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A Lighthouse Lab Services Company

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Opinion: Cigna PC/CP decision likely a temporary reprieve

The following is a column from Mick Raich, President of RCM Consulting for Ligthhouse Lab Services:

As many in the pathology world know, the payment of the professional component of clinical pathology (PC/CP) has been evolving in recent years. Traditionally, this process involves a pathology group or laboratory billing for the PC of a clinical pathology CPT performed at a hospital.

Over the years I have seen many changes in PC/CP compensation and have educated many hospital administrators on best practices for this process and the issues surrounding it. In the latest shift, Cigna noted in April that they would stop paying for these services beginning July 10. However, after significant industry pushback from The College of American Pathologists (CAP) and others, Cigna responded with a letter noting they would "reevaluate their approach" and "delay implementation" to allow time for further internal review before implementing this policy change.

So, what does this actually mean? Most likely, Cigna will slowly and by degrees stop paying for this service over time. I expect this gradual cutoff will not be as prominently announced as it was during this recent attempt. Labs and groups will instead learn of this change from their billers, or through audit from Vachette. That's why it will be imperative to monitor your PC/CP payments for the remainder of the year.

--Continued on Cigna PC/CP, 2

Recent payer and coding news

- UnitedHealthcare announced July 1 it is delaying implementation of its Lab Test Registry "until further notice" due to Covid.
  In a notice announcing the move, UHC said there is no need to register or place unique test codes for non-genetic tests at this time. However, the registry is still in use for the Genetic and Molecular Lab Test Prior Authorization & Advanced Notification (PAAN) program.
  As a reminder, the program requires freestanding and outpatient hospital lab claims to include unique test codes for in-scope lab test services. The codes will serve as the lab's unique identifier that a physician would use to order a test (aka "test code, "order code, or "test identifier"). Claims without the codes may be denied.
  Initially slated to go into effect on Oct. 1, 2020, the program has been delayed several times amid significant industry push back. It was set to launch Jan. 1, 2022 before this latest delay.

Webinar: Examining buy-sell agreements and A/R

We recently welcomed Dr. Stephen Ruby, MD, MBA, FCAP, to discuss the importance of having a buy-sell agreement in place for your lab and how your accounts receivable factors in to that discussion. Vachette's Ann Lambrix and Josh Yelen also covered how to effectively collect outstanding AR as part of your revenue cycle management process (RCM) and report it on your financial statements. -- **Watch it for free today!**

Don't forget, **UHC's Designated Diagnostic Provider program is still set to go into effect on July 1** despite opposition from CAP and other lab advocates.

Are you prepared for 2022 MPFS cuts?

After taking steps to reduce MPFS cuts last year due to the Covid-19 Public Health Emergency, CMS is again going to have to make some tough decisions in this summer's proposed fee schedule in order to meet budget requirements triggered by recent relief spending. Watch for the 2022 proposal to drop in July and check back for our analysis.

Vachette's Ann Lambrix will be a featured speaker during the **Dark Intelligence Group's July 8 Covid-19 Briefing**. Don't miss out!

At Vachette, we specialize in consulting and auditing for labs and pathology practices

We have been working with hospitals, laboratories, and hospital-based groups for more than 16 years.

Visit vachettepathology.com, call 517-759-7147, or contact Mick Raich, President of RCM Consulting, at 517-403-0763. Our experience and expertise are second to none!

-Cigna PC/CP, continued from 1

This shift echoes what other payers have done during the past ten years in regards to PC/CP reimbursement. If you have a direct contract with Cigna, read it carefully. It will likely say they can change the payment for this service "from time to time," leaving you vulnerable to their whims.

So, what is the recourse to gain this revenue back? Your lab or group must consider renegotiating your anatomic payment rates to make up for this loss. The renegotiation takes time and leverage to complete, a process Vachette excels at.

Other items to consider:

- Is your hospital contract up for re-negotiation? Can you add reimbursement for PC/CP in your Part A agreement?
- Consider locking in a "carve-out" agreement with Cigna that pays a flat rate per test, instead of being tied to the Cigna RVRBS?

Need assistance navigating these renegotiations or projecting for these cuts? Reach out to us directly at 517-486-4262

How antibody testing can bolster your lab's revenue stream

With Covid-19 diagnostic testing numbers declining throughout the country as vaccines proliferate, and the Center for Disease Control recommending vaccinated individuals skip testing, now is a good time for labs that have been engaged in this line of business to consider alternatives to bolster their revenue stream moving forward.

One emerging alternative is testing for the presence of neutralizing antibodies in vaccinated individuals or those who have previously had Covid-19 through the use of titers. A titer is a laboratory test that measures the presence and number of antibodies in blood. A titer may be used to prove immunity to disease, such as Covid-19.

"As we go forward into the fall and approach the next flu season, people are going to have concerns about different variations of Covid and their overall immunity levels," says Mick Raich, President of RCM Consulting for Lighthouse Lab Services. "Given that reality, antibody testing is a classic way to provide peace of mind for people, while also creating an avenue for labs to continue to generate revenue moving forward."

Pricing for these tests

Due to the relatively recent emergence of these tests, most are not currently listed on the Medicare Physician or Clinical Lab Fee Schedules. Instead, titers are currently priced by individual Medicare Administrative Contractors (MACs). For example:

- 0224U – Traditional Antibody Titer = $42.13 (All MACs)
- 86409 – Neutralizing Antibody SarsCov2 Titer = $79.61 to $105.33 (Depending on MAC)

While the FDA has previously issued Emergency Use Authorizations (EUAs) to more than 50 antibody (serology) tests, those tests only detect the presence of binding antibodies. Binding antibodies bind to a pathogen, such as a virus, but do not necessarily decrease the infection and destruction of cells. As you can see below, pricing for these tests is fairly consistent across MACs:

- 86769 – Traditional Antibody Test = $42.13 (All MACs)
- 86408 – Neutralizing Antibody SarsCov2 Screen = $42.13 (All MACs)
- 86413 – Quantitative Antibody Test = $42.13 to $51.43 (Depending on MAC)

Validation and referencing costs

Lighthouse is available to assist you if you have interest in validating these tests for your laboratory. The total cost is about $62,000 for equipment, validation supplies, and clinical validation consulting.

Additionally, we can also help with the process of referencing this type of testing out to another lab. For example, META Lab Dx is offering lab-to-lab reference work for $28/test for Quantitative Antibody Testing and $48/test for Covid Titer testing.

"As the country continues to open back up, these tests can help folks understand the level of individual precaution they need to be taking," says Raich. "This is a great way to provide peace of mind while boosting your revenue stream at the same time."

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Case study: Insurer holding payments over tax ID confusion

The following is a column from Mick Raich, President of RCM Consulting for Lighthouse Lab Services:

It has recently come to our attention that a large national health plan is denying payment for a pathology group due to confusion over their tax ID number. According to the payer, payments for the group cannot be processed because the payer believes the group of pathologists are listed under another ID number. (Yes, you read that correctly).

Here's the kicker: The payer will not even tell the group what tax ID number it has them listed under! Instead, the pathologists are being asked to submit every single tax ID number they have ever worked under in hopes the payer can de-list them from their old group and add them to their current group. In the interim, the payer is not even reimbursing them at an out-of-network rate! They are paying zero, nada, nothing.

To add insult to nonpayment injury, the payer is also making them wait a YEAR until they can load their new contract, if they ever get one into the system at all. Simply put, this is unacceptable. More to come…

Medicare doubles at-home Covid vaccine payment

In an effort to get more Covid-19 vaccinations into the arms of the general public, the Biden Administration announced Wednesday that Medicare payments for in-home vaccinations will be nearly doubled from the current rate.

Medicare will now pay providers $75 per vaccine dose when administered at a patient's home, up from the previous $40 rate. Administering a two-dose vaccine will pay $150 total, nearly doubling the current rate. In explaining the move, CMS notes there are nearly 1.6 millions adults 65 or older who may have trouble accessing vaccines due to difficulty leaving their homes.

"CMS is committed to meeting the unique needs of Medicare consumers and their communities – particularly those who are home bound or who have trouble getting to a vaccination site. That's why we're acting today to expand the availability of the Covid-19 vaccine to people with Medicare at home," said CMS Administrator Chiquita Brooks-Lasure in a press release announcing the move.

The additional payment amount also accounts for the clinical time needed to monitor a beneficiary after the vaccine is administered, as well as the upfront costs associated with administering the vaccine safely and appropriately in a beneficiary's home.

As a reminder, Covid vaccines must be provided without cost sharing or administration fees for the patient. Providers may submit reimbursement claims for administering vaccines to uninsured individuals through the HRSA Uninsured Patient Portal.

HHS sets reporting, sending deadlines for Provider Relief Fund payments

Health care providers who received distributions from the Health and Human Services Provider Relief Fund during the Covid-19 Public Health Emergency now have instruction on how to report on the use of those funds after HHS published new rules Friday.

In addition to establishing spending and reporting deadlines, HHS also clarified recipients are required to report for each Payment Received Period in which they received one or more payments exceeding $10,000. Original guidelines indicated anyone who received at least $10,000 cumulatively across all payment periods would be required to report.

PFR recipients are required to only use payments for eligible expenses, including services rendered, and lost revenues attributable to coronavirus. These requirements do not apply to those who have received funds from the HRSA Uninsured Patient Portal or the Rural Health Clinic Covid-19 Testing Program.

The reporting portal will now be available beginning July 1 for provides who received funds between April 10 and June 30, 2020. This table (linked) also outlines all spending and reporting deadlines for subsequent payment periods.

Those who have not done so already are being encouraged to register in the PRF Reporting Portal in advance of the relevant reporting dates. The registration process takes about 20 minutes to complete and must be completed in one session.

Keep in mind that recipients who spend a total of $750,000 or more in federal funds (including PRF payments and other federal financial assistance) during their fiscal year are also subject to Single Audit requirements, as set forth in the regulations at 45 CFR 75 Subpart F.

Cigna to continue paying professional component of clinical pathology

After previously stating its intent to stop paying the professional component of clinical pathology (PC/CP), Cigna has reversed course and will continue paying for these services after receiving significant pushback from the College of American Pathologists and others pathology advocacy groups.

On Tuesday, June 8, CAP shared the following update on its website:

“In response to the CAP’s engagement, Cigna informed the CAP on June 7 that the decision is imminent. The CAP learned health insurance payer Cigna plans to continue reimbursing pathologists for the professional component of clinical pathology services. A formal update regarding the policy to pay for the professional component of clinical pathology would be forthcoming soon.”

In its initial update to the Modifier 26 Professional Component Policy published April 12, 2021, Cigna said codes inappropriately billed with a 26 modifier would be denied beginning July 11, 2021. Further reading showed this would include the PC for clinical pathology claims.

Pathologists in several states would have seen their reimbursements negatively impacted if the change had been allowed to take effect. As is stands, Cigna is one of the last commercial payers to still reimburse PC/CP.