CAP proposals on IHC, PQRS accepted for Medicare in ’15

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November 2014—The Centers for Medicare and Medicaid Services on Oct. 31 published its 2015 Medicare physician fee schedule to set payment rates and policy for the next year, including the relative value units for existing and new Current Procedural Terminology codes. Several of the CAP’s recommendations and proposals were accepted for inclusion, such as three new quality measures designed for pathologists and eliminating G-codes to pay for immunohistochemistry services.

While total Medicare expenditures to pathologists will remain stable in 2015, reimbursements for certain services targeted by the CMS as overvalued are adjusted downward. Pathology services will see a one percent decrease based on the impact of changes to the work relative value units used to calculate the professional component of pathology services as well as global payment.

Some pathology services will see payment increases. The impact of changes to the practice expense used to calculate the technical component and global payment resulted in a one percent increase in pathology payment. The net impact of those payment cuts and upward adjustments is a zero percent change. That estimate considers all pathology services in the aggregate. The impact on individual pathology practices will vary depending on volume and types of services provided to patients.

The Protecting Access to Medicare Act of 2014 had provided a zero percent update for physician services between Jan. 1, 2015 and March 31, 2015. The CMS noted that current law requires physician fee schedule rates to be reduced by an average of 21.2 percent from the 2014 rates if Congress does not enact legislation to stop the cut. The CAP supports efforts to permanently repeal and reform the flawed sustainable growth rate formula responsible for the cut.

Immunohistochemistry. The CMS in 2014 created G-codes to report immunohistochemistry for Medicare patients. This change caused confusion between Medicare and non-Medicare payers and cut reimbursement for the services. The CAP worked to fix the problem by proposing an alternative to alleviate CMS concerns about the service and seeking changes to CPT codes to allow for revaluation of the initial single antibody stain procedure as well as for each additional single antibody stain, when necessary.

For 2015, the CMS will delete the G-codes established for 2014. The descriptions (with CPT instructions in italics) for the codes that replace the G-codes pathologists will use to report immunohistochemistry services are as follows:

- 88342, Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure.
  (For quantitative or semiquantitative immunohistochemistry, see 88360, 88361.)
  (88343 has been deleted. For multiplex antibody stain procedure, use 88344.)

- 88341, Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure. (List separately in

addition to code for primary procedure.)
(Use 88341 in conjunction with 88342.)
(For multiplex antibody stain procedure, use 88344.)

- 88344, Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure.
(Do not use more than one unit of 88341, 88342, 88344 for each separately identifiable antibody per specimen.)
(Do not report 88341, 88342, 88344 in conjunction with 88360, 88361 unless each procedure is for a different antibody.)
(When multiple separately identifiable antibodies are applied to the same specimen [ie, multiplex antibody stain procedure], use one unit of 88344.)
(When multiple antibodies are applied to the same slide that are not separately identifiable [eg, antibody cocktails], use 88342, unless an additional separately identifiable antibody is also used, then use 88344.)

Prostate biopsy services. The CMS finalized its proposal to use a G-code, G0416, to report prostate biopsy services for Medicare patients. The CAP opposed the proposal and stated current codes accurately capture the service.

"Since CPT code 88305 was revalued with the understanding that prostate biopsies are billed separately, we believe that allowing CPT code 88305 to be reported in multiple units for prostate biopsies would account for significantly more resources than is appropriate," the CMS said. "With respect to the concern about higher numbers of specimens, we note that our claims data on the G-codes shows that the vast majority of the claims used G0416, rather than any of the G-codes for greater numbers of specimens."

The CMS believes its G0416 code is potentially misvalued. The CMS will modify the descriptor to reflect all prostate biopsies but will maintain the current value for 2015, and it requested that the current value be reviewed. A revised prostate biopsy payment rate is anticipated for 2016.

In situ hybridization services. The CMS accepted new and revised CPT codes for in situ hybridization services (FISH, e.g. 88364, 88365, 88366, 88368, 88369, 88373, and 88374 and 88377). The new and revised codes were created to address the CMS' payment concerns and to avoid creation of Medicare G-codes to address the agency's concerns. The 2014 National Correct Coding Initiative policy manual limited payment for multiple units of service for FISH due to concerns about overpayment of multiples and the use of multiple probes. The policy change decreased reimbursement by placing limits on the units of service reportable for FISH. However, for 2015 the CMS lowered the value recommended by the American Medical Association's RVS Update Committee for FISH add-on services. It accepted values for the majority of the new multiplex FISH codes.

FISH services had been under review for several years through the CMS' misvalued code initiative. The CAP had used its position on the RVS Update Committee, or RUC, to mitigate payment reductions to services targeted as overvalued. The CAP further advocated that revaluations of pathology services accurately account for the cost of providing the services. The CMS does not always agree with or take the RUC's recommendations. In fact, the CMS rejected many of the code-specific medical supply costs recommended by the CAP and approved by the RUC, which led to reductions in the technical component and global payment for these services.

The CMS did not take further action on practice expense relative value recommendations from the RUC associated with 22 pathology code families. These services include cytopathology, flow cytometry, and consultation services.

The CMS is still considering how to proceed. The Medicare agency noted its increased authority under the Protecting Access to Medicare Act to develop and use alternative approaches to establish practice expense relative values. Alternative approaches would use data from other suppliers and providers of services, such as hospitals. The CMS said it would consider comments it received as it continues to review alternatives for determining practice expense values for physician services.

PQRS. The CAP developed three new quality measures for the Medicare Physician Quality Reporting System program. The CMS included the three measures, in addition to five existing pathology measures, in the 2015 PQRS program. The new measures are as follows:

- Lung cancer reporting (biopsy/cytology specimens). Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non-small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report.
- Lung cancer reporting (resection specimens). Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category, and, for NSCLC, histologic type.
- Melanoma reporting. Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and, for pT1, mitotic rate.

The CMS will release more information on how to report the new measures, and the CAP will review the details during a Dec. 2 webinar. Participation in the 2015 PQRS will affect the 2017 PQRS payment adjustment and the 2017 value-based modifier. No bonus will be associated with successful participation in the PQRS; however, high performers may see an increase in payment through the value-based modifier. The CAP has developed an online tool, which is being updated for 2015, to help pathologists determine eligibility for the programs. The tool is accessible on www.cap.org in the advocacy section.

LCD proposal. Several changes were proposed to the Medicare Local Coverage Determinations process for clinical diagnostic laboratory tests, but the CAP and several other stakeholders, such as the AMA, opposed them. Proposed changes included expanding Medicare administrative contractor Palmetto's MolDX program to all LCDs for clinical diagnostic laboratory tests. New processes also would have shortened the public comment period from 45 to 30 days and limited the opportunities for stakeholders to suggest improvements to draft LCDs.

The CMS responded to concerns from the physician community by saying it would not move forward with the LCD proposal through this rulemaking. However, the CMS said it would explore the possibility of future notice and rulemaking on this issue.
"The comments received have given the agency much to consider prior to moving forward with any changes to the LCD process; therefore we will not finalize any changes to the LCD process in this final rule," the CMS said.
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