Medicare physician fee schedule: Advocacy pays off, though 2014 CMS cuts will sting

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January 2014—A grassroots effort that mobilized pathologists around the country, and subsequent pressure from pathologists' congressional representatives, beat back plans to limit non-hospital Medicare payments. But other pay changes instituted by the Centers for Medicare and Medicaid Services have created significant concerns for physicians and laboratories.

In the final 2014 Medicare physician fee schedule published Nov. 27, the CMS halted its plan to limit certain payment rates in the fee schedule by lowering them to Hospital Outpatient Ambulatory Payment Classification rates. Pathologists and other specialties advocated strongly against this policy because it would have cut pay for 39 pathology services billed for non-hospital patients by as little as four percent and as much as 80 percent. In addition, the policy change would have circumvented a well-respected and established process with the AMA's Specialty Society Relative Value Scale Update Committee, a physician-driven decisionmaking process that provides the CMS with relative value recommendations supported by data reflecting the costs of performing services in physician practices.

One of the services that would have been capped by this proposal was 88367, in situ hybridization, which is commonly performed in a non-facility setting. The service requires a DNA probe kit that costs physicians $157. While the fee schedule rate for 88367 in 2013 was roughly $260, the CMS proposed to cap the total payment at $103—a 60 percent cut and $54 below the cost of the probe kit.

The CMS responded to evidence like this by halting its plan, but the agency said it will revise and submit a similar proposal in the future. This issue could come up again before 2015.

Molecular testing SPECs

Two PowerPoint presentations on the diagnosis of respiratory viruses and molecular testing in breast cancer are the latest additions to the CAP series of short presentations on emerging concepts, known as SPECs.

They and five others are free to pathologists, who can customize and use them for medical staff, tumor board, and other presentations.

The other five in the series are on colorectal cancer workup, therapeutic guidance for metastatic melanoma, diagnosis and workup of thyroid cancer—BRAF, screening for hereditary colon cancer—Lynch syndrome, and workup of thrombocytosis and polycythemia—use of JAK2. The SPECs are written by a work group of the CAP Personalized Health Care Committee.

SPECs are online at www.cap.org; enter SPECs under Search. Direct questions or comments about the SPECs to spec@cap.org.

CAP members submitted to the CMS hundreds of comments opposing the policy, and they responded to action alerts by sending more than 4,000 messages to members of Congress. Forty-one in-district meetings with respective members of Congress were held during the August and September congressional recesses. The CAP later held a fly-in, for which pathologists traveled to Washington to meet with their members of Congress, which amounted to 41 congressional office visits to discuss the proposed cuts.

CAP staff and members will continue their advocacy regarding all Medicare payment policies. CAP members will further have the opportunity to discuss national policy and legislative and regulatory issues during this year's CAP Policy Meeting, May 5–7 in Washington. Registration for the meeting is now open.

The Medicare agency surprised physicians with its decision to reject an AMA coding change proposal by creating new Medicare-only G codes for reporting immunohistochemistry, despite the concerns and intense advocacy work of the CAP and other medical societies. The AMA's Current Procedural Terminology Editorial Panel revisions to 88342 and the add-on code 88343, according to the CMS, allowed for the reporting of multiple units for each slide and each block per antibody. "We believe that this coding would encourage overutilization by allowing multiple blocks and slides to be billed," the CMS wrote in the fee schedule rule.

"To avoid this incentive," it went on, "we are creating G0461 (Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain) and G0462 (Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (List separately in addition to code for primary procedure)) to ensure that the services are only reported once for each antibody per specimen. We believe this will result in appropriate values for these services without creating incentives for overutilization."

Physicians who perform these services should check with their non-Medicare payers to determine whether they will follow recent Medicare billing and coding changes published in the fee schedule rule. The CMS establishes G codes for use by Medicare, but private insurance companies are required to use CPT. Pathologists will have to work with non-Medicare fee-for-service plans to ensure they receive reimbursement for their services because individual payers may take different approaches.

Two years ago, 88342 had been flagged as a high-volume code that was potentially overvalued, and the CMS' national correct coding initiative limited use of the code. In light of these actions, the CAP initiated a strategy to clarify the code and then revalue the service through the AMA RUC. The CAP has strong concerns about the CMS' immunohistochemistry change because it represents a pay cut to pathologists and fails to recognize the full value of the service. The College met with CMS officials to discuss these concerns and will continue to urge the administration to reverse its policy for immunohistochemistry codes. At the same time, the CAP and its members will remain vigilant of other Medicare payment policies.

Also in the 2014 final ruling, the CMS established new restrictions on the billing of 10 or more prostate biopsy specimens by requiring G codes G0416–G0419 to bill for these services. The CMS clarified that this new policy applies to all prostate biopsy specimens of 10 or more. Increased scrutiny in the reporting of multiple prostate biopsy specimens led to this policy change.

Not reviewed for 10 years and targeted by CMS for review was 88112—Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal. The CMS accepted the RUC's recommendations and reduced the global payment for 88112 by 43 percent, the professional component by 52 percent, and the technical component by 33 percent. These cuts are significant but were expected.

The CMS surprised pathologists by declining to set payment for the unique pathology services of optical endomicroscopy and suggested that pathologists bill for this service using existing codes when applicable.

The CMS finalized its proposal to create a new process, to take place over five years, that will revalue the clinical laboratory fee schedule payment amounts. The proposal had come on the heels of a June 2013 report, released by the Office of Inspector General, "Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings," which said Medicare paid between 18 and 30 percent more than other insurers for 20 high-volume and high-expenditure lab tests. The CAP anticipates significant downward pressure over the next few years.

The CMS rejected suggestions to form an advisory committee and will revalue payment through the annual

rulemaking process. It intends to consider data from all available sources to evaluate the impact of technological changes on payment amounts. The CAP is disappointed that the CMS rejected the suggestion to create an advisory committee including pathologists and other laboratory stakeholders. In this revaluing process, the CAP expects to be at the table and heavily engaged in the rulemaking process. Payments for clinical laboratory services are expected to see cuts starting in 2015.

The CMS targeted other services for review, too, among them fluorescence in situ hybridization, which will see changes next year, and microdissection services. In situ hybridization services—88365, 88367, and 88368—have not been reviewed for payment accuracy in 10 years. Microdissection services are more prevalent and therefore the CMS has signaled that a revaluation could take effect in 2015.

Beginning this month, Medicare payment for all clinical diagnostic laboratory tests (other than molecular pathology tests) performed on hospital outpatients that are currently billed to the clinical laboratory fee schedule will be "bundled" into payment for primary hospital outpatient procedures.

The CMS will package laboratory tests "when they are integral, ancillary, supportive, dependent, or adjunctive to a primary service or services provided in the hospital outpatient setting," the agency said. To be packaged, the laboratory tests would have to be provided on the same date of service as the primary service and ordered by the same practitioner who ordered the primary service. A laboratory test will be paid separately at the clinical lab fee schedule rate when it is the only service provided to a beneficiary on that date of service or the lab test is the same date of service as the primary service but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.

The bundling of these payments pertains to services reimbursed through the hospital outpatient prospective payment system and ambulatory surgical center payment systems maintained by the CMS. They pertain to the technical component of these services and not the professional component, which remain paid under the physician fee schedule.

In addition, seven add-on pathology codes are included in this packaging initiative. These codes are 88177 (Cytp fna eval ea addl), 88185 (Flow cytometry/tc add-on), 88311 (Decalcify tissue), 88314 (histochemical stains add-on), 88332 (path consult intraop addl), 88334 (intraop cyto path consult 2), and 88388 (tiss ex molecul study add-on).

For many pathologists, capturing and reporting quality activities in Medicare's Physician Quality Reporting System, or PQRS, remains challenging. The CMS has kept the five PQRS measures specific to pathology but rejected three new measures.

The rejection was based on a technicality and not on the merits of the proposed measures. CMS officials told the CAP that the new measures—lung cancer (biopsy/cytology specimens), lung cancer (resection specimens), and melanoma reporting—had been inadvertently left off a list that was included for the proposed fee schedule in July 2013. Furthermore, the CMS has assured the CAP that the measures will be considered for the 2015 PQRS measures list.

The CMS fee schedule and other Medicare payment rules were published before lawmakers took action on Capitol Hill in Washington to prevent a 24.4 percent sustainable growth rate cut on Jan. 1. They enacted a three-month delay of the across-the-board SGR reduction before adjourning for the holidays. The temporary measure was needed as members in the Senate and House drafted separate versions of an SGR repeal bill, which will continue to be debated as Congress works toward a permanent Medicare pay fix.

Latest estimates from the Congressional Budget Office show that eliminating the SGR would cost $116.5 billion over 10 years. Providing physicians with modest, annual Medicare payment updates of 0.5 percent through 2023 would cost $136.1 billion. The price tag is much lower than CBO estimates of about $300 billion just a few years ago.

Initial proposals appear to lay the groundwork for a more stable payment system. Legislation introduced by the House Ways and Means and Senate Finance committees, for example, would repeal the SGR and combine current incentive programs, such as PQRS and meaningful use of electronic health records. These would be merged to form a new payment update system under a value-based performance program.

The CAP will monitor the progress of these bills and other proposals to ensure pathologists can have the opportunity to fully and fairly participate in the performance-based program. Programs like PQRS and meaningful use of an EHR thus far have been geared toward primary care practices and patient outcomes.

CAP Federal and State Affairs Committee chair Kathryn T. Knight, MD, sent a letter Dec. 11 to Ways and Means chairman Dave Camp (R-Mich.) and Rep. Sandy Levin (D-Mich.), the ranking member on the committee, in support of the committee's legislation. The committee included a provision that would ensure all physician specialties, including pathology, can participate in the new value-based performance program.

Dr. Knight wrote, "It will help ensure that those pathologists and other physicians that have little or no face-to-face interaction with patients can be recognized for their substantial contributions to quality patient care."
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