Higher pay for therapeutic apheresis, bone marrow aspiration

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December 2017—For 2018, CMS estimates a one percent overall decrease in pathology reimbursement.

Pathologists will receive payment increases for therapeutic apheresis and diagnostic bone marrow aspiration services in 2018. At the same time, reimbursement for flow cytometry services will continue to decrease following phased-in reductions set by the Medicare program last year, but the CAP was successful in lessening the impact of cuts to those services in 2018.

The Centers for Medicare and Medicaid Services published the final 2018 physician fee schedule on Nov. 2. Overall, the CMS estimates that changes to the physician work and practice expense relative value units used to calculate global and technical component payments will result in a one percent overall decrease in reimbursement for pathology services. For independent labs, the overall decrease is one percent due mainly to the changes to technical component direct practice expense inputs. The CMS projections improved from what the Medicare agency had proposed in July, which had been an estimated two percent decrease for independent labs.

The effect of changes in the 2018 Medicare fee schedule varies for pathologists depending on the case mix of their practices. In addition, physicians receive payment from other Medicare payment systems. For example, independent laboratories receive 83 percent of their Medicare revenue from the clinical laboratory fee schedule.

In previous fee schedule regulations, the CMS targeted several pathology services as potentially misvalued, which may lead to potential cuts during subsequent review. Since 2006, 47 percent of pathology Current Procedural Terminology codes have been targeted for review. For 2018, the CAP successfully advocated to protect therapeutic apheresis, pathology consultation, and other pathology services targeted for revaluation, resulting in the Medicare program accepting all of the physician work recommendations for pathology services used to calculate professional component and global payment rates. As a member of the American Medical Association/Specialty Society RVS Update Committee, or RUC, the CAP leads the effort to develop and defend values for pathology services that are targeted for review. The CAP defended and sought increases to the existing physician work relative value units and the direct practice expense inputs for four sets of pathology services.

For the six therapeutic apheresis CPT codes under review, the CMS accepted the CAP's recommended increases to the physician work RVUs. The CAP worked with specialists and experts from the American Society for Apheresis, Renal Physicians Association, and American Society of Hematology to develop its recommendations after the CMS identified the codes for review in 2016.
The CMS identified for valuation review in 2014 the CPT codes for pathology consultation during surgery. The CAP performed a physician work survey, recommended that physician work RVUs for pathology consultation during surgery (codes 88333 and 88334) be maintained, and defended the services in the RVS Update Committee. In the final 2018 fee schedule, the CMS accepted the recommendation.

2018 Medicare physician fee schedule relative value units

The CMS also had identified tumor immunohistochemistry services as potentially misvalued through a screening process across physician specialties. The physician work and direct practice expense inputs for the services had been under review since 2014 and, through the RUC process, the professional component for these services was

reduced. The CMS finalized the recommended physician work RVU changes and made adjustments to direct practice expense inputs that were also developed by the CAP and recommended to the agency by the RUC. During reviews of these tumor immunohistochemistry services, the CAP advocated for appropriate reimbursement by engaging with the CMS during face-to-face meetings and in formal written comments.

The CAP also advocated at the AMA RUC to maintain and increase the physician work RVUs for diagnostic bone marrow aspiration and biopsy services. The CMS finalized these recommendations while also eliminating the Healthcare Common Procedure Coding System (HCPCS) code G0364 due to CPT changes to the bone marrow aspiration and biopsy code family. In the 2016 fee schedule regulation, the CMS identified these services as potentially misvalued.

The final 2018 fee schedule includes the CAP's requested changes affecting the technical component for flow cytometry services. In 2014, the RUC began reviewing the technical components for the services after the services were identified as potentially misvalued. In 2016, the CMS finalized the 2017 Medicare fee schedule, which planned for phasing in reductions, capped at 19 percent per year, in 2017, 2018, and 2019. In the final 2018 physician fee schedule, the CMS reexamined, at the CAP's request, the RUC recommendations for direct practice expense inputs for these services. The CMS finalized some of the key direct practice expense inputs found in those recommendations, inputs it had previously excluded. For example, the final 2018 rule now includes a 10 percent increase for CPT code 88184. This is in contrast to the 2018 proposed rule, which projected a one percent decrease for CPT code 88184 in 2018. CPT codes 88185, for flow cytometry add-on, and 88187, for flow cytometry interpretation, will still decrease by 19 percent in 2018.

In a separate regulation for the 2018 Hospital Outpatient Prospective Payment System, the CMS addressed the CAP's concerns by adding an exception to its 14-day rule policy for laboratory date-of-service requirements. Previously, the CAP advocated that in order to improve the consistency of Medicare payment policy, the laboratory date of service for all molecular testing should be the date of performance rather than the date of collection.

The new exception to the laboratory date-of-service policy permits laboratories to bill Medicare directly for advanced diagnostic laboratory tests and molecular pathology tests excluded from CMS' packaging policy ordered fewer than 14 days after the date of the patient's discharge from the hospital. This new policy applies if the specimen was collected from a patient during a hospital outpatient encounter and the test was performed after the patient's discharge from the hospital outpatient department.

The CAP argued for this change in its comments submitted in response to the 2018 Medicare Hospital Outpatient Prospective Payment System proposed rule. In addition, the CAP had worked with the American Society of Clinical Oncology and the AMA to develop its comments and successfully advocate for the rule change.n
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