Price Cuts, Long Delays in Payment Are Expected

Revised policies for molecular CPT codes, prostate biopsies, and 88305 may cause confusion

CEO SUMMARY: In addition to a steep cut in the 88305 CPT code, anatomic pathology laboratories can expect cuts in the payment from Medicare for molecular and prostate biopsy testing. Two national experts in lab billing and reimbursement warn labs to expect confusion in how both public and private payers implement these new policies. Overall, 2013 will be a tough environment when it comes to ensuring full compliance with all the new billing and reimbursement policies for this testing.

EVERY CLINICAL LABORATORY and pathology group faces an uncertain environment for billing and reimbursement during the coming year. That's because labs are poised to be paid significantly less for certain important CPT codes as a result of new polices that take effect on January 1, 2013.

Three primary issues are getting the most attention. But there are associated issues that, if unaddressed, have the potential to trip up laboratories and create unwelcome Medicare compliance violations.

The three policy shifts expected to have a major impact on laboratory finances have been widely reported to date. They are: 1) new molecular diagnostics CPT codes and associated coverage guidelines and prices; 2) price adjustments for surgical pathology tests billed under CPT code 88305; and, 3) prostate biopsy testing.

Further, because some of these policy changes have been challenged by lab industry groups, there is some uncertainty about how the federal **Centers for Medicare & Medicaid Services** (CMS) will pay for prostate biopsy and molecular diagnostic testing. This uncertainty is likely to lead to payment delays and denials, according to lab billing experts.

"What has the full attention of anatomic pathology groups is the sizeable decline in payment from Medicare for tests billed under 88305," stated Donna Beasley, DLM(ASCP). She is the Laboratory Specialty Vice President at **McKesson Corporation's** Revenue Management Solutions.

88305 Payment Decline

"The payment cut for 88305 will come primarily from a reduction of 52% in the technical component (TC) of testing for CPT code 88305, according to CMS," explained Beasley. "Since this new policy will reduce payments by millions of dollars, it is going to have considerable impact on many labs.

"This will happen because CPT 88305 is the most frequently billed code in many anatomic pathology labs," noted Beasley. "It is believed that, at least for some labs, the resulting reduction in revenue may force them to close.

"One class of labs expected to be financially hurt most by the 88305 change

will be in-office pathology labs owned and operated by specialty physicians," stated Beasley. "Examples of these labs are those operated by physician specialists in gastroenterology, dermatopathology, and urology groups. These in-office labs lack the diversity of specimens needed to easily absorb the deep cuts to 88305."

Prostate Biopsy Confusion

Whereas the announced fee cuts to 88305 are relatively straightforward, the situation with new reimbursement policies for prostate biopsies is more complicated. Important questions remain unanswered.

"According to the CMS physician fee schedule (PFS) announced for 2013, it looks like CMS is saying that when labs submit one to four prostate biopsy specimens, they should code with CPT 88305," Beasley said. "And when billing for 10 to 20 specimens, labs should use the G0416 code. This part is fairly straightforward.

"The confusion comes when billing for five to nine prostate biopsy specimens," explained Beasley. "This change in the 2013 Medicare Physician Fee Schedule (PFS) seems to indicate that CMS expects biopsy specimens of five to nine to be coded with 88305, while 10 or more biopsy specimens are to be coded with the 'G' code series.

"This assumption is based on the fact that—with the new G0416 code descriptor—specimens five to nine have no specific direction within the 'G' code descriptors," she said. "The assumption is that 88305 would be used for five to nine prostate biopsy specimens."

How Labs Should Bill

"There has been no further instruction from CMS nor any publications from Medicare contractors on how they will treat these services," added Beasley. "Lacking such instruction, there is likely to be confusion as to how labs should bill for prostate biopsies when submitting five to nine specimens."

Further complicating this situation is the fact that different lab industry challenges have been raised about the new polices for both 88305 and prostate biopsy testing. Labs will need to track the success of multiple lab industry challenges to these revised guidelines.

"Once the new policies were made public, several lab associations immediately stepped forward and challenged the rules regarding how to bill for prostate biopsies and the reduction in fees for 88305," noted Rina Wolf, Vice President of Commercialization Strategies, Consulting & Industry Affairs, for **XIFIN, Inc.**, in San Diego, California. "These challenges may lead CMS to make changes in these policies in the coming months. For that reason, all labs should follow events as they unfold."

New Molecular CPT Codes

Wolf also cautioned laboratories performing molecular diagnostic testing to expect plenty of confusion among payers about how to handle the new molecular test codes. "CMS contractors have been instructed to price the new codes utilizing the 'gap-fill' process," she said. "This is a very laborious process. Some contractors may not be familiar with the tests that are represented and, for that reason, will be delayed getting this done in time for the January 1, 2013, deadline.

"Also, CMS released a Clinical Lab Fee Schedule with zeros in the pricing column," continued Wolf. "That spills over into the private payer sector because private payers often purchase these fee schedules from CMS to use as a basis for their pricing. This likely means uncertainty as to pricing with the commercial payers as well. We have called the private payers, but none had any guidance for us.

"Under the gap-filling method, Medicare contractors determine reimbursement based on local pricing patterns," added Wolf. "Then CMS may use the various regional reimbursement determinations to arrive at a final national reimbursement rate that it would implement in 2014.

"Because the gap-filling process is so complex, it may not be completed by all the contractors on time," she observed. "This could potentially give CMS a reason to delay this policy and have Medicare contractors use the old stack codes to pay labs for molecular tests. Use of stack codes is not ideal for payers because they do not provide transparency.

"For its part, Palmetto plans to use the Z codes or its PTI codes and has received inquiries from other payers about possibly sharing these codes," noted Wolf. "If a delay in implementation of the new molecular codes does happen, CMS and other payers may require labs to submit the new code—if there is one—along with the old stack code. We may even see the use of temporary G codes that are created as an interim pricing fix.

"CMS contractors are obligated to adjudicate claims according to mandated timelines," concluded Wolf. "Therefore, it is imperative for a payment mechanism to be set in place to avoid delays for CMS and for laboratories."

Coding Molecular Tests

Beasley explained the issue further. "At one point it was questionable—but the Z-Code Identifiers associated with Palmetto's MolDx program are in effect and are being continued," said Beasley. "At recent speaking events, Palmetto has publicly addressed key points on this issue.

"The MolDx program is a separate contract between CMS and Palmetto GBA," she explained. "It is therefore separate from the Medicare J1 contract. The Z-Code Identifiers and the McKesson Diagnostics Exchange exist as technology components of the MolDx program.

"Therefore, were Palmetto to lose the J1 contract (which is a possibility but is under appeal and won't be settled for months), the MolDx program would not be affected," she said. "Therefore, coverage policies and edits that use the Z-Code Identifiers and are used in Local Coverage Determinations would remain in effect.

"Palmetto has said publicly that it intends to roll out the MolDx program nationally," added Beasley. "As well, several commercial payers are considering licensing the Z-Code Identifiers."

Payers May Follow CMS

Commercial payers often follow the lead of CMS on such issues, Wolf said. "Once CMS sets its fee schedule, then the **Blues plans**, **Aetna**, **UnitedHealthcare**, **Humana**, **Cigna**, and other commercial payers purchase those fee schedules and load them into their own payment systems.

"The commercial payers then use those fee schedules to create their own allowable rates," she continued. "But if payers purchase the fee schedules from CMS with zeros in the amount column, what will the commercial payers do then? So far, that question is unanswered, which means there could be as many different fee schedules as there are Medicare contractors!

"At present, Palmetto is the only Medicare carrier with a procedure in place to pay for molecular tests," said Wolf. "Another contractor, **First Coast Service Options**, has requested information from labs on how to price molecular tests, but we have not yet seen a payment policy in place. First Coast Service is the Medicare Administrative Contractor (MAC) that serves Florida, Puerto Rico, and the U.S. Virgin Islands.

"All this uncertainty in how CMS and commercial payers will process claims for molecular tests represents a big downside for laboratories," advised Wolf. "That's because many labs have no way of modeling their expected payments for 2013.

"The large national labs, and other labs with commercial payer contracts, are likely to see less impact with the commercial payers because they have contracts in place with assigned payment levels for these tests," commented Wolf. "However, if their contracts are based on a percentage of

When Payment Declines for Certain Tests, Labs Will Need Data on Costs for Each Code

LABS THAT UNDERSTAND THEIR EXACT COSTS for each CPT code may succeed when others fail, said Donna Beasley, Laboratory Specialty Vice President, McKesson Revenue Management Solutions.

"When revenue declines, labs need to understand their per-test costs," said Beasley. "That is an essential element to calculate if you are profitable and are developing a strategic plan to gain market share."

Some industry observers predict that the recent dramatic reductions in the reimbursement for certain pathology CPT codes may cause some in-office pathology labs operated by specialist physicians to close.

"Should specialty in-office pathology labs close, local hospital labs and independent labs may pick up that additional testing. That's why it's essential for a lab to have accurate costs," Beasley said. "When labs don't know their cost for each CPT code, they have no strategy to stay profitable.

"In addition, it's essential to focus on improving revenues and not simply on reducing operational costs," she advised. "Every dollar due to your laboratory must be worked for collection. For hospital outreach labs, this point is often difficult to monitor because typically they use the hospital's central billing office and these systems lack lab-specific reporting.

"Because the hospital's central billing department posts payment at the patient-account level, labs don't see cash collections for each CPT code," she explained. "Understanding profitability at the test level is vital to the fiscal viability of the lab. Developing a strategy as to specific tests to send out and specific tests to keep in house requires this level of business intelligence.

"Also, the hospital's central billing is typically organized by payer and focuses on the high-dollar claims of other specialties," she said. "That means they may write off small balances, such as lower-dollar claims for lab tests.

"When linked to high volume tests, small balance write offs add up quickly," Beasley explained. "In this new reimbursement environment, every dollar will count. Many labs cannot afford to absorb or write off small balances as they do now. Therefore, labs should consider billing solution alternatives that help them collect every dollar that is legally reimburseable."

Medicare rates, they could be impacted and they could certainly see changes in payment for Medicare beneficiaries.

"Remember, we are talking about new molecular CPT codes and not new tests," Wolf noted. "Therefore, any lab that has a contract with a commercial payer that specifies how the lab will be paid for these tests will likely be fine. But most labs do not have such contracts.

"When it comes to getting paid for molecular tests, labs are likely to experience a logistical headache and endure long delays in getting paid," predicted Wolf. "Therefore, we recommend that labs make billing personnel available to answer payers' questions. Also, be prepared for payment denials and delays."

Beasley agreed that CMS will use the gap-fill method, and she acknowledged that it is a less than ideal way to pay claims. "The gap-fill method has not been used often and when it has been used, it has not worked well because there is no consistency from one Medicare contractor to another," Beasley concluded. TDR

—Joseph Burns

Contact Donna Beasley at donna.beasley@mckesson.com or 850-637-0367; Rina Wolf at 858-436-9509 or rwolf@xifin.com.