To: House of Delegates Steering Committee

Topic: CGPA Update (January/February 2013 Report)

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CAP Policy Meeting – Nancy-Ann DeParle, President Obama’s former deputy chief of staff for policy, and a former director of the Healthcare Financing Administration (HCFA, now CMS) under Bill Clinton will be among the health policy leaders featured at the CAP 2013 Policy Meeting May 6, 2013. Until recently, DeParle was the most senior female member of the Obama administration. A nationally recognized expert on the Affordable Care Act, she served as the director of the White House office of Health Reform, leading the law’s development and passage into law. DeParle’s presence at the CAP Policy Meeting is sure to provide an insider’s look at the political landscape and the role of the White House in the current legislative climate. Also confirmed to speak at the meeting will be Sean Cavanaugh, Deputy Director, Programs and Policy, in the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services, and Charlie Cook, Editor and Publisher of the Cook Political Report and a political analyst for NBC News and National Journal.

Federal

CMS Issues Guidance on Sequestration – CMS confirmed late last week that Medicare fee-for-service claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment due to the federal budget sequestration which took effect on March 1. With no signs that it will be lifted anytime soon, providers will likely see the new lower payments begin in mid-April. The claims payment adjustment will be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the reduction. CMS is encouraging Medicare physicians who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare’s reimbursement.

Threat to Core Pathology Services Continues – Key pathology code families are still under review and addition cuts are expected in 2014. Additionally CMS advanced an initiative included in health care reform legislation requiring the agency to establish a validation system for physician services to provide further scrutiny to specialists as contractors are in place to develop the system. CAP continues to advance unique strategies for each targeted code family to best protect reimbursement for services targeted as overvalued.
88305 TC

- While the technical component (TC) of CPT code 88305 saw a 52% cut in 2013, the battle is not over as CMS continues to question the reduced payment level. The agency asked for independent verification of the number of blocks used to base CAP’s recommended TC cost items. CAP developed and will present evidence to the RUC to defend its earlier recommendation, but CMS can still cut reimbursement further for next year.

- Additional TC cuts are expected if CMS rejects CAP block study. TC cuts impact Medicare global and TC billers while Medicare PC-only billers would see no reduction or possible increase due to shift in practice expense RVUs.

In situ Hybridization

- New requests from CMS could result in payment cuts to PC and TC of in situ hybridization. The rise in utilization for FISH on urine specimens created the heightened concern for how pathologists are paid for these services.

- PC payment is also at risk for cuts due to current utilization and increased scrutiny of the code value. There is the potential for separate payment for additional probes that may impact TC value.

Immunohistochemistry

- 2014 will bring changes in payment and coding for immunohistochemistry. CAP implemented a strategy to mitigate reductions and to best preserve payment for the first use of the code, however, multiple reportings are expected to see a cut.

- The financial impact to members would vary based on practice pattern with the greatest negative impact on those reporting multiple units.

Enhanced Cytology Services

- Enhanced cytology codes have been on CMS’ radar for a number of years due to their increased volume and CAP delayed changes, but reductions are possible in 2014.

- Any payment change would have the greatest impact on practices focused primarily on cytopathology as this is a high volume code for this subspecialty.

Microdissection

- Medicare carriers are questioning paying pathologists separately for microdissection together with molecular pathology services and one carrier will not pay pathologists separately for this work and expressing concern with the current RUC valuation. CAP is currently examining strategies to preserve its use by pathology.

- Pathologists in states served by Palmetto are affected by carrier action to not pay for some pathologist work. Any reduction due to potential revaluation is not expected until 2015.
New G-code for Medicare Molecular Pathology Physician Interpretation – CAP reaffirmed that Medicare physicians who interpret molecular tests and prepare written reports above and beyond laboratory results should already be billing for that service using the physician fee schedule (PFS) HCPCS G-code G0452 (molecular pathology procedure; physician interpretation and report). CMS announced the creation of the G-code in the 2013 PFS, to be used when physician interpretation of a molecular pathology test is medically necessary to provide a clinically meaningful, beneficiary-specific result. However, there have been reports that some institutions still have not added the G-code G0452 to their billing system. For those providing molecular pathology physician interpretation services for Medicare beneficiaries who meet CMS criteria, G0452 should be reported.

CAP Mobilizes For Accurate Molecular Pathology Payments – As disparate local Medicare pricing and coverage policies for the new molecular pathology molecular pathology CPT codes continue to surface, CAP recently issued an appeal to pathology representatives from each state’s Contractor Advisory Committee (CAC) to educate their Medicare contractors on national resource-based values and other supporting rationale developed when the new Molecular pathology codes were first proposed. The CAP is encouraging all providers to give timely feedback to their Medicare contractor to assist them with establishing gap-fill pricing for molecular pathology services. In addition, CAP is reminding pathologists of new rules for professional molecular pathology interpretation services provided to Medicare beneficiaries. The Medicare contractors have until April 1, 2013, to set their initial pricing for 2013 under Medicare’s gap-fill process.

HHS Declines to Clarify Genetic Testing’s Inclusion in Essential Health Benefits – The Department of Health published final rules governing “Essential Health Benefits” (EHB) provided through the state and federal health insurance exchanges created under the Affordable Care Act (ACA). The exchanges will offer insurance coverage to all citizens. The rule defines what must be covered in exchange plans, determines levels of coverage, and addresses other aspects of administering the insurance exchanges in each state. HHS declined a CAP request in December 2012 comments on the proposed rule, to have medically necessary ‘genetic and genomic testing’ expressly included under “laboratory services,” which is one of ten mandated essential health benefits under the ACA. HHS opted to not define the scope of “laboratory services”. Rather, HHS will rely on the state benchmarks in each state’s base benchmark insurance plan that has been selected by the State. Alternatively, HHS has also stated that the default base-benchmark plan for states, Puerto Rico and the District of Columbia that do not exercise the option to select a benchmark health plan would be the largest plan by enrollment offering the largest product by enrollment in the State’s small group market.

CAP Presents LDT Oversight Proposal to Cancer Leadership Council – While ongoing budget constraints threaten to delay the Food and Drug Administration’s (FDA) plans to increase oversight of laboratory developed tests (LDTs), interest in LDTs remains high among cancer patient advocacy groups. In January, former CAP Governor Gail H. Vance, MD, FCAP, led a discussion with the Cancer Leadership Council (CLC), a patient-focused coalition of the nation’s top cancer advocacy organizations, on CAP’s proposal to involve FDA, CMS and a third party accreditor in overseeing the safety of LDTs. The CLC’s members include the American Cancer Society, Susan G. Komen for the Cure Advocacy Alliance, National Breast Cancer Coalition, and the Ovarian Cancer National Alliance, among others (including CAP). The diverse coalition focuses largely on public policy initiatives that guarantee cancer survivors access to high quality care. Dr. Vance was invited to present CAP’s LDT oversight proposal since so many of the tests associated with cancer detection, prognosis and treatment are LDTs.
**New Proficiency Testing Law Implementation** - CMS proposed a number of changes to laboratory proficiency testing (PT) requirements under CLIA to increase the Agency’s discretion in prosecuting improper PT referral cases, and clarify key definitions and provisions. Specifically, the proposed rule makes several clarifications and changes to the proficiency testing requirements under CLIA to ensure that PT specimens are not referred to other laboratories. These changes and clarifications include regulatory language as prescribed by the Taking Essential Steps for Testing Act of 2012 signed into law in December 2012. CAP advocated for enactment of the law to increase the Agency’s discretion and help laboratories avoid severe sanctions for such violations. Key clarifications and changes in the rule include regulatory language as prescribed by the Taking Essential Steps for Testing Act of 2012 signed into law in December 2012; a statement to not refer PT specimens as you would a patient specimen; a narrow exception to CMS’s interpretation of “intentional” referral; and new definitions for reflex testing, confirmatory testing, and repeat PT referral.

**State**

**CAP Model ACO Legislation Introduced in California and Illinois** - CAP model legislation to promote the pathologist’s role within Accountable Care Organizations (ACOs) is now introduced in California and Illinois. Introduction of the legislation was a collaborative effort between CAP and the Illinois Society of Pathologists (ISP) and the California Society of Pathologists (CSP), with legislative language modeled on legislation advocated by CAP and enacted last year in Massachusetts as part of that state’s healthcare reform initiative. Illinois House Bill 2544 and California Senate Bill 264 require every ACO to establish a clinical laboratory advisory board to include a physician who is medical director of the clinical laboratory providing services to the ACO. The purpose of these boards is to advise the ACOs on “adoption of guidelines or protocols for clinical laboratory testing used for diagnostic purposes or disease management” and for “pathologist consultation on episodes of care.” Both bills were referred to their respective oversight committees for further consideration.

**New Jersey Legislature Amends Genetic Counselor Law** - Lawmakers in the New Jersey Assembly unanimously approved a bill in January to remove genetic counselor’s statutory authority to interpret genetic tests and other diagnostic studies from their scope of practice. The bill also clarifies that physicians are categorically exempt from the genetic counselor licensure law. The bill, A. 1757/S. 555, passed in the NJ Senate in June, and is now on its way to the Governor who has 45 days to sign or veto the legislation (Update: Governor signed bill on March 18, 2013.)

**CAP and NYSSPATH seek to remedy State Law Blocking Lab-Patient Contact** - CAP and the New York State Society of Pathologists (NYSSPATH) are seeking amendments to state legislation (Senate Bill 634) that would remove legal impediments to laboratories sharing test results with patients and reverse prohibitions on patients conferring with pathologist laboratory directors on the meaning of test results. The Senate legislation introduced by Senator Toby Ann Stavisky, would require laboratories to provide patients access to their laboratory test results. The CAP-NYSSPATH amendments would require labs to make test results available to patients after the results have been provided to the ordering clinician except in an emergency; and they would explicitly permit patients to contact or confer with the pathologist who performed or supervised their test. The CAP and NYSSPATH position is that patient care is best served when patient test results are first received by the patient’s ordering physician or ordering health care practitioner, allowing the patient to be able to immediately confer with the ordering health care provider, and eliminating any confusion or anxiety caused by such testing. Current New York regulations are a legal
impediment to pathologists' ability, in their capacity as laboratory medical directors, to confer with patients.

**North Carolina Patient Specimen Access Legislation** - Advocacy from both the North Carolina Society of Pathologists (NCSP) and the CAP prompted an Ad Hoc Committee of the North Carolina Legislature on January 4, 2013 to issue a report recommending against a new law regulating the release of pathological materials to patients. Instead, the committee report recommended new regulations that comply with the CAP’s professional standards. The NCSP, with the support of the College, had opposed legislation requiring health organizations to provide all pathological materials collected from the patient to the patient, upon written request. The report recommends that the state medical board and division of health draft regulations regarding patient access to this material that is consistent with CAP and North Carolina Hospital Association Standards.