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Labs and Pathologists Launch Blitz to Fight AP Cuts in 2014

The deadline for submitting comments to the proposed physician fee schedule for 2014 is Sept. 6. The final rule is due out by Nov. 1.

Laboratory and pathology groups are launching an all-out blitz to fight proposed drastic payment cuts to anatomic pathology (AP) services in 2014.

The Centers for Medicare and Medicaid Services (CMS) is proposing to compare payment rates for AP services under both the Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (HOPPS) and set reimbursement rates according to whichever is lower. CMS estimates that the change would cut payment for AP services provided in independent laboratories by an average of 26 percent; some of the most common AP services would be cut by nearly 75 percent. CMS proposed the change as part of its PFS rule for 2014, issued July 8.

The American Clinical Laboratory Association (ACLA) argues that the use of HOPPS data is flawed because it only contains lump, aggregate lab cost reporting from hospitals—not from independent labs. This is problematic for two reasons, says ACLA:

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Groups Split Over Bill to Close IOAS Exception

Depending on whom you talk to, legislation introduced in early August to close the in-office ancillary services exception (IOAS) to the Stark law is either a long overdue fix to a lingering problem or an attack on efforts by physician specialists to improve patient care.

The bill, Promoting Integrity in Medicare Act of 2013 (H.R. 2914), would exclude anatomic pathology (AP), advanced diagnostic imaging, physical therapy, and radiation services from the IOAS exception to the law prohibiting physician self-referrals. Physicians would still be able to self-refer simple laboratory tests, such as blood glucose, urinalyses, and strep tests that can be done during a patient's office visit.

The Alliance for Integrity in Medicare praised the bill, introduced by introduced by Rep. Jackie Speier (D-Calif.), saying it addresses the misapplication of the IOAS exception to the physician self-referral law and will improve patient care and coordination while preserving valuable Medicare resources.

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- ❑ HOPPS lab cost data are not broken down into lab services categories. In other words, the lump sum of lab costs includes not only AP service costs but also costs associated with other lab services billed under the Clinical Lab Fee Schedule, such as basic blood chemistry. CMS must apportion lab costs between categories based on a set of assumptions, rather than reported data.
- ❑ HOPPS data are not broken down to the service-code level by nature of the fact that the HOPPS assumes a bundling approach when reimbursing for hospital claims.

Overstepping Authority

The College of American Pathologists (CAP) agrees that the proposal is flawed, noting that it fails to take into consideration the technical costs associated with specific individual codes and fails to recognize the distinct costs of physician services.

TOP 10 REDUCTIONS TO PATHOLOGY SERVICES
(Based on Volume and Proposed Change)

CPT CODE	COMPONENT	DESCRIPTION	PROPOSED CUT
88307	Global	Tissue exam by pathologist	-50%
88342	Global	Immunohistochemistry	-27%
88312	Global	Special stains group 1	-46%
88313	Global	Special stains group 2	-45%
88112	Global	Cytopath cell enhance tech	-22%
88185	TC	Flow cytometry/TC add-on	-75%
88309	Global	Tissue exam by pathologist	-30%
88173	Global	Cytopath eval fna report	-25%
88367	Global	Insitu hybridization auto	-60%
88108	Global	Cytopath concentrate tech	-39%

Source: The College of American Pathologists

CAP also believes that CMS is overstepping its authority in proposing to pay for physician services using hospital-based payments. "By law, CMS is required to base physician payments on the resources required to perform the service," says CAP in a position paper. "Hospital payments are not determined using such a resource-based approach."

CAP says it supports the existing American Medical Association Resource Utilization Committee (AMA-RUC) process for valuing physician service codes, noting that the process involved many stakeholders, including CAP. "The AMA-RUC has shown itself to be accurate and fair and has been thoroughly vetted over many years."

The proposed 2014 cuts focus largely on Medicare technical component and global payments. Of the 211 codes impacted, the 39 pathology services account for nearly 70 percent of the cuts from this proposed policy change.

The top 10 pathology services that would be cut by the proposal encompass services for cancers such as breast, bladder, esophageal, lung, digestive, colon, prostate, thyroid, and leukemia.

The Takeaway: CMS's proposal to tie Medicare AP payment to hospital outpatient rates is flawed and would have serious consequences for independent laboratories. G2

Proposed Bundling Initiative Will Include Pathology Services

The technical component of pathology services provided in hospital outpatient settings would be subject to bundling under Medicare's recent proposal to include lab testing in ambulatory payment classifications.

Under the July 8 proposal, pathology services would be considered ancillary services and would be packaged when performed with another service but would continue to be paid separately when performed alone. A list of codes and services that would fall under this category is contained in Addendum P to the 2014 Hospital Outpatient System Proposed Rule (available on the Centers for Medicare and Medicaid Services (CMS) Web site at *www.cms.gov*). They include CPT codes 88125-88342.

These codes, which currently are assigned to status indicator "X," would be reassigned to status indicator "Q1" and would be packaged when provided with a service assigned a status indicator of "S," "T," or "V."

Clinical laboratory tests (CPT codes 82010-86793) also would be bundled when provided in hospital outpatient settings. CMS would consider a lab test to be unrelated to a primary service and, thus, not part of the packaging policy when the laboratory test is the only service provided on that date of service or when the laboratory test is provided on the same date of service as the primary service but is ordered for a different purpose than the primary service by a practitioner different from the practitioner who order the primary service provided in the hospital outpatient setting.

Lab test codes that CMS proposed to package would be assigned status indicator "N" and are also listed in Addendum P to the proposed rule.

Molecular pathology tests (CPT codes 81200-81383) would be exempt from this proposed packaging policy.

Impact Depends on Relationship

How much pathologists will be impacted by this bundling proposal will depend largely on their relationship with the hospital, says Jen Madsen, senior director of economic and regulatory affairs for the College of American Pathologists.

"The extent to which the pathologist is affected depends on the financial arrangement between the pathologist and the hospital lab … e.g., whether the pathologist is an employee of the hospital and earning a salary vs. working in an independent practice and capturing the Part B payment for tests that would previously be separately paid," she says. "I think a lot of the impact here will depend on the relationship between ordering physicians and the hospital."

One implication of this proposed bundling policy is that lab and pathology services that were not subject to the Medicare Part B deductible and coinsurance when listed separately under the Clinical Laboratory Fee Schedule now will be subject to deductibles and coinsurance.

"The purpose of the laboratory packaging proposal is not to shift program costs onto beneficiaries, but to encourage greater efficiency by hospitals and the most economical delivery of medically necessary laboratory tests," writes CMS in the proposed rule, which was published in the July 19 *Federal Register*.

The Takeaway: Pathologists who provide services to hospital outpatients under an independent contract could see a significant hit to technical component payment if the bundling proposal is finalized.

focus on: *Medicare Physician Pay*

Congress Making Progress on Physician Payment Reform

In an overwhelming and rare bipartisan vote of 51-0, the House Energy and Commerce Committee July 31 approved legislation (H.R. 2810) that would repeal Medicare's current physician payment system and create new payment incentives for physicians to deliver quality care.

Lawmakers have not said how they will pay for the bill, which would repeal the sustainable growth rate (SGR) formula in the payment system. Lawmakers will have to address that issue when they return from congressional recess in September.

The Energy and Commerce Health Subcommittee approved the measure July 23. The House Ways and Means Committee also is involved in crafting legislation.

The Senate Finance Committee, which has jurisdiction over Medicare in that chamber, has held several hearings on the issue but has yet to produce a plan. The committee July 31 held an informal meeting to discuss the issue, with senators saying the committee would produce its own plan this fall separate from that crafted in the House.

"I really do think there is momentum" to permanently fix the system.
—Sen. Debbie Stabenow

"Today's vote is an important milestone, but we are all resolved to achieve reform in a fiscally responsible manner, and despite our significant progress, we will not be satisfied until the ink is dry on the president's signature," commerce committee Chairman Fred Upton (R-Mich.) said in a statement issued after the committee vote.

Details of Bill

The Energy and Commerce legislation would repeal the SGR and create a fee-for-service system in which providers would 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.

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 quality measures that would be implemented in 2019, according to the proposal.

Physicians would receive a 0.5 percent annual increase for each of 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 with 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 also could opt to participate in demonstration programs featuring alternative payment models aimed at coordinating care and improving quality of care for patients.

Before voting on the final bill, lawmakers by voice vote approved an amendment by Reps. Michael C. Burgess (R-Texas) and Frank Pallone Jr. (D-N.J.) making several changes, including a restructuring of the alternative payment model section of the legislation.

Although the policy in the bill 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.

Senate Finance Committee Meeting

Shortly before the Energy and Commerce Committee vote, Senate Finance Committee members and staff held their first closed-door meeting to discuss replacing the SGR formula. As senators emerged from the hour-long session, both Republicans and Democrats said they were encouraged by the discussion.

SGR Background

Inception: Enacted in the 1997 Balanced Budget Act.

Purpose: To prevent annual increases in physician spending for Medicare beneficiary services from exceeding the growth in the gross domestic product.

How it works: In any year in which physician spending exceeds a target growth rate, the update to the Part B physician fee schedule is adjusted downward. If spending comes in below the target, the update is adjusted upward.

Effect thus far: Over the past decade, the SGR has triggered negative updates, prompting Congress to block them repeatedly with a series of short-term fixes.

Other senators emphasized that they had not discussed the details of any specific plan, which is being crafted by bipartisan committee staff members. "It was a listening session," said Sen. John D. Rockefeller IV (D-W.Va.).

Members attending the session said they agreed only on the general goal of developing a new Medicare physician payment system by the end of the year. "We have a Dec. 1 deadline," said Sen. Benjamin L. Cardin (D-Md.).

The Finance Committee is likely to draft its own legislation, rather than work from the House measure, Sen. Debbie Stabenow (D-Mich.) and Cardin said. Senators also said they did not discuss how any SGR replacement plan would be paid for.

"It's an issue, but we're looking to see if it's the right policy," Cardin said. "I think everyone agrees we should permanently fix [the] SGR."

The Takeaway: Momentum is a building in Congress for a permanent fix to SGR formula used to set Medicare physician payment.

Groups Split Over Bill to Close IOAS Exception, *from p. 1*

The College of American Pathologists (CAP) also applauded the measure, saying that there is clear evidence that self-referrals for AP services drive up Medicare costs. Speier's bill, if enacted into law, would "prevent powerful interest groups from exploiting a loophole in the law that wastes billions of Medicare dollars and adds no patient benefit."

The Coalition for Patient Centered Imaging, however, argues that if enacted, this bill would limit access to lifesaving services for many patients and stifle new innovative reforms already under way to improve care delivery and quality improvement. In addition, it would raise the costs to Medicare beneficiaries and the Medicare program by driving patients to more costly facilities, thereby requiring additional expenditures. The coalition represents a number of physician specialty groups, including the American Association of Clinical Urologists, the American Academy of Dermatology Association, and the American Association of Orthopaedic Surgeons.

Recent reports from the Government Accountability Office (GAO), the Health and Human Services Office of Inspector General, and peer-reviewed studies have criticized the self-referral loophole, charging that such referrals drive up utilization and Medicare costs. However, the Centers for Medicare and Medicaid Services has been reluctant to close the loophole, saying it has addressed overutilization by cutting payment for some pathology services.

President Obama's 2014 proposed budget included a provision to close the IOAS exception for radiation oncology, advanced imaging, and physical therapy, projecting that it would reduce the federal deficit by $6.05 billion between 2014-2023. AP was not included in that proposal. However, a report issued July 16 by the GAO estimated that in 2010, providers who self-referred AP services cost Medicare about $69 million. By removing all of the services listed above from the exception, the government stands to save almost $7 billion over a 10-year period.

Recent reports from the Government Accountability Office, the Health and Human Services Office of Inspector General, and peer-reviewed studies have criticized the self-referral loophole, charging that such referrals drive up utilization and Medicare costs.

While pathology groups believe that physicians who set up pathology labs and self-refer services are driving up utilization and cost with no clear benefit to the patient, others argue these in-office labs are actually providing better care.

Joseph Plandowski, co-owner of In-Office Pathology, a group formed to help physicians set up their own pathology labs, notes that the GAO report found urologists with their own in-office labs submitted an average of 12.5 cores for prostate biopsies while those without in-office labs were submitting an average of 8.5 cores per biopsy. According to Plandowski, the standard of care as determined by the National Comprehensive Cancer Network is 12 cores per prostate biopsy. Physicians who take fewer than 12 cores could actually be guilty of malpractice, argues Plandowski in a letter to GAO and an e-mail to G2 Intelligence.

However, Jen Madsen, senior director of economic and regulatory affairs for the College of American Pathologists, notes that there is an important distinction between the number of specimen cores take during a prostate biopsy and the number of specimen

jars containing a core that are billed to Medicare. She acknowledges that 12 cores is the guideline. However, Medicare pays a rate per jar, so a physician could put 12 specimens in 12 jars and bill 12 times, or (in theory) put all 12 in one jar and bill once.

"The average, 8.5, is the average number of jars that get used by physicians who do not self-refer," she explains. "Easy to see how you could fit 12 cores in eight jars, right? That's not malpractice, that's efficient use of health care resources and a conservative billing of the Medicare program."

The Takeaway: Pathology and physician specialty groups continue to disagree about whether self-referral of AP services drives up Medicare utilization, but Speier's bill, if enacted, will end the practice once and for all. The subsequent savings could be used to pay for physician payment reform.

ABP Diplomates Eligible for PQRS Incentives

American Board of Pathology (ABP) diplomates now have an opportunity to earn an additional 0.5 percent incentive payment on Medicare Part B allowed charges by participating in the Physician Quality Reporting System (PQRS).

The Centers for Medicare and Medicaid Services recently approved the ABP's participation in the maintenance of certification additional incentive program.

PQRS, formerly known as PQRI, is a federal voluntary quality reporting program that provides an incentive payment to eligible physicians who satisfactorily report data on specified quality measures. Pathology currently has five quality measures:

1. Breast cancer resection pathology reporting;
2. Colorectal cancer resection pathology reporting;
3. Barrett esophagus;
4. Radical prostatectomy pathology reporting; and
5. Immunohistochemistry evaluation of HER2 for breast cancer patients.

Physicians can choose to fulfill the PQRS reporting requirement through Medicare Part B claims (most commonly used by pathologists), a qualified electronic health record, or a qualified registry.

For 2013 and 2014, the PQRS incentive payment is 0.5 percent of a physician's total Medicare Part B allowed charges. Physicians who do not participate in PQRS in 2013 will incur a 1.5 percent penalty in 2015.

McDermott Seeks Plan to Resolve Self-Disclosure Backlog

Rep. Jim McDermott (D-Wash.), ranking member on the House Ways and Means Health Subcommittee, has asked the Centers for Medicare and Medicaid Services (CMS) to submit a written plan for revising its self-referral disclosure protocol, used by various health care providers to self-disclose actual or potential violations of the physician self-referral law.

As the lead author of the provision in the Affordable Care Act establishing the protocol, McDermott, in an Aug. 13 letter to CMS Administrator Marilyn Tavenner, said the agency was taking several months to settle disclosures that have been submitted under the law, often called the Stark law.

The letter calls on CMS to more promptly resolve disclosures made through the protocol. It also asks the agency to submit a detailed plan by Oct. 15 to address the backlog and to ensure that the protocol will function better in the future. McDermott said CMS has received nearly 300 submissions under the protocol since it was published in September 2010 but has settled fewer than 30. CMS received 18 submissions under the Stark self-referral disclosure protocol in the first three months of 2013 and expects roughly 100 submissions for the entire year, an agency official said March 21.

Reminder: August is a one-issue month for *NIR*.

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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