G2 INTELLIGENCE

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Medicare Lab Fees Cut to Pay for Physician Fee Fix

The congressional action underscores the fact that in the search for budget savings, clinical lab services remain a tempting and easy bipartisan target with limited political fallout.

INSIDE *NIR*

At press time, the president is expected soon to sign into law legislation passed by Congress on Feb. 17 that would cut Medicare lab fees by $2.7 billion over 10 years to help pay for another short-term Medicare physician fee fix. The bill was approved by the House, 293-132, and by the Senate, 60-36.

Starting in 2013, the change would cut lab payment rates by 2 percent under the Medicare clinical laboratory fee schedule. This is on top of any cut required by the schedule's update formula, as revised by the health care reform law, including a productivity adjustment (currently 1.3 percent) and a 1.75 percent cut in place from 2011 through 2015.

"As [this 2 percent] reduction is applied after the update is calculated, the resulting 2013 update amount becomes the new reset base" for 2014 and subsequent years, according to a summary prepared by staff of the House committees on Ways and Means and Energy and Commerce.

The physician fee fix—part of legislation agreed to by a House-Senate conference committee to extend the Social Security payroll tax cut and unemployment benefits—cancels a 27.4 percent cut in Medicare physician fee schedule rates, slated to begin March 1, and freezes the rates at their current level through Dec. 31 of this year.

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Pathology TC Grandfather Protection Set for Phase-Out July 1

Despite last-minute pleas from pathology and clinical laboratory groups as well as members of the House and the Senate, Congress approved the elimination of the pathology grandfather protection as of July 1.

The protection allows independent clinical laboratories to bill Medicare directly, as opposed to billing the hospital, for the technical component (TC) of pathology services to hospital inpatients and outpatients. The TC (preparation of the slide involving tissue or cells that a pathologist interprets for diagnosis) includes anatomic pathology, cytopathology, and surgical pathology. The protection applies to hospital-lab arrangements in effect as of July 22, 1999, the date when the Medicare program first proposed to end such direct billing.

The current grandfather provision expires Feb. 29 but got a four-month extension, through June 30, as part of House-Senate conference committee

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Pathology TC Grandfather Protection, *from p. 1*

legislation (H.R. 3630, enacted Feb. 17) that would continue for the rest of this year the Social Security payroll tax cut, unemployment benefits, and a freeze on Medicare physician payments.

According to a legislative summary prepared by staff of the House committees on Ways and Means and Energy and Commerce, "The four-month extension provides time for the labs and hospitals to establish payment arrangements. Expiration after a reasonable transition period addresses concerns that Medicare is paying twice for the same service, which causes beneficiaries to make an extra copayment.

"Minimal oversight of the policy by the Centers for Medicare and Medicaid Services (CMS) has also made Medicare susceptible to making inappropriate payments. Further, the Government Accountability Office has recommended that this policy expire."

With the expiration of the pathology technical component protection on July 1, hospitals will have to absorb new billing costs while independent pathology labs will likely receive less revenue from the hospital compared to when they billed Medicare directly.

But in a Feb. 14 bipartisan letter to conference committee chairmen Max Baucus (D-Mont.), who heads the Senate Finance Committee, and Dave Camp (R-Mich.), who heads the House Ways and Means Committee, some 30 members of the House and the Senate argued that allowing the grandfather protection to expire would be detrimental to all parties involved, including Medicare beneficiaries.

"Hospital and independent laboratories will have to establish new, costly, and administratively complex billing systems with little notice. About three-quarters of states would be impacted, with smaller and rural hospitals being affected the most.

"Using an independent lab allows many small and rural hospitals to access high-quality services when it simply does not make sense to have an in-house lab, usually because they do not necessarily have the surgery volume to support a robust state-of-the-art lab.

"Unlike a single hospital in this situation, an independent lab providing pathology services to multiple hospitals receives the volume necessary to purchase the most up-to-date equipment and employ skilled laboratory staff."

The College of American Pathologists called the phasing out of the grandfather protection an "ill-advised" decision. "It was not instituted to provide a benefit to pathologists, rather it was created to ensure patient care and hospital service in areas that need it most," said Richard Friedberg, M.D., Ph.D., FCAP, chair of CAP's Council on Government and Professional Affairs. "Over the past 10 years, it has helped hospitals that would otherwise not be able to provide laboratory tests and anatomic pathology services to their patients."

CMS has repeatedly sought to end the protection (most recently in the final Medicare physician fee schedule rule for 2012) but has repeatedly been overruled by Congress until now. Conference committee members apparently bought into CMS's argument that the TC of pathology services is included in the hospital's prospective payment and allowing independent labs to bill the TC separately amounts to a duplicate payment.

The conference committee decision sidelines bipartisan bills introduced in the Senate and the House that supported the grandfather protection. The Senate bill (S. 1680) would extend the protection through Dec. 31, 2012. The House bill (H.R. 2461) would make it permanent. G2

Long-Term Fix to Medicare Physician Fees Proves Elusive

While welcoming a reprieve from a steep double-digit cut in Medicare physician fees set for March 1, pathology and other physician groups lamented that Congress missed yet another opportunity to replace the sustainable growth rate (SGR) formula that has triggered negative updates for the past decade.

Blocking an SGR cut of 27.4 percent on March 1 was one of three priorities for the House-Senate conference committee on extending the Social Security payroll tax cut and unemployment benefits.

In the final extension legislation enacted Feb. 17, Congress cancelled the SGR cut and froze physician fees at their current level for the rest of 2012, according to the Congressional Budget Office. To help offset the cost, clinical laboratory services were cut by $2.7 billion over 10 years (*related story, p. 1*).

Unlike the payroll tax cut which conferees decided did not need an offset but would be covered by deficit spending, the physician fee fix had to be fully funded and in the end the cost of a permanent SGR overhaul, an estimated $300 billion over 10 years, proved too high for this budget go-round. A proposal to pay for it outside Medicare provider cuts by tapping unspent funds budgeted for the wars in Iraq and Afghanistan, a plan backed by Democrats and some Republicans on the committee, failed to get enough support.

Congress has now passed short-term fixes to the physician payment system 14 times, the American Medical Association (AMA) noted. With the latest patch, the AMA said, "People outside of Washington question the logic of spending nearly $20 billion to postpone one cut for a higher cut next year, while increasing the cost of a permanent solution by about another $25 billion.

"Congress had an opportunity to permanently end this problem, which is the sound, fiscally prudent policy choice. We appreciate efforts by members on both sides of the aisle who publicly supported a framework for a permanent end to this perennial problem. We are deeply disappointed that Congress chose to just do another patch—kicking the can, growing the problem, and missing a clear opportunity to protect access to care for patients."

The Obama administration's budget request for fiscal year 2013 does not include a proposal for a long-term fix to Medicare's physician payment system; however, it states that "to promote more honest and transparent budgeting, the budget includes an adjustment totaling $429 billion over 10 years . . . to reflect the administration's best estimate of the cost of future congressional action based on what Congress has done in recent years for physician payments. This adjustment does not signal a specific administration policy, but rather a willingness to work with Congress to achieve permanent, fiscally responsible reform."

The short-term fix only postpones the SGR issue to year's end before a cut of an estimated 30 percent kicks in on Jan. 1, 2013. A serious look at SGR reform is not expected before the November elections and would likely come in a lame-duck session in December. G2

Palmetto Delays Start of Molecular Diagnostics Program

Medicare contractor Palmetto GBA this month announced three main modifications to its controversial program, called MolDx, for determining coverage and payment for molecular diagnostic tests. The changes below were made, the contractor said, in response to comments from many in the clinical laboratory industry.

- ❑ The effective date for submitting MolDx claims is moved from March 1 to May 1. Claims received with dates of service on or after May 1, 2012, without one of the listed identifiers below or a fax with the required information will be rejected for insufficient documentation.
- ❑ Labs registering their molecular diagnostic tests with MolDx have a choice of applying for the preferred McKesson Z-Code or an alternative Palmetto test identifier (PTI).
- ❑ The electronic claims fax cover sheet has been updated to allow submission of the test identifier via fax attachment to an electronic claim. If no test identifier (Z-Code or PTI) has been issued, Palmetto has developed a MolDx test information form that may be faxed with each test claim to identify the MolDx service provided. This form may be used until Sept. 1, 2012.

Many in the lab industry expressed concerns about Palmetto's requirement that they obtain a unique Z-Code from McKesson, a consulting company and third-party vendor. Lab groups also said the March 1 start deadline did not give them enough time to prepare for the new program.

MolDx Program: Scope and Function

Under the program announced in November 2011, labs must register their molecular diagnostics tests with Palmetto and submit test information and supporting evidence to be reviewed by subject matter experts from academia and industry to help Palmetto make a coverage and reimbursement determination.

The MolDx program will operate in Health and Human Services Jurisdiction 1 (J1): California, Nevada, Hawaii, Guam, American Samoa, and the Northern Marianas Islands.

It will affect all hospital, private, and reference labs that perform molecular diagnostic testing and bill Medicare in J1. Labs that bill J1 services performed by a lab not in J1 will have to register their molecular tests.

Types of Molecular Diagnostic Testing Affected

The types in the MolDx program include those that are those that:

- Require or use more than one CPT code to identify the service.
- Use the methodology-based stacking CPT codes (83890-83914), microarray CPT codes (88384-88386), and cytogenetic CPT codes (88230-88291).
- Are all pathology and laboratory codes listed as Not Otherwise Classified.

Expect the Palmetto policy to be watched closely by other Medicare contractors and by private payers. Some could decide to tackle something similar. It could easily spread, analysts note, since Palmetto already serves as the Medicare contractor for North and South Carolina, West Virginia, and Virginia as well the states and territories in Jurisdiction 1.

To stay abreast of MolDX implementation, go to *www.PalmettoGBA.com/J1B/MolDx*.

Delay Announced for ICD-10 Compliance Date

Health and Human Services Secretary Kathleen Sebelius announced Feb. 16 that HHS will initiate a process to postpone the date by which health care entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must comply with use of the International Classification of Diseases, 10th Edition, diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 with a compliance date of Oct. 1, 2013, two years from the compliance date initially set in the proposed rule.

"HHS will announce a new compliance date moving forward," Sebelius said in a statement. "We have heard from many in the provider community about the administrative burdens they face in the years ahead. We are committed to working with the provider community to reexamine the pace at which HHS and the nation implement ICD-10 improvements."

Without postponement, all HIPAA-covered transactions, including outpatient and inpatient claims, would have been required to use the ICD-10 code sets by Oct. 1, 2013.

The acting administrator for the Centers for Medicare and Medicaid Services (CMS), Marilyn Tavenner, had earlier signaled that the delay was coming, noting, "There is concern that folks cannot get their work done around meaningful use of health information technology, ICD-10 implementation, and be ready for [insurance] exchanges," she told reporters Feb. 14. "So we decided to listen to that and be responsive."

The American Medical Association (AMA) early this month wrote to Sebelius, asking that implementation of the new disease coding system be halted.

In a January letter to House Speaker John Boehner (R-Ohio), AMA said that implementing ICD-10 requires physicians and their office staff to contend with 68,000 codes, a "fivefold increase from the current 13,000 codes." This conversion "is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers."

Although she acknowledged the need to revisit the implementation schedule, Tavenner praised ICD-10 as a "good idea and foundational to many positive improvements in our health care system, such as better prevention of fraud and abuse," and which is expected to improve patient care.

Meanwhile, CMS is moving ahead with a prerequisite for using the ICD-10 code sets—namely, ASC X12 Version 5010. While the effective date for adopting Version 5010 remains Jan. 1, 2012, the agency has granted a 90-day grace period, through March 31, for HIPAA-covered entities to achieve compliance.

Nonetheless, the CMS Office of E-Health Standards and Services will exercise its enforcement discretion with respect to any HIPAA-covered entity against which a complaint is filed for noncompliance during the grace period. If requested by this office, covered entities that are the subject of complaints (known as "filed-against entities") must produce evidence of either compliance or a good-faith effort to become compliant during the 90-day period.

All providers not yet in compliance should be following a Version 5010 transition plan that includes testing with payers and other business partners, CMS said. This will help address any potential issues in advance and avoid problems when submitting claims for reimbursement.

Medicare Lab Fees Cut, *from p. 1*

This provision also requires the Government Accountability Office and the Department of Health and Human Services to submit reports to help Congress develop a long-term replacement for the current Medicare physician payment system.

The lab fee cut is one of a series of offsets to pay for the physician fee fix through the rest of this year—$18 billion, according to the Congressional Budget Office. In other offsets, the legislation would reduce the amount of bad debt that Medicare providers, including hospitals and nursing homes, could recover from 70 percent to 65 percent, trim Medicaid allotments to disproportionate-share hospitals, and cut funding provided by the health care reform law for various programs, including programs to prevent diseases caused by smoking and obesity.

Surprised and Stunned

This sums up the reaction from clinical laboratory groups to the lab fee cut. By the time word surfaced that the cut was included in the legislative compromise hammered out by the House-Senate conference committee, it was too far along to be stopped, Washington sources told *NIR*, despite an 11th-hour appeal from the Clinical Laboratory Coalition (CLC), whose 16 members represent community, regional, and national labs.

Faced with the fee cuts, labs will be squeezed on their bottom line when doing Medicare work and may have to make cuts on the expense side, including with suppliers, to make up the difference. Labs also face an additional crunch from a 2.3 percent excise tax levied by the health care reform law and set to be imposed on in vitro reagents as of Jan. 1, 2013.

In a Feb. 15 letter to Sen. Max Baucus (D-Mont.), who heads the Finance Committee and co-chaired the conference committee, the CLC said that further reductions to the lab fee schedule, significantly cut during health care reform, will threaten the viability of hundreds of local and regional labs and thus access by beneficiaries to tests that physicians need to diagnose and manage clinical conditions.

"While less than 2 percent of all Medicare spending, clinical laboratory testing has been subject to significant freezes in payments and cuts over the last two decades. Medicare payment amounts for clinical laboratory services have been reduced by about 40 percent in real (inflation-adjusted) terms over the past 20 years," the CLC noted.

The National Independent Laboratory Association (NILA), which is a CLC member, called the lab fee cut a "devastating blow to regional and community clinical labs, putting thousands of jobs across the country at risk. These labs with high Medicare patient populations could face staff layoffs or worse as they try to manage the impact of" this cut on top of two others put in place by the health care reform law.

In a statement released the day the conference committee bill was enacted, NILA, which represents labs that primarily serve the long-term care community, said it "vehemently opposes these cuts. Many of our labs are family-owned and operated small businesses that have been serving communities and nursing homes for decades. These cuts will mean the end of business for some of them. We just don't see how they can survive."

For many NILA members, up to 80 percent of their business is focused on providing services to Medicare beneficiaries. "These new cuts also put jobs at risk as regional and community laboratories may be forced to lay off technicians and other skilled personnel to accommodate for lost revenue," said NILA administrator Mark Birenbaum.

Nursing home patients rely on these labs to provide services in their place of residence, he noted. Lab technicians travel to nursing homes daily to collect specimens

from residents, often performing stat testing to avoid patients being transferred to the hospital via ambulance for emergency testing.

"National labs have already said they won't assume the nursing home work—it's just not worth it for them. So who is going to do this work when regional and community labs are put out of business?" Birenbaum asked.

Warning for Labs in Fraud Recovery Case

There's a clear heads-up alert to clinical laboratories in a case involving fraud in billing Medicare for urine drug tests.

The alert is this: Keep a close eye on your billing records because the government is using data analysis tools to identify any coding anomalies that could lead to false claim charges.

In the case at issue, three Troy lab companies will pay $6 million in cash and property to the federal government to resolve allegations that they violated the False Claims Act, said Barbara L. McQuade, U.S. attorney for the Eastern District of Michigan.

"This fraud was discovered by analyzing data to flag billing anomalies. Providers should be aware that law enforcement is scrutinizing billing records to identify providers who are stealing from taxpayers."

—U.S. Attorney Barbara L. McQuade, Eastern District of Michigan.

The complaint alleged that Accela Medical LLC (Franklin, Tenn.) defrauded Medicare by improperly billing for lab tests. This was detected when an analysis of billing records revealed that Accela was using a particular billing code more than any other Medicare provider in the nation. Two Troy, Mich., companies, Coventry Diagnostics LLC and its wholly owned subsidiary, Western Slope Laboratory LLC, performed the testing. All three companies were controlled by Thomas McCormick of Troy.

Elements of the Scheme

According to the complaint, McCormick organized and operated Accela Medical LLC, a front company, to conceal his own involvement because he had been debarred from billing Medicare due to a previous health care fraud conviction.

A co-conspirator, Charles B. Reinhardt, of Tennessee, the nominal owner of Accela, applied to Medicare for a provider number, allowing Accela to bill the government and then split the profits with McCormick and his companies.

Cash and Property Recovered

- Approximately $4.7 million in assets that the court froze at the start of the case under the Federal Debt Collection Procedures Act;
- Payment of an additional $400,000 in cash;
- Transfer of a North Carolina beach home and a retirement account to the government worth approximately $500,000;
- $400,000 that was transferred to a shareholder in Singapore; and
- $18,000 representing double the amounts transferred to a company manager.

When Medicare raised questions about the ownership and control of Accela, Reinhardt and McCormick submitted falsified documents to Medicare hiding the real ownership and control of the company.

Under the scheme set up by McCormick and Reinhardt:

❑Reinhardt billed Medicare for approximately $900 worth of urine drug tests for virtually every patient referred to Accela by a physician, regardless of what the physician actually intended to order or what was medically necessary.

❑Accela also improperly billed for 18 "separate" procedures for each patient to evaluate urine levels of opiates.

Gains Cited in Use of Health Information Technology

The number of hospitals using health information technology (IT) more than doubled in the last two years, Health and Human Services (HHS) Secretary Kathleen Sebelius announced Feb. 17. New data also show that nearly 2,000 hospitals and more than 41,000 doctors have received $3.12 billion in incentive payments for meaningful use of health IT, particularly certified electronic health records (EHR).

A survey by the American Hospital Association and reported by the HHS Office of the National Coordinator for Health IT found that the percentage of hospitals that had adopted EHRs rose from 16 percent to 35 percent between 2009 and 2011. Further, 85 percent of hospitals now report that by 2015 they intend to take advantage of the incentive payments made available through the Medicare and Medicaid EHR Incentive Programs.

For more information about the Medicare and Medicaid EHR Incentive Programs, see www.cms.gov/EHRIncentive Programs.

In January 2012 alone, according to data from the Centers for Medicare and Medicaid Services, the agency provided $519 million to eligible providers. EHR incentive payments can total as much as $44,000 under the Medicare EHR Incentive Program and $63,750 under the Medicaid EHR Incentive Program.

According to the Bureau of Labor Statistics, the number of health IT jobs across the country is expected to increase by 20 percent from 2008 to 2018, a pace much faster than the average for all occupations through 2018.

Upcoming G2 Events

Webinar (2 p.m. – 3:30 p.m. Eastern)

March 7

CLIA Compliance, PT, and Quality Control: What's New for 2012?

Featured speaker: Judy Yost, top CLIA official at CMS

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April 17-19

MDx Next

Molecular Diagnostics Spring 2012

Gaining the MDxEdge

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Boston
www.mdxconference.com/Home

June 6-8

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Las Vegas
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