Millions at stake in ’21; CAP fights Medicare cuts

CMS finalizes proposal that will lower payments for non-e/m services billed by specialists

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December 2019—Medicare reimbursement to pathologists in 2020 is estimated to remain steady, but significant cuts in payments to pathologists and other specialists are expected in 2021 owing to a dramatic shift in how primary care physicians will be paid.

The CAP is already fighting the scheduled cuts to pathologists in 2021 as a result of a new plan that reimburses evaluation and management office visit services at a higher rate and lowers payments for non-E/M services billed by specialists. The Centers for Medicare and Medicaid Services finalized the proposal that will lead to an estimated eight percent reduction in Medicare payments to pathologists in 2021 when it published on Nov. 1 the 2020 Medicare physician fee schedule final regulation. At the same time, the CMS made favorable changes in response to the CAP’s advocacy on the practice expense components related to payment for pathology services, positively impacting payment rates for 2020.

Cuts tied to E/M services. The 2021 implementation of the CMS’ changes to evaluation and management office visit services redistributes $7 billion under Medicare’s budget-neutral physician fee schedule. Physicians who commonly bill E/M services stand to benefit the most while physicians who rarely bill E/M services will see their reimbursements reduced. According to CMS estimates, pathology will lose $97 million, or eight percent, in 2021. Providers that bill Medicare as independent laboratories will lose $24 million, or four percent, in 2021. The impact on individual pathologists will vary depending on their case mix.

2020 Medicare physician fee schedule relative value units

The changes to E/M services go beyond recommendations proposed by a workgroup led by the American Medical Association. The CAP participated in the workgroup, which advocated for the CMS to align its E/M payment policy with coding changes outlined by the AMA CPT editorial panel and values recommended by the AMA/Specialty Society Relative Value Scale Update Committee, known as RUC. The CMS accepted the AMA-RUC recommendations but then tacked on an additional E/M add-on code, which the agency believes is needed to reimburse the work associated with furnishing complex office visit services.

The CAP and the AMA have opposed this add-on code because it accounts for an additional $2.6 billion that will be redistributed to physicians furnishing office visits and further reduces payments to physicians who do not bill E/M services. For pathologists, three out of the eight percentage point reduction is attributable to the add-on code as such an increase must not increase Medicare spending for physicians.

Cuts to pathologists under this policy change could have been worse. Surgical specialties and the AMA advocated for increases to surgical procedures that have a global period to also reflect the E/M changes as surgeons typically conduct pre-op and post-op office visits as part of surgeries. The CAP opposed this effort, and the CMS agreed with the CAP and opted not to make changes to the global surgery codes at this time.

A $30 million increase. Earlier in 2019, the CAP submitted an extensive list of pathology supplies and equipment invoices to the CMS to correct errors the CAP found in several prices. Previously, the CMS reset prices for more than 2,000 medical supply and equipment items that are used to calculate payments for services on the Medicare physician fee schedule. These pricing inputs are used for the practice expense component of physician services, used to calculate the technical component and global payment of pathology services.

Because of the CAP’s advocacy and efforts to correct errors affecting Medicare reimbursements for pathology services, the CMS updated 36 direct practice expense supply and equipment prices, adding $30 million to Medicare payment for pathology services. Twenty-six of these price increases are owing to the direct work of the CAP’s

engagement to correct previous CMS errors.

The CAP will continue to provide to the CMS as needed additional clarification on appropriate pricing for pathology supplies and equipment.

Values for cytopathology services reduced. In the 2020 Medicare physician fee schedule, the CMS reduced the physician work relative value units used to calculate the payment for cytopathology services. The CAP had recommended maintaining the current physician work RVU of 0.42 for four cytopathology services identified as potentially misvalued. The CMS disagreed and decreased the physician work RVU to 0.26. The reduced payment rates will be phased in over two years, starting in 2020.

The CAP had secured the support of the AMA and worked with the CMS to protect the value of these services. However, the agency finalized its initial recommendation for the following services:

- Cytopathology, cervical, or vaginal (any reporting system), requiring interpretation by a physician (code 88141).
- Screening cytopathology, cervical, or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by a physician (code G0124).
- Screening cytopathology smears, cervical, or vaginal, performed by an automated system, with manual rescreening, requiring interpretation by a physician (code G0141).
- Screening Papanicolaou smear, cervical, or vaginal, up to three smears, requiring interpretation by a physician (code P3001).

The CAP remains opposed to these reductions and will continue to advocate for their accurate valuation. (See “Pathology values,” this page.)

Two proposals shelved. In a separate regulation for the Medicare Hospital Outpatient Payment System also released Nov. 1, the CMS agreed with the CAP’s advocacy by shelving two proposals.

The CAP turned back the CMS proposal to specify that the ordering physician would determine whether the results of the advanced diagnostic laboratory tests (ADLTs) or molecular pathology tests are intended to guide treatment provided during a hospital outpatient encounter. If the ordering physician had considered the test would guide treatment during the hospital outpatient encounter, the test would have been regarded as a hospital service. The agency had also proposed removing molecular pathology tests from the laboratory date-of-service exception and limiting it only to ADLTs. The CMS said it no longer believes the beneficiary access concerns that apply to ADLTs also apply to molecular pathology tests.

The CAP disagreed and advocated for the exception to continue to apply to molecular pathology tests, highlighting that the tests are still not commonly performed by hospitals, as they are not always practical or cost-effective due to lower test volumes.

In another date-of-service proposal, the CAP worked with the AABB to urge the CMS to finalize a date-of-service proposal for laboratory testing. In the final Hospital Outpatient Payment System regulation, the CMS decided that the date on which blood banks perform the laboratory test on specimens collected during a hospital outpatient encounter will be the date of specimen collection. As a result, the hospital will bill Medicare for the laboratory test, and the blood bank performing the test would seek payment from the hospital.

The CMS also agreed to define a blood bank as an entity whose primary function is the performance or

responsibility for the performance of the collection, processing, testing, storage, and/or distribution of blood or blood components intended for transfusion or transplantation.

Outpatient payment for 88307. After threatening another cut, the CMS retained its payment assignment for the surgical pathology code 88307 in the Hospital Outpatient Payment System. Initially, the CMS had proposed lowering the hospital ambulatory payment classification for 88307 by 46 percent. After considering the CAP's comment and analysis of the updated claims data for the final rule, the CMS decided to maintain the ambulatory payment classification assignment for 88307 in 2020.

MIPS scoring tougher in 2020. For pathologists participating in Medicare's Merit-based Incentive Payment System in 2020, the CMS increased its performance threshold to 45 points, from 30 points in 2019, to avoid a payment penalty. MIPS scores based on 2020 performance will affect Medicare reimbursement in 2022. MIPS-eligible physicians who score fewer than 45 points in 2020 will receive a nine percent payment cut in 2022. The CMS detailed these changes Nov. 1 in a regulation for its Quality Payment Program, which includes MIPS.

The CMS had sought to remove four pathology quality measures, but the CAP demonstrated the need for more appropriate measures for pathologist participation in MIPS. As a result, the CMS retained the four pathology measures that otherwise would have been removed and added a dermatopathology measure to the pathology measures set.

Starting in 2019, Medicare Part B claims measures could only be submitted via claims by pathologists in a small practice (15 or fewer eligible clinicians) and can be submitted with individual or group participation. Pathologists in a group of 16 or more can no longer submit quality measures using claims, regardless of whether participating as an individual or group, and must submit using a qualified registry or qualified clinical data registry. These rules will again be in effect for 2020. The CAP's Pathologists Quality Registry is a tool that provides both reporting options for MIPS-eligible pathologists, practicing in either small or large practices, to meet MIPS requirements.

Pathology values. The CAP advocates for the appropriate valuation of pathology services as the pathology representative on the RUC advisory committee. The AMA RUC is an expert panel that uses its independent judgment to assist specialties in appropriately valuing their work. It provides physicians with a voice to shape how they are paid for their services, and the CAP participates in the RUC process to advocate for appropriate payment of pathology services.

CAP members can participate directly in the RUC process by participating in the CAP's RUC survey process. These surveys assist the CAP in assessing the time, intensity, complexity, and ultimate value of pathologists' work. The CAP's advocacy staff conducts periodic physician work surveys to gather data used to advance the specialty and to accurately account for the pathologists' work efforts. These surveys may be associated with new, revised, or potentially misvalued pathology services in need of valuation or revaluation.

Pathologists chosen for a physician work survey receive an email requesting completion of a 10- to 15-minute online survey. CAP members are encouraged to take all AMA RUC physician work surveys and to be honest about the typical time and work spent on an individual service.

A July 2017 *Advances in Anatomic Pathology* article, "Current valuation of pathology service," coauthored by Jonathan L. Myles, MD, who served previously as the CAP's member on the AMA RUC advisory committee and is now a member of the CAP Board of Governors, explains how pathology services are valued and notes that the work RVU component represents a "physician's time to perform the service, the technical skill and physical effort, the required mental effort, and judgement, as well as the stress due to potential risk to the patient" (Myles JL, et al. 24[4]:222–225).

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