reform physician payment rates in a fiscally responsible way and to craft a reimbursement system that gives physician incentives to improve quality and efficiency, while providing predictable payments for care for Medicare beneficiaries" *(NIR 11, 4/Feb. 24, p. 1)*.

But getting lawmakers to commit to paying for more than a one-year fix may be problematic, Washington observers say, given the deficit-cutting mood on Capitol Hill.

Most recently, Congress canceled the SGR cut of 25 percent in physician fees for 2011 and froze the fee update for the year. In 2010, lawmakers enacted two one-month overrides, two two-month overrides, and one six-month override.

"While these stop-gap measures successfully averted payment cuts, their short-term nature has been problematic," MedPAC said in its report. The panel cited "mounting frustration of physicians, other health professionals, and their patients stemming from the uncertainty of future Medicare payments and the size of looming payment cuts" as well as the burden placed on CMS resources by having to "stop-start" processing of claims.

Implications of a 1 Percent Update

According to MedPAC, a 1 percent increase in physician fees in 2012 would, "relative to current law, increase federal program spending by more than an estimated $2 billion in the first year and by more than $10 billion over five years. Enactment of any positive update for 2012 would substantially increase Medicare spending relative to current law, because current law under the SGR system calls for negative updates in 2012 and 2013.

"The 1 percent update would increase Part B premiums and coinsurance liability amounts for beneficiaries. The payment increases for physician and other health professional services would maintain both provider willingness to serve Medicare patients and beneficiary access to their services."

Fixing the SGR

This has been an elusive goal, with pathology and other physician interests long advocating repeal of the SGR. But eliminating the SGR cuts requires significant offsets in federal spending.

Designed to control Medicare Part B spending, the SGR ties physician payment updates to growth in input costs, enrollment, and the volume of physician services relative to growth in the economy. It has resulted in significant decreases in physician payments that have been overridden by Congress since 2003.

MedPAC said a main flaw in the SGR is its blunt approach. "In setting across-the-board updates to Medicare's physician fee schedule, the system neither rewards individual providers who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases. Also, the SGR does little to counter the volume incentives that are inherent in fee-for-service payments. In fact, volume growth is one of the major factors that has caused cumulative spending to exceed the SGR's cumulative target."

A legislative package to repeal the SGR could include a major redistribution of payments, such as a major restructuring of fees and cutting the conversion factor but rewarding certain specialties, MedPAC noted.

Absent repeal, the panel cited possible technical changes that could be made to the SGR system, including:

- ❏ Using annual targets so that each time Congress overrides a cut, the differences do not add up cumulatively;
- ❏ Creating an "allowance corridor around the spending target line" (for example, two percentage points) so that the expenditure target is not exact;
- ❏ Applying targets separately for each category of service, such as evaluation and management, primary care, and anesthesia;
- ❏ Exempting from the current SGR target such providers as those in accountable care organizations but holding them accountable to other targets; and
- ❏ Penalizing physicians who are spending outliers.

MedPAC has been divided in the past over the role expenditure targets should play in policy, over their value in holding down growth in physician services. Commission chairman Glenn Hackbarth said any future targets could be used differently, such as serving as an "action forcing tool," rather than triggering cuts for all Part B services. Targets could trigger changes in some relative value units, he said. The panel's vice chairman, Robert A. Berenson, said, "I do think having some process to actually pick and choose where to achieve the savings could be much more palatable than simply an across-the-board cut."

The major legislative hurdle to replacing the SGR overhaul is its cost—an estimated $370 billion over 10 years. Congress has had little stomach for more than short-term fixes since the SGR began triggering cuts in 2003. However, since SGR cuts are cumulative, short-term fixes only increase the costs of a permanent solution, physician groups warn. Repeal efforts failed in the last Congress, largely because they did not account for how to pay for it. G2

