G2 INTELLIGENCE

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CMS Gets Pricing Advice for New 2014 CPT Lab Codes

Final determinations for the 2014 clinical laboratory fee schedule are due out in September.

Leading scientific societies and national clinical laboratory and pathology groups recommend that the Centers for Medicare and Medicaid Services (CMS) use the crosswalk method to set payment rates for virtually all of the new Current Procedural Terminology test codes to be added to the Part B lab fee schedule as of Jan. 1, 2014.

The groups differed on some recommendations for reconsideration requests, with some suggesting crosswalking, others not offering recommendations, and some urging CMS to use gap-filling. Under the crosswalk methodology, a new test code is matched to an existing code on the fee schedule and is paid at that rate. The gap-fill alternative is used when there is no comparable existing test. Local Medicare contractors set the fee for the first year based on local pricing patterns.

Recommendations from four organizations shown in the table on pages 2-3 were submitted to CMS at its July 10 public meeting, which kicked off the annual process to get pricing input from industry stakeholders.

INSIDE NIR

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CMS Still Reluctant to Close Self-Referral Loophole Despite Mounting Evidence It Drives Up Costs

The evidence is clear: Physicians who self-refer anatomic pathology (AP) services are costing Medicare tens of millions of dollars each year. Even so, the Centers for Medicare and Medicaid Services (CMS) remains reluctant to close the loophole in the Stark law that allows these self-referrals to occur.

Pathology and lab groups have long been at odds with other physician specialists over the issue of self-referral. Groups representing urologists, dermatologists, gastroenterologists, and other specialists argue that allowing them to self-refer pathology services is more convenient for patients. But those representing labs and pathologists say the loophole simply drives up costs and allows specialists to make more money.

A new report from the Government Accountability Office (GAO) provides further evidence that the lab groups are right. The report, issued July 16, concludes that financial incentives for self-referring providers were likely "a major factor in driving the increase in anatomic pathology referrals." GAO estimates that in 2010, providers who self-refer made an estimated 918,000 more referrals for AP services than they likely would have if they were not self-referring. These additional referrals cost Medicare about $69 million in 2010.

Continued on p. 4

MEDICARE LAB FEE SCHEDULE FOR 2014: NEW CPT CODES AND PAYMENT METHOD RECOMMENDATIONS		
CODE DESCRIPTOR	***CODE CROSSWAK OR GAP-FILL***	***PROPOSED NLA***
THERAPEUTIC DRUG ASSAYS		
80XXX1 Caffeine	**AACC:** Crosswalk to 80198 **ACLA, ASCP, CAP:** Crosswalk to 82491	$19.45 $24.82
80XXX2 Clozapine	**AACC, ACLA, ASCP, CAP:** Crosswalk to 80154	$25.43
80XXX3 Everolimus	**AACC:** Crosswalk to 80158 **ACLA, ASCP, CAP:** Crosswalk to 82542	$24.81 $24.82
80XXX4 Gabapentin	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82491	$20.02 $24.82
80XX5 Lamotrigine	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82542	$20.02 $24.82
80XXX6 Levetiracetam	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82542	$20.02 $24.82
80XXX7 Mycophenolate	**AACC:** Crosswalk to 80158 **ACLA, ASCP, CAP:** Crosswalk to 82542	$24.81 $24.82
80XXX8 Oxcarbazepine	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82542	$20.02 $24.82
80XXX9 Tiagabine	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82542	$20.02 $24.82
80XX10 Zonisamide	**AACC:** Crosswalk to 80157 **ACLA, ASCP, CAP:** Crosswalk to 82542	$20.02 $24.82
TIER 1 MOLECULAR PATHOLOGY PROCEDURES		
81161 DUPLICATION/DELETION ANALYSIS	**AACC:** Crosswalk to 81404 **ACLA:** Take the median of the code stacks which were used to bill this test prior to the adoption of the Tier 1 Molecular Pathology Codes **ASCP, CAP:** Crosswalk to 81407	
812XX MGMT (O6-methylguanine DNA methyltransferase)	**AACC:** Crosswalk to 81404 **ACLA:** Take the median of the code stacks which were used to bill this test prior to the adoption of the Tier 1 Molecular Pathology Codes **ASCP, CAP:** Crosswalk to 81401	
MULTIANALYTE ASSAYS WITH ALGORITHMIC ANALYSES		
0004M SCOLIOSIS 53 SNP SALIVA SCOR	**AACC:** Crosswalk to 81408 **ACLA, ASCP:** Administrative MAAA CPTs are not assigned an NLA	
0005M FETAL ANEUPLOIDY TRISOM RISK	**AACC:** Crosswalk to 81404 **ACLA, ASCP:** Administrative MAAA CPTs are not assigned an NLA This code is scheduled for deletion effective Jan. 1, 2014	
815XX1 Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes	**AACC:** No comment as this procedure is not commercially available **ACLA, ASCP:** No comment as this procedure is not currently available **CAP:** No comment	
81508 FTL CGEN ABNOR TWO PROTEINS	**AACC, ACLA, ASCP:** Crosswalk to 84163 + 84702	$41.40

CODE DESCRIPTOR	*CODE CROSSWAK OR GAP-FILL*	*PROPOSED NLA*
MICROBIOLOGY		
8766X1 Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique	**AACC, ACLA, ASCP, CAP:** Crosswalk to 87511	$48.24
RECONSIDERATION REQUESTS		
0001M INFECTIOUS DIS HCV 6 ASSAYS	**AACC:** Crosswalk to 84460 + 83520 + 82172 + 82247 + 82977 + 83010 **ACLA:** Administrative MAAA CPTs are not assigned an NLA **ASCP:** ASCP is not offering recommendations for this code, as it is an administrative MAAA code that is not intended to be on a fee schedule **CAP:** No comment	$80.46
0002M LIVER DIS 10 ASSAYS W/ASH	**AACC:** Crosswalk to 84460 + 83520 + 82172 + 82247 + 82977 + 83010 + 84450 + 82947 +82465 + 84478 **ACLA:** Administrative MAAA CPTs are not assigned an NLA **ASCP:** ASCP is not offering recommendations for this code, as it is an administrative MAAA code that is not intended to be on a fee schedule **CAP**: No comment	$106.84
0003M LIVER DISEASE 10 ASSAYS W/NASH	**AACC:** Crosswalk to 84460 + 83520 + 82172 + 82247 + 82977 + 83010 + 84450 + 82947 + 82465 + 84478 **ACLA:** Administrative MAAA CPTs are not assigned an NLA **ASCP:** Administrative MAAA CPTs are not assigned an NLA **CAP:** No comment	$106.84
815XX3 Fetal Aneuploidy (trisomy 21, 18, and 13)	**ACLA, ASCP:** Gap-fill **CAP:** No comment	
81500 ONCO (OVAR) TWO PROTEINS	**AACC:** Crosswalk to 86304 + 86305 **ACLA, ASCP:** Crosswalk to 86304 + 86305 + 33% of 87900 **CAP:** No comment	$57.22 $116.34
81503 ONCO (OVAR) FIVE PROTEINS	**AACC:** Crosswalk to 86304 + 82172 + 82232 + 84466 + 84134 **ACLA, ASCP:** Gap-fill **CAP:** No comment	$109.75
81506 ENDO ASSAY SEVEN ANAL	**AACC:** Crosswalk to 82947 + 83036 + 83525 + 86141 + 83520 + 84466 + 83520 **ACLA, ASCP:** Gap-fill **CAP:** No comment	$105.39
81509 FTL CGEN ABNOR THREE ANAL	**AACC, ACLA, ASCP:** Crosswalk to 86336 + 84163 + 84702 **CAP:** No comment	$62.82
81510 FTL CGEN ABNOR FOUR ANAL	**AACC, ACLA, ASCP:** Crosswalk to 82105 + 82677 + 84702 **CAP:** No comment	$77.01
81511 FTL CGEN ABNOR FOUR ANAL	**AACC ACLA, ASCP:** Crosswalk to 82105 + 82677 + 84702 + 86336 **CAP:** No comment	$98.43
81512 FTL CGEN ABNOR FIVE ANAL	**AACC:** Crosswalk to 82105 + 82677 + 84702 (x2) + 86336 **ACLA, ASCP:** Crosswalk to 82105 + 82677 + 84702 + 86336 + 82397 **CAP:** No comment	$119.13 $117.85
82777 Galectin-3	**AACC, ACLA, ASCP:** Crosswalk to 83937 **CAP:** No comment	$41.03

*Acronyms: AACC, American Association for Clinical Chemistry; ACLA, American Clinical Laboratory Association; ASCP, American Society for Clinical Pathology; and CAP, College of American Pathologists.
*CPT Codes © American Medical Association. Note: digits marked by XX are to be finalized.

CMS Still Reluctant to Close Self-Referral Loophole, *from p. 1*

A report published in the April 2012 issue of *Health Affairs* also concluded that self-referral is driving up Medicare costs. The study by health economist Jean Mitchell found that on average, self-referring urologists billed Medicare for 72 percent more AP specimens than physicians who did not benefit financially from ordering more tests and that the prostate cancer detection rate per biopsy episode was significantly higher for men who had the biopsy performed by non-self-referring urologists. That study was funded by the American Clinical Laboratory Association (ACLA) and the College of American Pathologists.

Although the Stark law prohibits self-referral, the in-office ancillary services (IOAS) exception allows patients the opportunity to receive certain medical services during the time of their physician office visit. In response to concerns about potential overutilization of AP services due to physician self-referral, CMS in 2008 imposed an "anti-markup rule" that prohibits providers from billing Medicare for AP services for amounts that exceed what the providers themselves pay to subcontract the services. However, CMS in 2009 allowed an exception to this rule for services provided by a physician who shares a practice with the billing provider. Since then, arrangements in which a provider group practice includes a pathologist in the practice's office space have become a common self-referral arrangement, notes the GAO.

Three provider specialties—dermatology, gastroenterology, and urology—accounted for 90 percent of referrals for self-referred AP services in 2010.

According to the GAO report, self-referred AP services increased at a faster rate than non-self-referred services from 2004 to 2010. During this period, the number of self-referred AP services more than doubled, growing from 1.06 million services to about 2.26 million services, while non-self-referred services grew about 38 percent, from about 5.64 million services to about 7.77 million services.

Similarly, the growth rate of expenditures for self-referred AP services was also higher. Three provider specialties—dermatology, gastroenterology, and urology—accounted for 90 percent of referrals for self-referred AP services in 2010. Referrals by these specialists increased substantially the year after they began to self-refer, finds GAO. Providers that began self-referring in 2009—referred to as switchers—had increases in AP services that ranged on average from 14 percent to 58.5 percent in 2010 compared to 2008, the year before they began self-referring. In comparison, increases in AP referrals for providers who continued to self-refer or never self-referred services during this period were much lower.

GAO Recommendations

GAO recommends that CMS identify self-referred AP services and address their higher use. Specifically, the report recommends that CMS:

1. Insert a self-referral flag on Medicare Part B claim forms and require providers to indicate whether the AP services for which the provider bills Medicare are self-referred or not.

2. Determine and implement an approach to ensure the appropriateness of biopsy procedures performed by self-referring providers.

3 Develop and implement a payment approach for AP services that would limit the financial incentives associates with referring a higher number of specimens per biopsy procedure.

In its comments to the report, CMS concurred with the third recommendation, noting that the payment revaluation for AP services in 2013 decreased payment by approximately 30 percent and significantly reduced the financial incentives associated with self-referral for those services. However, the GAO notes that this does not address the incentive to provide more services.

CMS did not concur with the GAO's recommendations that it insert a self-referral flag on the Medicare Part B claims form and require providers to indicate whether the AP services for which a provider bills Medicare are self-referred or not.

Lab Groups Respond

Lab and pathology groups quickly applauded the study, saying that it provided new evidence and is consistent with previous studies that have found self-referal for AP services is linked to increased utilization.

"Given the mounting evidence, the time has come for Congress to take legislative action to remove anatomic pathology, advanced diagnostic imaging, radiation therapy, and physical therapy from the IOAS exception," said Alan Mertz, president of ACLA. "For too long, CMS has addressed utilization increases through untargeted and broad cuts to referral laboratories—which have no control over the volume of services ordered by physicians—rather than examining the core drivers of utilization. This reform would restrict self-referral in order to safeguard patient safety and health care quality as well as to allow for better control of our nation's health care expenditures."

The Alliance for Integrity in Medicare (AIM), while also praising the report, disagreed with the GAO's recommendations for Medicare to track self-referred AP services, as well as to create policies to ensure appropriateness of biopsy procedures and to develop new payment approaches.

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>
> *—Alan Mertz, President, ACLA*

"These recommendations do not address the underlying profit incentives associated with this abuse, which continues today and is only possible due to the current regulations and the loophole in the IOAS exception," said the group in a statement. "AIM believes there is more than enough evidence that self-referral leads to overutilization, and it's time to get at the root of the problem and close this self-referral loophole."

The College of American Pathologists (CAP) also called on CMS to close the self-referral loophole, noting that the provision was never intended to protect self-referral of AP services because, unlike clinical laboratory services, they can almost never be performed at the time of an office visit.

The Takeaway: Despite mounting evidence that self-referrals drive up Medicare costs, CMS remains reluctant to close the loophole that allows physicians to self-refer AP services. Lab and pathology groups have their work cut out for them if they hope to convince CMS and lawmakers that the loophole should be closed once and for all. G2

Overhaul of Medicare Physician Payment Moving Ahead; House Subcommittee Approves Repeal

Efforts to revamp the system used to determine Medicare payment for physicians are moving forward, raising hopes that Congress might actually put an end to the antiquated sustainable growth rate (SGR) formula used to set payment.

By voice vote, the House Energy and Commerce Health Subcommittee July 23 approved bipartisan draft legislation that would repeal the current Medicare physician payment system and replace it with one based on quality-of-care measures and new care models. Subcommittee Vice Chairman Michael C. Burgess (R-Texas) says the full committee will consider the legislation July 31.

The committee has released several iterations of proposals to fix the current system, including three legislative drafts. The vote was a rare show of bipartisanship in the often politically divided House. The subcommittee quickly passed the measure shortly after convening after first approving a technical amendment to the measure.

SGR Repeal

The legislation would repeal the SGR formula in Medicare's current system and create a fee-for-service system in which providers report quality measures. Providers also would have the ability to leave fee-for-service and opt for new ways of delivering care, such as medical homes.

According to the proposal, during the phase-in period, physician groups—in coordination with the Department of Health and Human Services and medical standards-setting organizations—would work on a set of quality measures that would be implemented in 2019.

Physicians would receive a 0.5 percent annual increase per year for the first five years of the new payment system. Beginning in 2019, physician Medicare payments would include adjustments up or down, depending on how well their services met the new quality guidelines. Physicians receiving the highest quality scores would receive a 1 percent payment increase over standard Medicare rates, physicians with quality scores in the midrange would receive no increase, and physicians in the lower range would receive a 1 percent payment reduction.

Providers could also opt to participate in demonstration programs featuring alternative payment models aimed at coordinating care and improving quality of care for patients.

Funding the Bill

Although the policy in the draft has received bipartisan support, lawmakers have yet to identify ways to pay for the legislation, which could make the process of crafting a final bill more contentious. The Congressional Budget Office has said freezing physicians' Medicare reimbursement and preventing SGR-related cuts for 10 years would cost $139 billion. That is about $100 billion less than previously estimated, and as a result, lawmakers and physician groups say this year provides a rare opportunity to permanently fix the system at a lower cost.

Physicians' Medicare reimbursement will be reduced about 25 percent in January 2014 unless Congress acts to prevent such a cut, which it would likely do.

The SGR was included the Balanced Budget Act of 1997 to control Medicare spending by linking it to the nation's economic growth rate. Since then, Medicare spending has outpaced the nation's economic growth, causing lawmakers to pass a "doc fix" annually for the past decade to cancel resulting payment cuts. A permanent fix has eluded Congress, due to its high price tag.

Even with a lesser price tag, funding the legislation represents perhaps its greatest challenge to advancing. House Republicans have decided to first tackle the policy involved in replacing the SGR, choosing to address funding the measure later so as to not thwart momentum in crafting legislation.

House Republicans have acknowledged that funding the physician pay fix in part by taking money from the Affordable Care Act will be opposed by Democrats, as will changes to the medical malpractice system. "We have to come up with a pay-for, and that certainly will not be easy," Rep. Joe Barton (R-Texas) said July 22 during opening statements on the legislation.

Post-Acute Care Cuts

There appears to be bipartisan agreement that Medicare reimbursement to home health care providers and nursing homes could be cut to help pay for a doc fix, but that alone would not pay for the bill.

A doc fix bill also could be rolled into a larger budget and tax package that perhaps would be broached by Congress and the White House later this year, which could allow lawmakers to use unrelated health care provisions to offset the cost.

The Takeaway: Congress may actually repeal the SGR this year, but other providers may have to foot the bill for such a fix.

Medicare *Claims Advisory*

Interest Rate Declines for Overpayment, Underpayments

The rate of interest that Medicare will pay you for claims that were underpaid, or collect from you for claims that were overpaid, has risen to 10.375 percent, effective July 17, 2013, up from the 10.125 percent that has been in effect since April 17, 2013.

The Centers for Medicare and Medicaid Services (CMS) announced the latest update in Transmittal 223, Change Request 8415. Medicare Regulation 42 CFR 405.378 provides for the assessment of interest at the higher of the current value of funds rate (1 percent for calendar year 2013) or the private consumer rate as fixed by the Department of the Treasury. The Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 10.375 percent.

The highest interest rate in the past decade was in early 2001, 14.125 percent, but for most of the years since, the rate has hovered between 10.5 percent and 12 percent.

The interest rate fluctuations have taken on even greater importance to clinical laboratories, pathology practices, and other Medicare providers because their period of exposure to attempts by CMS to recover any overpayments plus interest has been extended from three years to five years, effective Jan. 2, 2013 (*NIR 13, 1/Jan. 9, p. 8*).

Flow Cytometry TC Could Be Cut by 75%

The July 8 proposal by the Centers for Medicare and Medicaid Services (CMS) to cut the technical component (TC) of certain pathology codes paid under the physician fee schedule (PFS) would hit independent laboratories especially hard. Under the proposed rule, CMS would cap TC payment of affected pathology services at the rates paid under Medicare's hospital outpatient prospective system. For example, CPT 88185, flow cytometry, would be cut by 75 percent, while the TC of CPT 88307, tissue exam by pathologist, would be cut by 50 percent.

Since the proposal targets only the TC of pathology services paid under the PFS, pathologists who bill only the professional component of these codes would not be affected. However, independent labs that perform the technical component of pathology tests could see substantial payment reductions. According to CMS, the proposed policy change accounts for a 6 percent reduction in overall Medicare PFS payment to pathologists and a corresponding 25 percent cut to independent laboratory PFS payments.

As part of the July 8 proposal, CMS also proposes several changes to the value-based payment modifier program that affect pathologists.

Upcoming G2 Events

Webinar *(2 p.m.-3:30 p.m. Eastern)*

Aug. 21

Confronting Reimbursement Realities: How Proposed Medicare Cuts Will Affect Your Lab's Bottom Line

www.G2Intelligence.com/MedicareCuts

Conferences

Oct. 16-18

Lab Institute 2013
It's Make or Break Time: A Path Forward For Labs

Hyatt Regency Crystal City
Arlington, Va.
www.labinstitute.com

Dec. 9

Lab Leaders' Summit 2013

Union League Club of New York
New York City

Dec. 10

Laboratory and Diagnostic Investment Forum

Union League Club of New York
New York City

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