Pay is up in Medicare proposal, but final picture unknown

Kevin B. O'Reilly

August 2015—After years of reading the latest news from the CMS with dread, pathologists and independent laboratories have some reason for revelry this summer as the agency's proposed physician fee schedule offers an overall uptick in Medicare payment for 2016. Yet it is the final physician fee schedule, due in November, that will tell whether pathologists feel grateful toward the CMS when Thanksgiving rolls around.

"Overall, pathology and independent labs have something good to smile about here. Compared to other specialties, both of these areas received a nice increase," says Mick Raich, president of Vachette Pathology, a practice management firm that reviews about $900 million in annual billing for 83 pathology practices nationwide.

Raich

According to the CMS' proposed physician fee schedule—published July 15 and available at https://federalregister.gov/a/2015-16875—independent laboratories would be in line for an aggregate nine percent increase in payment on charges of $823 million. Eight percentage points of that nine percent raise are due to the impact of changes to practice expense relative value units, or RVUs, while the remaining percentage-point increase is due to work RVU changes.

Pathologists, meanwhile, are estimated to see an eight percent pay raise under the proposed fee schedule on charges of $1.3 billion. Changes in work RVUs and practice expense RVUs of four percentage points each contributed to that increase for pathologists.

"Most of the increases are tied to the technical component. I believe this is a bit of a correction as many of the code descriptions for these codes have moved from per block to per specimen," Raich tells CAP TODAY. "The professional component was increased slightly, the best news being a 1.41 percent proposed increase for the 88305–26"—for a tissue exam by a pathologist.

Some of the biggest year-over-year proposed pay raises come for codes used to report immunohistochemical work. For example, Medicare now pays $67.91 for code 88341 (immunohisto antibody slide). Under the proposed fee schedule, that would jump 35 percent to $91.72. That code with the 26 modifier earns $21.92 now and would bring in $28.17 in 2016, about 29 percent more. Meanwhile, another IHC code, 88344, would bring in 50 percent more ($176.58) under the CMS proposal. The TC modifier for that code would see pay rise 75 percent to $135.41, while pay for the 26 modifier also would increase by about two percent to $41.16.

"In regards to immunohistochemistry, we see some significant increases in payment for both the technical component as well as the professional component. While these increases are quite marked, remember that we're coming off the rather large cliff when these codes were cut last year," Jonathan L. Myles, MD, said in a July 14 CAP webinar available at http://j.mp/capwebinar_2016proposed. He is chair of the CAP's Economic Affairs Committee and pathology advisor to the American Medical Association's Relative Value Scale Update Committee, or RUC.

"What this is an example of is successful advocacy," Dr. Myles said. "Throughout 2015, the College on several occasions engaged with the CMS, advocating for why certain things need to be included in the practice expense, as

well as on the professional side that the professional component shouldn't be cut like they did. We still have some work to do, but we're certainly off to a great start with the proposed rule for 2016 in terms of immunohistochemistry."

Raich says the Centers for Medicare and Medicaid Services' turnabout on payment for IHC "is still not an increase compared to two years ago."

"It's three steps forward and three steps back," he says. "It's their strategy to drive down utilization, or overutilization."

Several codes for in situ hybridization work also are in line for a big Medicare pay bump. Pay for 88364 would increase about 40 percent, with the technical component jumping 44 percent to $101.83 and the 26 modifier bringing in $35.39, a nearly 30 percent increase over this year. The CAP has compiled a table—available at http://j.mp/2016proposed_pathrvus—that compares 2015 pathology RVUs with those proposed for 2016.

Dr. Myles warned that the apparent good news from Medicare comes with caveats.

"Importantly, the impact to 2016 pathology payment doesn't include the values CMS will assign to G0416—the prostate bundling code—or any other changes in the 2016 final rule," he said.

Dr. Myles

In 2014, the CMS created a new definition for G0416 and stated pathologists would use the code when reporting all prostate biopsy services for Medicare patients starting this year. At the same time, the agency said that payment for the service was potentially misvalued and that a revised pay rate would be published for 2016.

"It's likely that in the final rule we'll see some decrease in the technical component, as well as global payment, for prostate services in G0416," Dr. Myles said. "Also, CMS can make adjustments to any of the final codes we talked about."

Another CAP leader, George F. Kwass, MD, echoed during the webinar Dr. Myles' note of caution.

"We have to remember that one big piece of this puzzle has not as yet shown itself, and that's the prostate bundle code—the G-code 0416 that we anticipate in the final rule," said Dr. Kwass, chair of the CAP Council on Government and Professional Affairs. "Whether payment for that will go up, down, or stay the same remains a question which we don't know the answer to, and which we can't predict at the moment."

As part of its ongoing effort to cut costs by reconsidering what it considers misvalued codes, the CMS proposed re-evaluating the following codes: 10022 (FNA w/image); 36516 (apheresis selective); 88160 (cytopath smear other source); 88161 (cytopath smear other source); 88162 (cytopath smear other source); 88185 (flowcytometry/tc add-on); 88189 (flowcytometry/read 16&>); 88321 (microslide consultation); 88360 (tumor immunohistochem/manual); 88361 (tumor immunohistochem/computl).

Also, payment for two flow cytometry-related codes, 88184 and 88185, is targeted for 38 and 69 percent cuts, respectively, phased in over the next two years. The CMS judged that the cost of performing these tests has fallen and that is why it has proposed cutting the pay so dramatically. Dr. Myles said the CAP will comment on this issue specifically "to get some of that back" and explain to the agency why, for example, a computer is needed in the room to run flow cytometry tests.

Aside from the bread and butter changes to payments for individual services, the proposed rule also includes the CMS' first statements on a move toward the new Merit-Based Incentive Payment System created under the Medicare Access and CHIP Reauthorization Act, the law that put an end to the sustainable growth rate formula.

The new incentive system will replace the Physician Quality Reporting System and Medicare's value-based modifier in 2019. In the meantime, the CMS has included all eight pathology measures for PQRS in its proposed rule. That includes two new measures on lung cancer reporting (for biopsy/cytology specimens and resection specimens, respectively) and another new measure for melanoma reporting.

While the PQRS will end in 2018, that also is the year when a two percent across-the-board penalty would be applied to eligible pathologists or group pathology practices that do not participate in the program in 2016. Those who are eligible and do participate in 2016 would not see their Medicare pay affected for good or ill. The CAP has clarified that participation in an accountable care organization satisfies PQRS requirements.

Similarly, the agency's value-based modifier would hit all eligible physicians in 2018 based on how well they do next year on cost and quality metrics. Pathologists judged to provide low-quality, high-cost care in groups of 10 or more eligible CMS providers would see a four percent penalty, while pathologists in smaller group practices would face a two percent cut. Meanwhile, pathologists judged to provide high-quality, low-cost care could see a four percent Medicare pay increase.

"Many of these measures are, in general, constructed around the typical office-based physician practice and are harder to apply to pathologists," W. Stephen Black-Schaffer, MD, said during the CAP webinar. He is vice chair of the College's Economic Affairs Committee.

"One of CAP's recent advocacy efforts has been to include a provision which directs the secretary of the HHS to consult with non-office-based physicians, typically referred to as non-patient-facing physicians, to develop alternative measures for their categories," Dr. Black-Schaffer said. "CAP plans to engage with CMS on this. We anticipate the significance of this will become greater over time. One of the things we got when we had the SGR taken away was the expectation that in the future adjustments of this sort will be predicated primarily on this sort of performance score rating."

Comments on the proposed physician fee schedule are due by Sept. 8.

Medicare's move toward value-based care also is reflected in the other major proposal published in July and available at https://federalregister.gov/a/2015-16577. The CMS, in its proposed rule on hospital outpatient and ambulatory surgical center payment, presented further bundling of hospital outpatient payment for ancillary services—including certain laboratory and pathology services—into what it calls ambulatory payment classifications.

Notably, the agency excluded from its packaging policy all "molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479." Those codes listed in the clinical laboratory fee schedule will continue to be paid at CLFS rates, outside the outpatient prospective payment system, the proposal said.

The agency also says it erred in its estimates about the value of the clinical laboratory services that would be swept into its outpatient bundling program. The CMS had expected that $2.4 billion in laboratory tests would be shifted into the packaging initiative, but only $1.4 billion actually was, with the other $1 billion paid separately. To make up for that, the agency proposed cutting the 2016 conversion factor by two percent. The deadline for comments on the proposed Hospital Outpatient Prospective Payment System rule is Aug. 31.

Kevin B. O'Reilly is CAP TODAY senior editor.