

2013 Medicare Physician Fee Schedule Final Rule FAQs

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Overview

1. How will the 2013 Physician Fee Schedule rule impact pathologists?

A: The most striking changes for pathologists include:

- i) Revaluation of the technical component expenses for the 88305 code family, -52% cut to 88305 TC; 88305 global payment down by 33%.
- ii) Payment reduction (1%) to Medicare fees to offset increased pay for primary care;
- iii) CMS determination on molecular pathology fee schedule placement.
- iv) A potential 26.5% cut on physician pay in 2013 unless Congress averts this action.

2. What did CAP do to influence the outcome of these changes?

A: CAP influenced the outcome of CMS decisions and mitigated the impact on pathologists by ensuring the accuracy of the data used to revalue the codes. CAP also spearheaded the development of the new molecular codes.

CAP advocated to CMS on the 2013 Medicare PFS proposed rule published in August 2012, which touched on a number of issues important to pathologists. CAP also developed and submitted a white paper for CMS outlining the agency's current legal authority to place the molecular codes on the physician fee schedule to counter allegations raised by industry and other opponents of

physician fee schedule placement. Read the [CAP comment letter](#), which appears in our 2013 PFS Resource Center.

3. What is CAP doing to help members prepare for Medicare program changes?

A: CAP has resources to help explain the Medicare changes in 2013. In addition to a webinar in September preparing CAP members for potential payment cuts, covering the 2013 Medicare PFS Rule in Statline and CAP Today in November and December, CAP is also holding two webinars in November. The first, on November 14 titled, [Confronting New Medicare Payment Realities Part 1: How 2013 Reimbursement Changes Will Impact Pathologists](#), will provide an overview of the Medicare program changes for 2013, focused largely on payment changes. The second webinar, scheduled November 15, titled [Confronting New Medicare Payment Realities Part 2: What CAP Members Need to Know about 2013 PQRS Changes](#), focuses solely on expansion of the PQRS program. Click on the highlighted text to register for each webinar.

4. What should I do to prepare for Medicare program changes?

A: The changes specified in the 2013 Medicare PFS will take effect on January 1, 2013, and now is the time for individuals and practices to determine what, if any, income will be lost due to code revaluations and rate cuts. Also, CAP members are advised to weigh the cost/benefit of participating in the PQRS program with the understanding that non-participants will face penalties in 2015 based on 2013 data.

SGR, 88305 Technical Component & Other Payment Updates

5. What physician payment changes were announced?

A: The Medicare 2013 PFS calls for a 26.5% cut in physician pay as determined by the flawed SGR formula. In addition, it includes a one percent physician pay cut due to accounting changes and another one percent cut to offset the pay increase for primary care physicians. With the impact of reductions to the TC of 88305, Medicare estimates that pathology together with the above changes, Medicare estimates a 6% reduction for pathology. Add to those cuts the 2%-

across the-board “sequestration” hit to Medicare if Congress fails to agree on \$600 billion in additional budget cuts before January 1, 2013.

6. Will Congress intercede to prevent the 27% SGR cut?

A: Legislators have voted to avert the SGR cut 14 times since 2002, and CAP believes Congress will prevent the 26.5% SGR cut for 2013 from taking effect. CAP and others in the physician community have urged Congress to find alternatives to the flawed SGR formula. It is possible Congress will address the issues of SGR and sequestration in the lame duck session after the election, or they could pass a temporary patch for both and allow the new Congress taking office in January to address the problems.

7. What is CAP’s position on finding alternatives to SGR and fee for service?

A: CAP has long supported seeking viable alternatives to the SGR formula. Earlier this year the CAP joined the AMA and other medical societies urging Congress to eliminate the SGR formula and develop new federal policy on a transition from SGR to a higher performing Medicare program. In a [joint letter to Congress](#), the physician groups identified driving principles and core elements of that plan which physicians could support. These include payment updates that reflect the cost of providing services as well as efforts and progress on quality improvements and managing costs; allowing physicians to choose their payment model, and rewarding physicians for savings achieved across the health care spectrum.

8. Who is impacted by the cut in technical component of the 88305 service code?

A: Revaluation of this code impacts those who bill the technical component (TC) or globally for the 88305 service code, or receive payment based on global or TC billing for that code.

9. Why was the 88305 TC changed?

A: Scrutiny of the costs associated with the 88305 TC has increased since the TC was originally valued in 2000. CAP was able to mitigate the impact of the code review by limiting the review to the 88305 TC, and by ensuring the accuracy of the data used to revalue the codes.

10. How did the TC change affect PC payment?

A: There is only a small relationship between the TC payment and the PC payment for any service code. Each component is valued independently with entirely different inputs for each one. The allocation of indirect costs, which are split between the TC and PC and include costs such as overhead, can shift with the revaluation of either the physician work or practice expense relative value units as they are part of Medicare's indirect cost formula. This formula resulted in a 2% increase in the professional component of CPT code 88305 based on the TC revaluation. There is no trade off from one component to the other.

New Molecular Pathology Code Set

11. What are the changes for reporting molecular pathology services?

A: There are two major changes. First, the stacking codes currently used for billing molecular pathology services are likely to be eliminated on January 1, 2013 and replaced by new analyte specific codes on clinical laboratory fee schedule (CLFS). CMS did not publish payment rates for these codes, which instead will be paid by gap fill methodology for 2013. The agency did, however, provide a new G-code for use by physicians, specifically pathologists, asserting that physician interpretation of these tests is sometimes medically necessary. CMS will monitor the use of the new G code.

12. How will gap-fill payments be determined for the new codes?

A: In the first year a test is gap-filled, contractor-specific amounts are established for the new test code using the following sources of information: charges for the test and routine discounts to charges; resources required to perform the test; payment amounts determined by other payers; and charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant. For the second year, the national payment is calculated, which is the median of the carrier-specific amounts.

13. Does CAP support the molecular pathology payment changes?

A: CAP led a multi-stakeholder effort to develop the codes, and supported their placement on the Physician Fee Schedule. While CAP does not agree with CLFS placement, CAP supports the establishment of a G code to ensure that pathologists are recognized for their professional work associated with molecular pathology.

14. Will all of the new molecular pathology codes take effect in 2013?

A: Yes, all of the category I and II codes published in the 2013 CPT book will be accepted on January 1, 2013. Additions to the code set for future years will be ongoing.

15. Can I still code molecular tests by stacking process codes?

A: The stacking codes were eliminated by CPT and are invalid starting on January 1, 2013.

16. If the new molecular pathology codes are not listed on the physician fee schedule, can I still bill for those tests?

A: You will be able to bill for the professional component on the physician fee schedule with the new G code. Other aspects of the new molecular pathology codes would be billed on the clinical lab fee schedule.

17. As the payment for interpretation and preparing the report is paid on the physician fee schedule with the new G code, how do laboratories bill for PhDs performing these services?

A: CMS stated that the interpretation and report service of non-physicians associated with the molecular pathology codes is captured in the CLFS payment and no separate payment will be made for PhD interpretation.

18. What tests are covered by the new codes?

A: The new CPT codes include Tier 1 molecular pathology codes which represent gene-specific and genomic procedures, Tier 2 molecular pathology codes used to report procedures not listed in the Tier 1 codes which represent medically useful procedures that are generally performed in lower volumes than Tier 1 codes and arranged by level of technical resources and interpretative work.

19. Where can I find the list of new molecular pathology codes?

A: The 2013 CPT book includes a list of all of the new molecular pathology CPT codes. In addition, the final Medicare physician fee schedule includes additional information regarding the payment for these services.

PQRS Changes

20. What PQRS changes were made for 2013?

A: CMS also finalized the expansion details in next year's Physician Quality Reporting System (PQRS) program. Providers—including pathologists—who participate successfully in 2013 will receive a 0.5% bonus of total 2013 Part B allowed charges in 2014 and avoid a 1.5% deduction in overall Part B Medicare payments in 2015. Pathologists who do not participate in 2013, or do so unsuccessfully, will face a 1.5% penalty in 2015 based on overall Part B Medicare payments.

Pathologists will continue to qualify for incentives for reporting on three quality measures. There are [five CAP-developed quality measures](#) that pathologists may choose to report.

There are also new group reporting options. Physician groups of between two and 99 members can participate and report—as a group—on three measures through a registry. By participating through the registry group practice reporting option, all group members will get PQRS credit in 2013 to avoid the penalty in 2015. Practices must notify CMS by October 15, 2013, if they plan to choose the group reporting option.

And finally, providers in group practices of 100 or more will be subject to a value-based payment modifier adjustment in 2015 determined by their 2013 PQRS participation.

21. Did CAP support these changes?

A: The CAP has taken the lead role in developing quality measures for pathology, and makes a significant investment in the resource- and time-intensive process of verifying and attaining endorsement for the measures from bodies such as the Physicians Consortium on Performance Improvement (PCPI) and the National Quality Forum (NQF.) CAP measure development efforts have allowed pathologists to have one of the highest participation rates among medical specialties. In 2010, 61.5% of eligible pathologists participated in the program. This figure compares favorably to the total eligible physician participation rate of 26%. Still, there are pathologists who cannot participate in 2013, and CAP advocates waiving penalties for pathologists who cannot participate due to lack of applicable measures.

22. What resources are available from CAP to help me understand how the PQRS changes will impact me?

A: CAP is launching a “[PQRS Resource Center](#)” on www.cap.org/advocacy ; a clearinghouse for information on the Medicare PQRS program relevant to pathologists. Content will include an overview of the program; indepth analysis from Statline and CAP Today; links to the final and proposed Rules; descriptions of the current pathology measures, and links to CAP webinars on the program. In addition, CAP is hosting a webinar on November 15, titled [Confronting New Medicare Payment Realities Part 2: What CAP Members Need to Know about 2013 PQRS Changes](#), focuses solely on expansion of the PQRS program. Click on the highlighted text to register for each webinar. (A recording of the webinar will be available in the PQRS Resource Center after November 15).

23. I have not reported on any measures for 2012 yet. How can I do so?

A: Yes. Effective now until February 28, 2013, physicians who have not done any claims reporting in 2012 (or are concerned their reporting was unsuccessful) and want to participate in PQRS this year, can report retrospectively on three measures through a CMS-approved registry. The registries set a higher bar for performance, requiring an 80% success rate vs. the 50% success rate required for claims-based reporting, but they also offer a higher probability of successful reporting. There are 21 CMS-approved registries that have at least four of the five pathology measures available.

24. Where can I find a listing of the registries that contain pathology measures?

A: A list of public registries that allow reporting on the pathology measures is available on the CAP [PQRS Resource Center](#).

25. How much can I expect to receive in terms of incentives and bonuses for reporting?

A: Physicians who participate successfully on three measures in 2013 will receive a 0.5% bonus of total Part B allowed charges in 2014. If providers only report on one measure, they will avoid the 2015 penalty, however will not receive the bonus for 2013 unless only one measure applies to them. In this situation, the provider is eligible for the bonus.

26. How much will the penalty for not participating be in 2013?

A: Pathologists who do not participate in 2013, or do so unsuccessfully, will face a 1.5% penalty in 2015 based on overall Part B Medicare payments.

Group Reporting for the Value Based Modifier (VBPM)

27. How will the Value Based Payment Modifier program work and when will it begin?

A: Groups of 100 or more will be subject to the value-based payment modifier (VBPM) beginning in 2013. Members in a group practice of 100 or more, must choose the PQRS Group Practice Reporting Option by October 15, 2013, and then successfully report in order to avoid an additional 1% deduction in 2015 Part B Medicare payments.

The member and their group must then decide whether to elect to report using the Quality Tiering Calculation or to have No Election in December 2013:

- The Quality Tiering Calculation option would offer the possibility of a higher upside or a lower downside (the bottom would be a 1% deduction of 2015 Medicare Part B payments as if no PQRS were attempted).
- The No Election option would result in no upside but also no further downside with a 0% adjustment of 2015 Medicare Part B payments.

Non-satisfactory VBPM reporters (including groups submitting no data) would have a 1% downward adjustment of 2015 Medicare Part B payments in addition to the penalty from failing to participate in PQRS.