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Congress Delays Medicare, Other Sequestration Cuts

Unless blocked legislatively, sequestration will impose a cut of up to 2 percent on top of other Medicare payment reductions for pathologists and clinical laboratories in 2013.

Across-the-board cuts in federal spending scheduled to kick in Jan. 1 have been postponed for two months, until March, under the American Taxpayer Relief Act that Congress passed on New Year's Day and the president signed into law Jan. 2.

The delay postpones a maximum cut of 2 percent in Medicare payments to physicians, clinical laboratories, and other health care providers and health plans in 2013, or a total of nearly $11.1 billion, under sequestration rules.

Sequestration refers to automatic spending cuts required by the deficit reduction deal reached in July 2011 to raise the federal debt ceiling. Unless Congress decrees otherwise, the deal mandates that beginning in 2013 at least $1.2 trillion in federal spending must be cut over 10 years, split equally between defense and nondefense accounts. The portion of Medicare subject to the cut, capped at 2 percent, totals $554.265 billion over the 10-year period.

Sequestration will also force major cuts in programs created by the health care reform law and not subject to the 2 percent cap: $66 billion from grants to states to create health insurance exchanges and $76 billion from the prevention and public health fund.

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Physicians Escape Medicare SGR Cut, But Payments Frozen for 2013

On New Year's Day, in the last hours of its second and final session, the 112th Congress blocked a 26.5 percent cut in Medicare Part B physician payments scheduled to take effect Jan. 1 and approved a 0 percent update, freezing fees through Dec. 31, 2013.

The cut was scheduled under the sustainable growth rate (SGR) formula used to calculate the annual payment update. It has triggered negative updates over the past decade but Congress has overridden them.

This year's physician fee fix was included in the "fiscal cliff" legislation, the American Taxpayer Relief Act of 2012 (H.R. 8), which the president signed into law Jan. 2. The bill also extends through Dec. 31 the 1.0 floor on the physician work geographic adjustment practice cost index.

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Physicians Escape Medicare SGR Cut, *from p. 1*

On Jan. 3 the Centers for Medicare and Medicaid Services (CMS) announced that it was revising the 2013 physician fee schedule to reflect these changes and that the 2013 conversion factor is $34.0230. The factor is used to translate the relative value units of a physician's service (work, practice expense, and malpractice expense) into a dollar amount.

Medicare contractors are expected to release for processing claims with January 2013 service dates no later than Jan. 16. This should have minimal impact on a provider's cash flow, CMS said, because, under current law, clean electronic claims are not paid sooner than 14 calendar days after the date of receipt (29 days for paper claims). Medicare contractors will be posting the revamped physician payment rates on their Web sites no later than Jan. 23, the agency said.

Cost of the Fix and Who Pays for It

The one-year physician fee fix will cost an estimated $10.6 billion in 2013 and $25.2 billion over 10 years, according to preliminary projections from the Congressional Budget Office. It will be offset by cuts in other Medicare and Medicaid spending.

Hospitals will absorb the lion's share. Inpatient prospective payment is reduced through 2018 under case mix documentation and coding adjustments in the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs), saving an estimated $10.5 billion over 10 years. Payment to disproportionate share hospitals that treat large numbers of Medicaid recipients is cut by $4.2 billion over that same period.

Other major offsets and estimated savings over 10 years are as follow:

- ❑ Bundled payment for end-stage renal disease services is to be rebased in 2014, while packaging oral drugs in the payment bundle is delayed for two years. Savings: $4.9 billion.
- ❑ Under the Medicare Advantage program the coding intensity adjustment minimum rate is raised by 0.2 percentage points. Savings: $2 billion.
- ❑ Effective April 1, 2013, the 25 percent multiple procedure payment reduction for multiple therapy services is increased to 50 percent. Savings: $1.8 billion.
- ❑ The equipment utilization factor used to set payment for advanced imaging services is increased from 75 percent to 90 percent. Savings: $800 million.
- ❑ Competitive bidding is applied to diabetic test strips purchased at retail pharmacies. Savings: $600 million.
- ❑ The period to recover Medicare overpayments is extended from three to five years, saving $500 million (*related story, p. 8*).
- ❑ Payments for stereotactic radiosurgery services are equalized under outpatient prospective payment for a savings of $400 million over five years. This does not apply to hospitals in a rural area, hospitals classified as rural referral centers, and a sole community hospital.

The bill also wiped out funding for the Medicare Fee-For-Service Improvement Fund, saving $1.7 billion over 10 years, and cut remaining funding for the Consumer Operated and Oriented Plan program established under the health care reform law, saving $200 million over that same period.

SGR Repeal Still Urged

While relieved to avert the 26.5 percent fee cut this year, medical groups continue to urge Congress to repeal the SGR formula, which is on track to slash physician fees again in 2014. They want lawmakers to establish federal policy to shift to a new reimbursement system that provides stable annual updates and includes payment models that reward quality and outcomes rather than service volume. The cost of SGR repeal has been a legislative obstacle for years, upward of $300 billion over 10 years, and increasing as the deferred cuts accumulate.

Payment, Processing Anxiety Over MDx Code Gap-Fills

Despite speculation in some industry circles that its implementation might be delayed, the gap-fill method remains the approved process whereby local Medicare contractors determine the payment rates for 114 molecular pathology codes new to the 2013 Part B clinical lab fee schedule, effective Jan. 1.

This has triggered anxiety among pathology practices and independent clinical laboratories for several reasons. Does this give local contractors enough time to calculate reasonable payment rates based on pricing patterns in their jurisdiction? Will this delay processing of 2013 claims for these codes and thereby disrupt providers' cash flow?

The new codes are arranged in two tiers: Tier 1, CPT 81200-81383, for analyte-specific, high-volume tests, and Tier 2, CPT 81400-81479, for resource-based, low-volume procedures. They replace the stacking codes, CPT 83890-83914, that have been eliminated in 2013.

The Centers for Medicare and Medicaid Services (CMS) said it adopted the gap-fill method because it did not have sufficient information to set national payment caps for these codes in 2013. But the agency said it would tap pricing data from local Medicare contractors to establish national fee caps for these codes in 2014.

Gap-filling is one of two approved methods that CMS uses to establish payment rates for tests covered under the Medicare lab fee schedule. It is used when there is no comparable crosswalk to an existing code or set of codes. It is rarely used and only for new tests with low volume initially and that Medicare has not covered in the past. Gap-filling requires local contractors to set their Medicare rates based on several factors in their jurisdictions, such as the cost of the testing, charges for it after discounts, and reimbursement rates set by other payers.

"Until local contractors complete the gap-filling process, clinical labs may not be paid for molecular pathology tests with the new CPT codes," the American Clinical Laboratory Association has warned. The impact of gap-filling has been minimal in the past "because new tests typically have low claim volumes. In contrast, here, gap-filling would be used for well-established and frequently ordered tests."

One local contractor, Palmetto GBA, which handles claims for California, Nevada, Hawaii, and the Pacific territories, has already announced that for services on or after Jan. 1, the Tier 1 and Tier 2 codes will be included in its controversial MolDx program, requiring labs to register each assay and, if applicable, get a McKesson Z-Code identifier in order to bill and be paid.

Latest Snapshot of National Health Spending

Health care spending in the United States rose 3.9 percent in 2011 to a total of $2.7 trillion and accounted for 17.9 percent of the gross domestic product (GDP), according to the annual report that the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) released Jan. 7.

This was the same growth rate and GDP percentage as in the previous two years and marks the lowest in the report's 52-year history. It reflects continued economic weakness that has depressed demand for health care services and increased the ranks of the uninsured, said the report, published in the January 2013 issue of *Health Affairs*.

"Although the health sector tends to be somewhat insulated from overall recessions, this one had an immediate effect on health care spending," CMS noted. "High levels of unemployment, a considerable reduction in the number of people with private health insurance, lower household income and assets, and financial uncertainty all had a substantial impact on consumers, providers, and sponsors of health care."

2011 Trends in Spending Growth

- **Medicare**: 6.2 percent versus 4.3 percent in 2010, due in large part to a one-time change in payment rates to skilled nursing facilities and faster growth in spending for physician services under fee-for-service and for Medicare Advantage plans.
- **Medicaid**: 2.5 percent versus 5.9 percent the previous year, attributed to tight state budgets, an end to enhanced federal aid to states, and slower enrollment growth (from 4.9 percent in 2010 to 3.1 percent in 2011).

Despite a stable growth rate from 2009 through 2011, health care spending could rise at a faster pace depending on how the economy recovers from the recession. Possible offsets would be steps by providers and health plans to improve efficiency and patients' outcomes, which could help control health care costs.

- **Physician and clinical services**: Up faster in 2011 than in 2010, 4.3 percent versus 3.1 percent, due mainly to factors not linked to price, such as the use and complexity or intensity of services.
- **Hospital services**: Up 4.3 percent in 2011, but below spending growth of 4.9 percent in 2010, because of slower growth in hospital prices, lower growth in the use of hospital services, and less Medicaid spending on hospital care. The number of inpatient hospital days fell by 1.1 percent in 2011, following a decline of 1.6 percent in 2010. Outpatient hospital visits were up only slightly in 2011.
- **Prescription drug spending**: Up 2.9 percent for a total of $263 billion, compared with a rise of 0.4 percent the previous year. The accelerated pace was attributed in part to price increases for brand-name and specialty drugs, though this was moderated somewhat by fewer prescriptions dispensed and an increased use of generics.
- **Private health insurance**: 3.8 percent versus 3.4 percent in 2010, mostly due to an increase in enrollment in private plans of 0.5 percent.
- **Out-of-pocket spending by individuals**: 2.8 percent versus 2.1 percent the previous year, due to higher cost-sharing limits and more people enrolled in consumer directed health plans, which often require large deductibles.
- **Personal health care goods and services**: 4.1 percent versus 3.7 percent in 2010.

The report found that the health care reform law has yet to make a big impact on the health care system because most of its major provisions will not be implemented until 2014. But the law has had some impact on some components of national health care spending, CMS noted. "As many as 2.7 million people age 26 and younger had been added to their parents' health plans by 2011 and Medicaid prescription drug rebates have helped lower the growth in Medicaid prescription drug costs."

Free Access to Electronic Interface OK, Says OIG

The Health and Human Services Office of Inspector General (OIG) has given the green light to a proposed arrangement whereby a hospital would provide physicians with free access to an electronic interface for sending lab and diagnostic test orders to the hospital and receiving the results.

In Advisory Opinion 12-20, released Dec. 19, the OIG said the arrangement would not generate prohibited remuneration under the anti-kickback statute (42 U.S.C. §1320a-7b(a)) or lead to administrative sanctions under its exclusionary authority or provisions governing the imposition of civil money penalties.

Facts Presented to the OIG

The party that sought the OIG's opinion is a hospital operated by a county government and located in a health professional shortage area. It would provide free access to an electronic interface to community physicians and physician practices that request it. The physicians could use the interface to transmit to the hospital orders for laboratory and diagnostic services to be performed by the hospital and to receive the results of those services.

In addition, the hospital would provide, through a contractor, support services necessary to maintain the interface, including software updates. The physicians who chose to participate in the arrangement would remain responsible for all aspects (*e.g.*, acquiring, installing, and maintaining) of their own electronic health records system, including all necessary hardware and connectivity services, that would allow them to communicate with the hospital through the interface. The hospital certified that the interface would serve no purpose other than to transmit the orders and results.

Legal Analysis

The OIG said the arrangement would not violate the anti-kickback statute because it would not provide remuneration to the participating physicians. In light of the facts presented, the OIG concluded, "interface access would be integrally related to the hospital's services, such that the free access would have no independent value to the physicians apart from the services the hospital provides. Accordingly, we conclude that the proposed arrangement would not implicate the anti-kickback statute."

If physicians were able to use the free interface for additional functions beyond transmitting test orders, then the free interface would have an independent value and could be an illegal inducement prohibited under the anti-kickback statute, the OIG cautioned.

The advisory opinion is posted at *oig.hhs.gov*. It applies only to the party requesting it and is based on information the party provided. It has no application to, and cannot be relied upon by, any other individual or entity.

Medicare, Other Sequestration Cuts Delayed, *from p. 1*

Also hit: the Food and Drug Administration, which would lose $318 million (more than 8 percent of its budget), and the National Institutes of Health, whose budget would be cut by more than $2.5 billion.

Exempt From Sequestration

Medicare benefits to enrollees are not affected. Nor are Medicare incentive payments to physicians and hospitals for meaningful use of certified electronic health records. Also spared are Medicaid and the state Children's Health Insurance Program.

While hospital and medical groups are lobbying Congress to repeal the 2 percent Medicare cut, its fate as part of sequestration will hinge on the outcome of other budget battles to increase the federal debt ceiling (due in February) and continue funding of government agencies (due in March).

Added Pain on the Bottom Line

For clinical labs, the Medicare sequestration will bring the total cut to 4.95 percent versus the 2.95 percent cut effective Jan. 1. For pathologists, it will come on top of other scheduled cuts, including a 1 percent cut to offset primary care fee increases, another 1 percent cut due to a change in the practice expense methodology, and a 52 percent cut in payment for the technical component of the most commonly ordered surgical pathology code, CPT 88305, while the global rate is to be cut by 33 percent (*Statline, 2012, Nov. 1 and 5 at www.cap.org*).

January Update of CLIA-Waived Tests, Billing Codes

The Jan. 1, 2013, update to the list of tests waived under the Clinical Laboratory Improvement Amendments (CLIA) includes 36 more devices, the latest approved by the Food and Drug Administration for this category (*see table*). New waived tests are approved on a flow basis and are valid as soon as approved.

When billing for the tests below, you must use the QW modifier. This enables your local Medicare contractor to recognize the code as waived. Prior to payment approval, claims are checked for waived testing certification.

CPT CODE	EFFECTIVE DATE	DESCRIPTION
86803QW	Nov. 29, 2011	OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference Panel
87809QW	April 24, 2012	AdenoPlus (human eye fluid)
81003QW	May 8, 2012	McKesson 120 Urine Analyzer
81003QW	May 11, 2012	Acon Laboratories, Inc. Foresight U120 Urine Analyzer
86294QW	May 15, 2012	LifeSign Status BTA
82055QW	May 25, 2012	Alere Toxicology Services, iScreen Saliva Alcohol Test Strip
82055QW	May 25, 2012	American Screening Corporation, Reveal Saliva Alcohol Test Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Cassette Amp/Amphetamine
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Secobarbital Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Oxazepam Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Strip Amp/Amphetamine
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Secobarbital Strip

CPT CODE	EFFECTIVE DATE	DESCRIPTION
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Oxazepam Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (COC/Cocaine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MET/Methamphetamine) {Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MDMA/ Methylenedioxymethamphetamine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MOP/Morphine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MTD/Methadone){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Morphine (2000){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (PCP/Phencyclidine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Notriptyline{Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (COC/Cocaine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MET/Methamphetamine) {Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MDMA/ Methylenedioxymethamphetamine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MOP/Morphine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MTD/Methadone){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Morphine (2000){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (PCP/Phencyclidine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Notriptyline{Dip card format}
83036QW	May 30, 2012	Bayer AICNow+ Professional Use
87880QW	June 7, 2012	Mooremedical Strep A Rapid Test—Dipstick
G0434QW	July 13, 2012	Ultimate Analysis Cup UA Cups
86701QW	July 20, 2012	bioLytical INSTI HIV-1 Antibody Test {Fingerstick Whole Blood}
G0433QW	July 20, 2012	OraSure Technologies OraQuick In-Home HIV Test {Oral Fluid}

The update, plus a complete list of CLIA waived devices, can be found in Change Request 8054, at *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2553CP.pdf.*

Your carrier or Medicare Administrative Contractor is not required to search its files to either retract payment or retroactively pay claims; however, it should adjust claims you bring to its attention.

Medicare Overpayment Recovery Period Extended

As of Jan. 2, 2013, Medicare has five years to recover overpayments plus interest from providers and suppliers. Previously the deadline was three years. The change in the statute of limitations was approved in H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA), signed into law on that date.

Waiver of Liability

Before ATRA, a provider who received an overpayment was "to be deemed without fault" if the determination of an overpayment "was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid," according to Section 1870 of the Social Security Act. Under Section 638 of ATRA, "third year" was replaced with "fifth year."

Savings and Impact

This provision is estimated to save $500 million, according to preliminary projections of the Congressional Budget Office, but critics say it will cost clinical laboratories, pathology practices, and other providers more time and resources to monitor the Medicare payments they receive for an additional two years in order to limit their potential exposure to an attempted overpayment recovery.

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