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Proposed Medicare Cuts Would Significantly Impact Independent Laboratories

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Last week, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule setting forth revisions to payment policies under the Medicare Physician Fee Schedule (MPFS) and other revisions to Medicare Part B for calendar year 2014. The rule proposes several changes that, if finalized, would have grave consequences for independent laboratories.

Pathology laboratories would take the greatest hit as a result of CMS's proposal to adjust payment rates for about 200 codes that supposedly have "misvalued" resource inputs. The focus is on services that Medicare pays more for when furnished in an office, laboratory, or other non-facility setting than in an outpatient hospital department or ambulatory surgical center (ASC). To address "anomalous site-of-service payment differentials" that "are the result of inaccurate resource input data used to establish rates" under the MPFS, CMS proposes to limit reimbursement to the total payment that Medicare would make when the service is furnished in a hospital outpatient department or ASC. According to CMS, the cost data provided by non-hospitals for purposes of calculating the Practice Expense Relative Value Units is less reliable than the annual, auditable data provided by hospitals for this purpose. In taking this position, CMS fails to take into account the vast differences in the way that hospitals and independent laboratories deliver laboratory services.

Overall, this change could reportedly decrease reimbursement to independent laboratories by 25%, but for pathology laboratories the reduction would be closer to 50% or more because their revenue comes primarily from physician services. Payment for the technical component (TC) of 88185 (flow cytometry) would be reduced by a whopping 76% while payment for the TC of 88342 (immunohistochemistry) would be cut by 47%. Reimbursement for special stains would also be substantially reduced. The fact that payment for the TC of 88305 would go down by only 7% is cold comfort given that CMS already instituted a substantial cut in reimbursement for this service, as detailed in a previous post.

Many are wondering why CMS would propose such drastic cuts in reimbursement for much-needed pathology services. CMS may be seeking to discourage self-referrals for pathology services performed in physician office laboratories, a practice that was highlighted in a recent GAO report and that has received considerable attention since CMS loosened its restrictions on reimbursement for self-referred pathology and certain other diagnostic services in 2009. But punishing independent laboratories in the process seems unfair when CMS could more effectively remedy the situation by

amending the Stark Law's in-office ancillary services exception. The American Clinical Laboratory Association and others have vigorously lobbied CMS to tighten both regulations to prevent abusive self-referral arrangements for a number of years now.

Adding insult to injury, CMS also proposes to begin reexamining the payment amounts established under the Medicare Clinical Laboratory Fee Schedule to determine if changes in technology warrant a payment adjustment. If the proposed rule is finalized, CMS would identify specific test codes subject to payment adjustment, discuss the impact of technological changes on those codes, and propose adjustments as appropriate to reflect the impact of such technological changes. This course of action would begin with the calendar year 2015 MPFS proposed rule. CMS proposes to review all codes over a five-year period.

The American Clinical Laboratory Association (ACLA) and the College of American Pathologists (CAP) issued statements critical of the proposal. Public comments are due in early September, and the final rule, which would become effective on January 1, 2014, is expected in November.

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