Medicare IHC change adds to administrative burdens

Charles Fiegl

February 2014—Pathologists and laboratories have found new administrative challenges following deep payment cuts and policy changes in the 2014 Medicare physician fee schedule.

By the time the fee schedule was finalized Nov. 27, 2013, pathologists were left with little time to sort through the impact of the changes before they became effective Jan. 1. Overall, the Centers for Medicare and Medicaid Services data show a six percent reduction to pathology services in the 2014 physician fee schedule, which includes large cuts and new billing codes for immunohistochemistry services despite objections from the CAP.

Dr. Strate

In the fee schedule, the CMS requires pathologists to use new G codes (G0461 and G0462) to bill Medicare for immunohistochemistry in 2014, while practices must check with commercial payers to determine the correct codes to bill for the same service provided to non-Medicare patients. Changes need to be loaded into practice billing systems as office staff now must delineate the different policies between insurance carriers before claims go out the door, says Susan M. Strate, MD, a Wichita Falls, Tex., pathologist who is a CAP liaison to the AMA House of Delegates and a former member of the AMA/Specialty Society Relative Value Scale Update Committee. The billing problem is a new hassle created by the IHC change, but many practices and laboratories already are familiar with similar disjointed policies, especially in quality programs.

“One of the biggest problems is that regulators make the health care system more complex and expect that it will become less expensive,” Dr. Strate says. “We are overburdened and overregulated.”

The CAP has strongly opposed the change and in January met with the CMS to discuss reversing the policy. The CMS has expressed concern about “current and potential future frequency of immunohistochemical procedures that include multiple separately identifiable antibodies on the same histologic slide (ie, ‘multiplex antibody stain procedure’)” as a reason for implementing its new billing rules for IHC, the CAP summarized in a Jan. 27 letter to the agency. The vast majority of these procedures are used in the evaluation of prostate needle biopsies to detect carcinoma.

However, the instances of multiplex IHC procedures are rare. The CAP analyzed data for a small group of members and found a range of zero percent to 6.5 percent, for an average of 2.2 percent, of these procedures compared with overall cases. In addition, the CAP contacted a major pathology billing company that offered data from 114 pathology groups, and the average of all practice cases that used multiplex staining was 3.6 percent.

“At this time, we are unaware of evolving technologies that would suggest that significant changes to the clinical utilization of these services will emerge in the foreseeable future,” the CAP wrote in the letter. “Hence the G code language will result in inappropriate reimbursement for immunohistochemistry, because approximately 96% of services that are currently billed use single antibodies on separate slides and only roughly 4% of services use multiplex antibody stain procedures. With the G codes, only the first antibody per specimen will be billed as G0461. This causes a significant undervaluing of the G0462 in a vast majority of cases when subsequent separate antibodies are applied to a different slide.”

The CAP will continue to oppose the CMS' rejection of revised CPT codes for immunohistochemistry and the agency's decision to use the G codes. Pathologists also will need to remain active in local, state, and national health policy arenas to advocate on behalf of patients and the profession, Dr. Strate says.

Raich

Pathologists and administrative staff likely won't fully come to grips with the IHC billing problem until late February or early March, says Mick Raich, founder of the revenue cycle management company Vachette Pathology in Blissfield, Mich. In January, laboratories were still sending claims for services provided in December and were billed using the AMA's CPT codes for IHC. Unfortunately, determining how to correctly bill IHC for patients with commercial plans may be clear only after practices start receiving denials for using the wrong codes and then file appeals, Raich says.

"It might take until June to get January's money collected," he says. "Only then will we know how bad the cuts are."

Currently, practices can gauge the impact of the IHC and other fee schedule cuts. The bottom line number depends on the type of practice or laboratory and the case mix, says Raich, who has provided analyses for his clients. For instance, one analysis for a three-pathologist anatomic pathology laboratory in the Midwest showed a $159,000 total revenue decrease, or –28.6 percent, from Medicare when compared with 2013 Medicare payments. On the professional side, the total loss amounted to $4,600 per physician, or –5.1 percent.

The estimate for the laboratory was bleak, but the best-case scenario would not provide a rosier outlook, Raich says.

"It would still be pretty bad," he says. "You are looking at a drastic change in the revenue system. There is only so much a laboratory can do to make money—you can't just increase volume."

Many laboratories will look to renegotiate contracts with vendors, Raich adds. Pathologists also will need to find new ways to be efficient, such as using automation features in health information technology systems.

"The pressure is on all physicians to provide more services under heavy regulatory burdens with less payment," Dr. Strate says. "That's unfortunate for patients and physicians." n
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