



## Frequently Asked Questions CMS 2014 Physician Fee Schedule Final Rule

As you are aware, on November 27, CMS released the final 2014 Physician Fee Schedule (PFS) Rule and the Hospital Outpatient Payment Rule. The following FAQs have been prepared to assist you in responding to questions regarding the outcomes in the 2014 Final Rule.

### **Q1. What happened regarding the 2014 Anatomic Pathology Code Revaluations?**

A1. The rule includes payment decisions to the code families listed below. The code reductions go into effect on January 1, 2014.

**Immunohistochemistry:** 88342 (PC & TC) – CMS rejected CAP's proposal and instead they will require the use of 2 new G codes for this service; G0461 to report one unit of service per specimen and G0462 to report each additional stain.

The following chart documents the percentage reduction and payment rate change for the new G codes compared to the current reimbursement for CPT code 88342:

<b>CPT Code</b>	<b>Modifier</b>	<b>88342 2013 Total Payment</b>	<b>2014 Total Payment</b>	<b>Total % Change from 2013 88342</b>
G0461		\$115.34	\$88.04	-24%
G0461	TC	\$73.15	\$57.39	-22%
G0461	26	\$42.19	\$30.65	-27%
G0462		\$115.34	\$68.08	-41%
G0462	TC	\$73.15	\$55.61	-24%
G0462	26	\$42.19	\$12.48	-70%

**Enhanced Cytology Services** – 88112 (PC & TC) were reduced as documented in the following chart:

CPT Code	Modifier	2013 Total Payment	2014 Total Payment	Total % Change from 2013
88112		\$109.55	\$62.73	-43%
88112	26	\$58.18	\$28.16	-52%
88112	TC	\$51.37	\$34.58	-33%

**88305 TC** – In the 2013 physician fee schedule rule, CMS requested additional data review by the RUC to support 2013 revaluation of this service. Based on the input received, no further cuts in the cost data were taken for 2014.

**In situ hybridization services; 88365, 88367, and 88368 (PC & TC)** – CMS deferred final action on the revaluation of these services for 2014 but changes are anticipated starting in 2015.

**Prostate biopsies** – CMS established new restrictions on billing of 10 or more prostate biopsies specimens that require individuals who bill more than 10 or more to utilize G codes G0416-G0419 to bill for these services. CMS clarified that this new policy applies to all prostate biopsy specimens of 10 or more.

**In Vivo Microscopy (88375)** – CMS rejected the CAP developed and RUC recommended values to capture the pathologists' work for this new service and stated that pathologists can bill other existing codes to capture their work for this service such as codes for pathology consultation during surgery.

**Q2. Why did these changes to the codes occur?**

A2. Specifically for each service:

**Immunohistochemistry** – Two years ago CMS flagged CPT code 88342 as a high volume code that was potentially overvalued. Subsequently, CMS' National Correct Coding Initiative limited the use of the code. In light of these actions, CAP initiated the strategy to clarify the code and then to revalue the service through the RUC. The intent of the CAP's CPT code revisions were to use 88342 to capture the single antibody on a single slide. The CPT intent of new code 88343 was to capture staining a second antibody on the same slide. The new G-codes do not include this clarification and instead require G04061 to report one unit of service per specimen and G0462 to report each additional stain. CAP will be meeting with CMS to address their assumptions with the intent of reversing the direction suggested in the final rule.

**Enhanced Cytology Services, 88112 (PC & TC)** – The code, which had not been revalued in 10 years and was targeted for review due to its high volume, is delivered utilizing less resource intensive techniques since it was first valued.

**In situ hybridization services; 88365, 88367, and 88368 (PC & TC)** – The code has not been looked at in nearly 10 years. Increased use since the 2004 establishment of the FISH codes has prompted CMS to repeatedly call for payment review.

**New Restrictions on Prostate Biopsies** – Increased scrutiny in the reporting of multiple prostate biopsy specimens led to this policy change.

**Optical Endomicroscopy** – CMS declined to set payment for unique pathology services and suggested that pathologists can bill for this service utilizing existing codes when applicable.

**Q3. What did CAP do to influence the outcome of these payment determinations?**

A3. CAP used its position on the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to mitigate payment reductions to the specific high-volume pathology services targeted as overvalued. CAP advocated that the revaluations of pathology services accurately account for the cost of delivering the services provided. CMS doesn't always agree with or take CAP's recommendations. CAP will be able to advocate for changes going forward.

**Q4. What happened regarding capping payment rates in the Medicare physician fee schedule at Hospital Outpatient Ambulatory Payment Classification (APC) rates?**

A4. In contrast to working within the established RUC processes, on July 8, 2013, CMS proposed to link payment for over 200 services to hospital outpatient rates as part of its "misvalued code" initiative. The rule would have reduced the technical component and global payment of 39 pathology services billed for non-hospital patients by as little as 4 percent and as much as 80 percent depending on the services.

**Q5. Why did CMS propose this policy change?**

A5. CMS is advocating they want to pay the same rate for a service regardless of where it is delivered. CMS claimed hospital data is more reliable than what is submitted by physicians through the RUC. The APC proposal represents a step toward severing the ties with the resource based relative value system (RBRVS).

**Q6. What did CAP do to influence the outcome on this issue?**

A6. CAP has been engaged in a broad coalition and an extensive grassroots campaign to fight this policy decision. CAP sent a letter to CMS opposing this policy which was signed by 40 Members of the Senate and 115 members of the House. Further, CAP advocated for its position with regulatory decision-makers at CMS, HHS, and OMB; and in meetings with the White House.

CAP remains opposed to implementation of this policy and will continue to work with our congressional supporters to prevent its implementation. CAP has drafted legislative language, and as evidenced in its letter to CMS, has dozens of congressional champions on both sides of the aisle. CAP will be sending Action Alerts to its members calling upon them to contact their Members of Congress. The Action Alerts will make clear CAP believes:

- Hospital data does not accurately account for the cost of delivering services in the laboratory.
- The agency is required by statute to base payment rates on actual resource based costs of providing the service. The hospital APC grouping represents the average costs for a group of codes.

**Q7. What happened regarding CMS' Proposed Changes to Medicare's Hospital Outpatient Prospective Payment System (HOPPS) (i.e. "Bundling")?**

A7. Beginning Jan. 1, 2014, 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 (CLFS) will be "bundled" into payment for primary hospital outpatient procedures. The expanded bundling payment would apply for services that are provided on the same date of service as the primary service and ordered by the same practitioner who ordered the primary service. The CAP is continuing to analyze the potential impact of this proposal on physician pathology services provided to hospital outpatients.

**Note:** This was a separate rule from the 2014 PFS Rule and was released as part of the Hospital Outpatient Rule.

**Q8. Why did this occur?**

A8. Out of a concern for overpayment, CMS is moving toward bundling of payments.

**Q9. What did CAP do to influence the outcome on this issue?**

A9. CAP made clear its serious concerns with the proposal on behalf of pathology and the laboratory community and offered to meet with the agency to discuss the design and the feasibility of bundled payments for pathology. CAP underscored these are complex proposals that are impossible to assess without fully understanding the methodology employed by CMS, particularly how payments will be distributed on a code-by-code basis, for both the primary and supporting services. A broad range of stakeholders responded there was not sufficient information to understand the proposal or to project its impact. Of interest, CAP believes this rule is signaling future policy decisions.

**Q.10. What happened regarding the Physician Quality Reporting System (PQRS) Measures for pathologists?**

A10. While CMS did not accept the CAP's three new pathology measures in its final rule, CMS will allow pathologists to qualify for 2014 incentives by reporting on the existing five measures proposed by the CAP by either claims or registry.

**Q.11. Why did this occur?**

A11. CAP will be meeting with CMS in the days to come. We expect to gain a better sense of their rationale on the PQRS measures and will share what we learn with CAP members.

**Q12. What did CAP do to influence the outcome on this issue?**

A12. CAP developed the three measures and submitted them to CMS. CAP has advocated for their adoption with CMS. CAP has previously secured approval for five pathology measures in the 2013 PQRS. CAP developed three additional measures in 2012 for the 2014 PQRS. In 2011, pathologists received a bonus of \$856.50 on average. By participating in the 2013 PQRS, pathologists avoided penalties that begin at 1.5 percent of their Medicare Part B billing in 2015.

**Q13. What happened regarding the Clinical Laboratory Fee Schedule (CLFS)?**

A.13 CMS finalized its proposal to create a new a process that will revalue the CLFS payment amounts. The process will occur over a five-year period.

**Q14. Why did this occur?**

A14. A combination of changes have made the CLFS outdated. CMS has for years expressed concern that the CLFS needed to be revalued. In fact, the proposal followed on the heels of a June 2013 report, released by the Office of Inspector General Report (OIG), "Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings". The report concluded that Medicare paid between 18 and 30 percent more than other insurers for 20 high-volume and/or high-expenditure lab tests.

**Q15. What did CAP do to influence the outcome of this proposal?**

A15. In this revaluing process over the next five years, CAP expects to be at the table and heavily engaged. CAP anticipates significant downward pressure over the next few years. In 2014, CAP's focus is on influencing the process of revaluing the codes. Payment reductions to CLFS fees are anticipated beginning in 2015.

**Q16. What is happening with the SGR? Will there be another short term fix or a long term solution?**

A16. If Congress doesn't act by year's end, the SGR cuts go into effect on Jan. 1, 2014. Congress is currently working on legislation to repeal and replace SGR. Since 2003, Congress has enacted 15 SGR patches at a cost of \$146 billion.

**Q17. Where can I find a copy of the rule?**

A17. The rule is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>