ATP SUBCOMMITTEE REPORT

July 19, 2016

Subcommittee on Automated Profile Tests (ATP)/Disease Oriented Panels for the Medical Advisory Committee on Clinical Diagnostic Laboratory Tests

Discussion:

- Dr. Phurrough reviewed the issue: Currently, laboratories bill CMS using 23 CPT codes for chemistry analytes that CMS currently pays as bundled services based on computer software assignment into ATP categories of ATP02-ATP23. While there are some existing pre-specified automated chemistry panels described in CPT coding, there are some CPT codes that are not included in those panels.[1] PAMA requires CMS to re-price the individual CPT codes as the weighted median of private payer rates. However, it is common practice for commercial payers to also pay for these CPT codes using their own bundling algorithms. As a result, CMS is unlikely to get valid data from laboratories for each individual code as prices are attached to the panels, not the individual components. PAMA would force CMS to pay each individual code most likely at a much higher rate than is currently paid under the ATP scale.
- The PAMA Final Rule defined Applicable Information that Labs are required to submit to exclude data from bundled payments for a group of codes. Applicable Information for the 23 Chemistry codes can only be submitted if all the tests on a particular claim were paid individually.
- The CPT automated panels are specified bundled tests and thus are Applicable information.
- PAMA does not discuss unbundling an established CPT panel. Our current regulations/guidelines would allow us to have claims processing language that would roll individual codes into an appropriate panel and only pay separately for the remainder. Neither rules would prevent someone from ordering 12 of the 13 tests in the CompPanel and billing for those separately.

CMS Response to Subcommittee Questions:

- Must CMS ask for private payer data on all lab HCPCS codes or can they select the codes to be reported?
  - RESPONSE: CMS has to ask for the data for all HCPCS codes for which payment is made under the CLFS. CMS may also choose to collect data for HCPCS codes that are covered by Medicare but currently are not payable by Medicare because providers are instead required to use another code to bill Medicare.
- Once data is received, can CMS decide not to use it if appear unusable or invalid?
  - RESPONSE: CMS must calculate the weighted median private payer rates with data received. If data is not received for a code, that code will be taken to the next CLFS public meeting to be crosswalked or gapfilled.

[1] CPK (82550), GGT (82977), LDH (83615) and uric acid (84550) are not in an existing panel.

- If labs report bundled pricing, CMS is concerned about how to best allocate a portion of the bundle price to individual components of the bundle. Would labs be able to allocate according to relative cost of running each analyte in the bundle?
    - The PAMA Final Rule defined Applicable Information such that labs cannot report data for payments for a bundle of CPT codes.

Recommended Options:

1. Pay CPT panels and single test CPT codes using PAMA data
   PRO: easiest compliance with final rule.
   CON: could increase cost to Medicare

2. Pay CPT panels using PAMA data. Set prices for individual test codes using PAMA data but only pay for the first X number of individual codes on the claim.
   PRO: Limits payments to similar prices paid for panels
   CON: payment for the 1st code likely too low; potential to promote inappropriate panel use

3. Create ATP G codes for current individual CPT codes. Do not recognize CPT individual codes. Pay for CPT panel codes using PAMA data.
   Options:
   a. List CPT codes on claim form in addition to the G code
   PRO: transparency
   CON: potential software problem for labs; burdensome for lab and contractor, i.e., manual review
   b. Do not list CPT codes
   PRO: easier to implement
   CON: potential Medical Necessity & utilization problem; lose specificity, i.e not transparent