Medicare revises 2017 discount on add-on codes: Increases professional, cuts technical, pay for prostate biopsies

Charles Fiegl

December 2016—Overall Medicare reimbursement for some professional pathology services will rise in 2017 due to increases sought by the CAP for add-on codes and other services provided by pathologists to Medicare beneficiaries. At the same time, the Medicare program will move forward with cuts affecting the technical component of pathology services, including flow cytometry, due to a targeted revaluation mandated by federal law.

The Centers for Medicare and Medicaid Services on Nov. 2 released its final federal regulation for the 2017 Medicare physician fee schedule. The CMS continues to move forward with its authority under the Patient Protection and Affordable Care Act to revalue and authenticate the payment for all physician fee schedule services. This includes the revaluation of pathology codes and will affect payment for key anatomic pathology services during the 2017 calendar year.

The Affordable Care Act requires the Department of Health and Human Services secretary to identify potentially misvalued services and to review and adjust the relative values for those services. Through another piece of legislation, the Achieving a Better Life Experience Act of 2014, Congress set a target for adjustments to misvalued codes in the fee schedules for 2016, 2017, and 2018. The target was one percent for 2016 and is 0.5 percent for 2017 and 2018.

If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued code reductions must be made to all physician fee schedule services. This is carried out through the calculation of the conversion factor, which is also used to set reimbursement rates. Misvalued code changes achieved a 0.32 percent reduction in net expenditures. These changes did not fully meet the misvalued code target of 0.5 percent and thus required an adjustment to the overall physician update for 2017. After applying this and other adjustments required by statute, the 2017 physician fee schedule conversion factor was set at $35.89, an increase from the 2016 conversion factor of $35.80.

The targeted revaluation of pathology services will have an effect on Medicare reimbursements to pathologists and independent laboratories in 2017. The overall combined impact on pathology services in the 2017 Medicare fee schedule is a one percent decrease due to final changes that decreased direct practice expense inputs, such as medical supplies used to calculate relative value units. However, there were increases to the work RVUs but not enough to offset decreases to practice expense values. The CMS estimates in the fee schedule that changes to the practice expense RVUs used to calculate technical component and global payments would result in a two percent decrease in Medicare payment for pathology services for 2017. The work relative value units, which rose slightly, represent the majority of the professional component payment for pathology services as well as global payments. The physician fee schedule payment received by independent laboratories is estimated to decrease five percent due to these same changes in practice expense costs. The actual impact on an individual pathologist or practice will depend on the mix of services provided to beneficiaries with Medicare or other public or private health plan coverage.

IHC and FISH add-on codes. Due to the CAP's continued engagement with the agency, the CMS again increased the value of a select group of pathology add-on services by reducing the discount applied to immunohistochemistry, immunofluorescence studies, and in situ hybridization. For instance, the CMS will decrease

the current 25 percent gap between the valuation of the base and add-on codes for immunohistochemistry to 20 percent in 2017. This policy change represents a $4.06 million increase in payment to pathologists based on Medicare volume. This includes a $3.81 million change to CPT code 88341. However, the CAP continues to maintain that the difference in physician work from the base code to the add-on service is diminutive and no discount should be applied.

In comments about the proposed 2017 Medicare fee schedule published in July, the AMA/Specialty Society Relative Value Scale Update Committee (RUC), of which the CAP is a standing member, endorsed the CAP's recommendation for the add-on codes and said the proposed work RVUs for CPT codes 88341 and 88350 did not represent the work involved in furnishing the procedure—presenting a rank order anomaly for other services. The RUC also said the noncoronary intravascular ultrasound CPT codes, 37252 and 37253, which the CMS had used to establish the discount between the base code and the add-on code, are not medically comparable services to CPT codes 88341 and 88350. Additionally, the RUC said each pathology service has individual intensities and complexities. Specifically, for additional immunohistochemistry services represented by add-on CPT codes 88341 and 88350, each antibody is evaluated separately on different slides and each additional service is separate and distinct.

Finally, the RUC said its approach of evaluating the actual work associated with each unique base and each unique add-on service is far more accurate, rational, and responsive to the specific circumstances than holding codes equal to a fixed discount from the base code. Applying ratio comparisons and fixed discounts to arrive at a work relative value will continue to create interspecialty rank order anomalies of physician work RVUs, the RUC said.

In response, the CMS said the agency continues to believe the metric used to value add-on codes relative to their base codes was appropriate and representative of the work involved. The CMS disagreed there is rank order anomaly within this particular code family. In the 2017 fee schedule, the CMS said: "In response to the commenter's statement that there should be no comparison of intravascular ultrasound services to any pathology service, we continue to believe any difference in work RVUs for codes describing different kinds of services should reflect the relative differences in time and intensity involved in furnishing the services. Therefore, we believe that it is imperative that we can compare the assumptions regarding overall work between any two codes, regardless of their characteristics." The CMS added that it appreciates commenters' concerns regarding a standard discount and does not consider the use of a particular increment to establish a new standard.

Prostate biopsy G-code. Dating back to the 2009 physician fee schedule, the CMS created a set of four government codes, or G-codes, for the surgical pathology of prostate saturation biopsy services. The number of specimens distinguished the codes: 1–20 specimens for G0416, 21–40 for G0417, 41–60 for G0418, and 60-plus for G0419. The CMS changed the set of descriptors for the codes in 2013 and 2014, and in 2015 the CMS sought reductions in expenditures. According to the CMS, these changes caused significant confusion among pathology practices and enhanced the administrative burden of coding differently for similar services. In particular, the CMS' 2015 coding changes were substantial for the prostate biopsy interpretation services. The agency eliminated codes G0417, G0418, and G0419, and revised the descriptor for G0416 so that the definition of the code would apply to all prostate biopsy specimens regardless of the number of specimens or technique used to obtain the biopsy. The CMS also requested revaluation, and the CAP worked with the RUC to review the code and make physician work and practice expense recommendations for 2017.

The CAP sought an increase to the professional component of the prostate G-code reported for all prostate biopsy services. As a result of this effort, the CMS finalized an increase to the physician work component of G0416 from 3.09 to 3.60 in the 2017 Medicare fee schedule. This represents a 17 percent increase. At the same time, the CMS also reduced the technical component payment for prostate services.

Microslide consultation. The CMS also had targeted for revaluation the microslide consultation codes 88321, 88323, and 88325. The CAP led the RUC review of the services, which involved defending the physician work and practice expense RVUs. And the CAP's efforts resulted in the CMS retaining the current physician work values for 88321 and 88323, as well as finalizing the CAP's recommended increase to 88325. The CMS' agreement with these

recommendations results in a 14 percent increase in the work value for 88325 for 2017.

Flow cytometry. The 2016 fee schedule included cuts to flow cytometry technical component codes 88184 and 88185 as the Medicare agency previously identified the services as potentially misvalued. The CMS is planning to phase in further reductions, capped at 19 percent per year, in 2017, 2018, and 2019. The CAP had worked with the RUC and met with the CMS in an attempt to reinstate some of the previously identified reductions to these codes.

The 2017 changes include reductions to the professional and technical component valuations of the flow cytometry codes. The physician work of the flow cytometry codes 88187, 88188, and 88189 will be lower by more than 20 percent each due to the CMS' misvalued code initiatives. The practice expense RVUs for flow cytometry will also decrease again in 2018 as the CMS will phase in its reductions to the services.

View 2017 Medicare physician fee schedule relative value units.
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Charles Fiegl is director of CAP advo-cacy communications, Washington, DC.