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For pathologists, 8% aggregate hike in Medicare pay

Kevin B. O'Reilly

December 2015—The final Medicare physician fee schedule for 2016 delivered on the Centers for Medicare and Medicaid Services' July proposal of an overall increase in payment for pathologists and independent laboratories. The agency also fulfilled some pathologists' fears by cutting payments for prostate biopsy services by 19 percent for the technical component and 18 percent for the global payment.

When a relatively good year on the Medicare pay side means treading water, laboratory consultants say it is all the more imperative for pathology groups to get the most out of their negotiations with private payers, hospitals, or accountable care organizations.

The 2016 physician fee schedule—published Nov. 16 and available at https://federalregister.gov/a/2015-28005—estimates an eight percent bump in pay for pathologists on charges of $1.3 billion, and a nine percent rise on $834 million in charges for independent laboratories. Increases are found throughout the fee schedule for the technical component, professional component, and global payments.

"We saw nice increases on the technical component side for quite a few CPT codes, of 30 to 40 percent. That was very nice," said Mick Raich, who addressed the fee schedule's impact during the question-and-answer period of a Nov. 17 webinar hosted by The Dark Report. "Remember, they've changed a lot of the CPT codes from per block to per specimen. This is kind of a giveback. It gives some money back on the stains they hammered pretty hard last year. On the AP side, for the professional component you're only looking at maybe a one percent overall across-the-board increase dependent on what you do."

For instance, the global payment CPT code 88305—for tissue exam by a pathologist—will rise one percent to $74.16. The professional component of 88305 will increase two percent to $39.77. One example of the kind of change that led to the overall Medicare pay bump for pathologists is the climb in global payment for several immunohistochemistry services.

Of special note is a 33.47 percent hike, to $90.64, for CPT code 88341, used to report an additional slide and antibody for an IHC study. In the 2015 fee schedule, the CMS valued the second IHC antibody procedure at 40 percent of the first one.

"We at the CAP argued that there should be only a minimal or no reduction for the second antibody," said Jonathan L. Myles, MD, during a Nov. 5 webinar hosted by the CAP. "We were successful in advocating to the CMS, in explaining the procedure, and looking at the survey data to indicate why compensation for the service should increase."

Despite this and other changes in Medicare pay, Robert H. Tessier, principal at the hospital-based physician consulting firm HBP Services, said during The Dark Report webinar that he does not expect the fee schedule

to make waves in either direction.

"I've told staff, when talking about projecting revenue for clients, don't even bother talking about Medicare in 2016. It's going to be a wash, or at best a slight improvement," he said.

During the CAP webinar, Dr. Myles noted important caveats about the aggregate pay increases estimated by the CMS.

"The headline negative news for surgical pathology is the valuation of the prostate G-code G0416," said Dr. Myles, chair of the CAP's Economic Affairs Committee. As part of the Affordable Care Act's directive to identify "misvalued codes," the CMS reexamined payment for prostate biopsy services.

The revaluation means that, for 2016, global payment for G0416 will fall 17.8 percent to $533.84, while the professional component will drop 13.6 percent. The overall revaluation of the technical component will be phased in over two years, resulting in about a 60 percent drop in valuation. These TC decreases will have an impact on the global payment through 2017. Dr. Myles, pathology adviser to the AMA/Specialty Society Relative Value Scale Update Committee, said the cuts were explained in part by lower indirect practice expenses borne by the independent laboratories that are shouldering an increasing share of prostate biopsy billing. The CMS may change the prostate biopsy physician work RVU for 2017 in response to a recommendation of the RVS Update Committee that is forthcoming, he added.

Two other implications of the Affordable Care Act are worth noting, experts said during the CAP webinar. One is that, in the final rule, the CMS listed as "potentially misvalued" the following additional pathology-related 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/computer).

"This is not looking to see whether there are underpaid services but rather the reverse," W. Stephen Black-Schaffer, MD, said during the CAP's webinar, available at http://j.mp/cap_2016medi carefinal.


Dr. Myles

"The PAMA [Protecting Access to Medicare Act] regulation under which we're now operating, which alleviated the SGR [sustainable growth rate], also made certain changes to remove unnecessary payments from the CMS system and set a target for a one percent reduction," said Dr. Black-Schaffer, vice chair of the CAP's Economic Affairs Committee. "The primary focus in achieving this is looking for misvalued services CMS can evaluate, so they can adjust them appropriately downward."

This year, the CMS missed its one percent overall goal in cuts through revaluing codes across all specialties, achieving only a 0.23 percent reduction. Because of that, Medicare physician pay in 2016 will see a 0.77 percent across-the-board cut. Meanwhile, pathologists who do not successfully participate in the Physician Quality Reporting System and score poorly on the value-based metric in 2016 could see a four to six percent

penalty in 2018, depending on the size of the pathology group in which they practice.


Dr. Black-Schaffer

The precise impact of Medicare's 2016 fee schedule will vary from pathologist to pathologist, laboratory to laboratory, depending on the individual pathologist's case mix, Dr. Myles noted.

"This increase just has to do with Medicare physician fee schedule services," Dr. Myles explained. "As physicians, we typically bill non-Medicare entities as well and the effect of those changes is not reflected here. Also, if you're an independent laboratory, most of your income is typically from the clinical laboratory fee schedule. In fact, independent labs typically derive 83 percent of their revenue from the CLFS."

Moreover, a laboratory that does a lot of flow cytometry and uses codes 88184 and 88185 to report the work will see about 20 percent cuts in Medicare pay for those services.

"That eight and nine percent increase is aggregate payment. Most people don't have the exact case mix of the typical laboratory," Dr. Myles said. "So, if you do a lot of flow cytometry for 2016, your effect is not going to be the same as a laboratory doing a lot of immunohistochemistry. That's why we, as pathologists, need to know what types of codes are being billed in our laboratories so that when we see these changes we are able to calculate what the impact will be on our individual laboratory. As a laboratory director, you're going to need to know that to plan your budget for next year."

The critical importance of understanding, demonstrating, and arguing for the true value of pathology and laboratory services was a constant refrain during The Dark Report webinar, "Boosting Your Pathology Lab's Revenue in 2016."


Raich

Vachette Pathology's Raich delivered a sobering bottom line.

"You have to be a good businessman," he said. "We've been in a time where it was very lucrative to be in a medical practice. I think the changes taking place now are a little bit different than what we've seen over the last 10 years. There's a concept you need to have of margin, and how much you can make per CPT code, and per episode of care."

Raich says the big-picture trend at Medicare, and consequently among private payers, is a greater move toward bundling payments for care, including laboratory medicine.

"The CMS has said it wants to package a lot of services and it mentions pathology services," he said. "We can't put our heads in the sand on this. We can't say it's not going to happen. I've had people say to me that it's going to be predominantly fee-for-service for the next 25 years. I would like that, but I believe we're out of money. And whenever you're out of money, you have to cut your budget, and that budget's going to come out of the physician side."

Anticipating the trend, more hospitals are asking pathologists to join ACOs or come in-house as salaried groups, Raich said. When that is the offer on the table, it is essential for pathologists to put forward data that accurately reflect the revenue they bring in.

"One thing we know is that the health systems struggle from the revenue side on data. They can tell you their gross charge, they can even tell you their budget, but they have trouble telling you their revenue," he said. "You need not only utilization numbers on your volume, but the numbers on your margins. You need to know, if your pathology group does a breast case, how much money you make on that case. Not collections, not charges, but collections versus revenues to show your margin."

Tessier, of HBP Services, cited data from the MGMA showing that hospital-paid pathologists earn 80 percent of what their counterparts in private practice do while they are 22 percent less productive by workload units. He said pathologists on salary at hospitals should include incentives as part of their group agreements. "As part of the value-based world, you have to demonstrate your value by engaging effectively with patients and ACOs," Tessier said. "The first step in that process is by demonstrating engagement with the hospital administration's concept of entrepreneurial spirit.... You need to be going into contract talks with goals and objectives and accomplishments."

Examples of contract incentives that HBP clients have secured include a 25 percent share in savings from reducing send-out costs, 10 percent of the savings from slashing blood-acquisition costs, and a $10,000 bonus for achieving a 20-minute turnaround time on 90 percent of frozen sections.

"It's extremely important to get away from flat-fee Part A arrangements, and to get into incentivized arrangements," Tessier said during The Dark Report webinar, available for purchase at http://j.mp/dark_pathologyrevenue.

The difficult work that many pathologists and laboratories are doing to lead the way in reducing improper test utilization should not be rewarded with merely a pat on the back, Tessier added.

"I do feel strongly that if pathology groups can get to lower test utilization and controlling unnecessary send-out tests, we should anticipate a shared-savings incentive paid by the hospital," he said.

In negotiating with private payers, Tessier advises clients to "go long" and seek four- or five-year contracts by giving up a bit on cost-of-living adjustments, reducing the increase to as little as one percent or even less in the fourth and fifth years of a deal. This can provide a corpus of stability in the payer mix during this period of payment pangs.

"This can still be a great move to make because payers love to get a deal," Tessier said. "The more you go long, the more you hold on to the base of what the current reimbursements are."

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