Reimbursement Considerations for Molecular Diagnostic Testing

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Learning Objectives

After this presentation, you should be able to:

1. Describe the current coverage, coding and payment landscape for molecular diagnostics tests
2. Explain how recent policy developments will affect future reimbursement for clinical laboratory testing
3. Develop a high-level reimbursement plan for your molecular diagnostic test offerings
The Reimbursement Framework

Will payers pay for the service, and under what conditions?

Coverage

Payment

Coding

What is the specific payment amount that providers will receive?

How will providers identify the service on claim forms?
Keys to Coverage for Molecular Diagnostics
Payer Coverage Drives Test Volume/Sales

Evidence of Clinical Utility Drives Coverage for Diagnostic Tests

- **Analytical validity**, or how a diagnostic test compares to a gold standard (clinical truth), is typically the only requirement for FDA approval.

- **Clinical utility**, or the ability of the test to alter the way patients are managed and/or improve net health outcomes, is **key to securing payer coverage**.

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**Analytical Validity**
- Accuracy, precision, reproducibility

**Clinical Validity**
- Association of the test result with outcomes of interest

**Clinical Utility**
- Evidence that test use influences clinical decision-making AND/OR improves patient outcomes.
Payers Have Varying Definitions of Clinical Utility

Clinical Utility Definition #1:
Refers to the ability of the diagnostic test results to influence physician decision-making when treating a patient.

Clinical Utility Definition #2:
Improved health outcomes downstream of treatment selection may also be a requirement to demonstrate clinical utility for some payers.

Payers are increasingly requiring evidence of improved health outcomes as a condition for coverage.
Keys to Coverage

- Technology Assessments
- Clinical Utility Evidence
- Inclusion in Professional Society Guidelines

COVERAGE
Top-Down vs. Bottom-Up Strategies to Secure Coverage

**TOP DOWN STRATEGY**
- Developing and publishing strong clinical utility evidence
- Engaging payer medical directors to advocate for publication of favorable coverage policies

**BOTTOM UP STRATEGY**
- Developing a robust appeals program to overturn medical necessity claim denials
- Leveraging successful appeals to make a case for formal coverage

_in the absence of strong clinical utility evidence, a robust appeals program can be an effective tool to secure coverage_
Case Study: Genomic Health Launched a Three-Prong Plan to Expand Coverage for OncoType Dx

1. Develop a publication plan to address evidence gaps that were hindering payer coverage

2. Promote grassroots support for OncoType Dx among the oncology and patient advocate communities

3. Appeal denied claims on the basis of medical necessity to fight negative payer coverage policies

Coding for Molecular Diagnostics
New Molecular Pathology (MoPath) Codes WereIntroduced in 2013

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83907</td>
<td>Lysis of cells prior to nucleic acid extraction, each specimen</td>
</tr>
<tr>
<td>83891</td>
<td>Isolation or extraction of highly purified nucleic acid, each nucleic acid type</td>
</tr>
<tr>
<td>83892</td>
<td>Enzymatic digestion, each enzyme treatment</td>
</tr>
<tr>
<td>83912</td>
<td>Interpretation and report</td>
</tr>
<tr>
<td>83896</td>
<td>Nucleic acid probe, each</td>
</tr>
</tbody>
</table>

**Before 2013**

**CPT 81210**

BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant
The AMA Has Established Several CPT Code Sets for Molecular Diagnostic Tests

Molecular Diagnostic CPT Codes

- MoPath Codes
  - Tier 1 Codes: Codes for commonly-performed gene-specific and genomics procedures, where a single test or procedure corresponds to a single CPT code
  - Tier 2 Codes: Codes for less-commonly performed single-gene tests, organized into nine ascending levels of technical resources and interpretative work performed by the clinician
  - MAAA Codes: Codes for Multianalyte Assays with Algorithmic Analyses (MAAAs), or assays that analyze multiple biomarkers with application of a proprietary algorithm to obtain a risk score
  - NGS Codes: Codes for tests using next-generation sequencing (NGS) technologies, specified by methodology (e.g., whole genome vs. whole exome) and indication (scheduled for implementation in 2015)
Determining Coding Options for Your Test

Do existing code(s) accurately describe the test?

Yes

Use existing code(s) to bill for the test
- Considered the path of least resistance
- Corresponding payment rate, if any, may not be ideal

No

Use an unlisted code (e.g., CPT 84999)
- Often requires extra documentation
- Claims will likely be flagged by payers for manual review, delaying time to payment
- No set payment rate

Apply for a new code
- Ultimately facilitates claims processing
- Application process is time- and resource-intensive
- Opportunity or challenge for rate-setting
Applying For a New MoPath/MAAA CPT code

Criteria for a new Category I MoPath or MAAA CPT code¹:

- Published evidence of clinical validity and clinical utility
- Test is offered by at least 2 US labs, unless proprietary
- Evidence of widespread use within the relevant clinical community
- Support from the relevant specialty societies

CPT Application Process for Lab Codes

1. Draft and submit CPT coding application
2. Present at Pathology Coding Caucus (PCC) meeting
3. Present at CPT Editorial Panel Meeting

Securing a new Category I CPT code can take anywhere from 12 to 18 months

McKesson Z-code™ Identifiers Are An Additional Way to Identify Molecular Diagnostic Tests

- A McKesson Z-code™ Identifier is a 5 character alpha-numeric identifier that provides further granularity for billing a molecular diagnostic test.

- The AMA and McKesson have partnered to develop a reference product, CPT CodeBridge™, that maps McKesson Z-code™ Identifiers to AMA MoPath CPT codes.

- This product is currently available to providers and payers through licensing agreements with the AMA.

### Implications of CPT CodeBridge™ for Labs

- *Increased billing transparency to payers*
- *Potentially increased coverage scrutiny*
- *Potential payment variations for tests billed with the same CPT code*
Molecular Diagnostics Payment Systems
Medicare reimburses diagnostic laboratory services under one of two payment systems, depending on whether the test is performed by a lab technician or by a physician:

1. Clinical Laboratory Fee Schedule (CLFS)
2. Medicare Physician Fee Schedule (MPFS)

Private payers may utilize a variety of methodologies to determine payment rates for diagnostic laboratory services, which typically also varies based on contracting status (“in-network” vs. “out-of-network”).

However, private payers often benchmark their payment rates to Medicare’s (e.g., Medicare +20%).
Medicare CLFS Payment Rates Are Set By Either Crosswalking or Gapfilling

Medicare CLFS Rate-Setting Methods

- **CROSSWALKING**
  - Payment is benchmarked to that for comparable test(s)

- **GAPFILLING**
  - In the first year, each Medicare Administrative Contractor (MAC) sets local rates based on:
    - Charges and routine discounts to charges
    - Resources required to perform the test
    - Payment rates determined by other payers
  - In the second year, a National Limitation Amount (NLA) is set at the median of local MAC payment rates
The AMA approved the creation of analyte-specific Tier 1/Tier 2 MoPath CPT codes to replace the methodology-based “stacking” codes.

The new MoPath codes were implemented, and the old “stacking” codes retired.

The MoPath codes were gapfilled for Medicare payment under the CLFS.

CMS released NLAs for the MoPath codes, but excluded many Tier 1 codes and all of the Tier 2 codes.
## Sample 2014 Medicare NLA Payment Rates for MoPath Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>2014 NLA</th>
<th>LabCorp 2012 Code Stack Payment*</th>
<th>Quest 2012 Code Stack Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>81210</td>
<td>BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant</td>
<td>$179.25</td>
<td>$53.00</td>
<td>$259.10</td>
</tr>
<tr>
<td>81235</td>
<td>EGFR (epidermal growth factor receptor) (e.g. non-small cell lung cancer) gene analysis, common variants (e.g. exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)</td>
<td>$330.01</td>
<td>$533.48</td>
<td>$301.92</td>
</tr>
<tr>
<td>81275</td>
<td>KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13</td>
<td>$197.48</td>
<td>$265.64</td>
<td>$212.64</td>
</tr>
<tr>
<td>81292</td>
<td>MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g. hereditary nonpolyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis</td>
<td>$646.24</td>
<td>$2,147.96</td>
<td>$930.52</td>
</tr>
</tbody>
</table>

*Quorum estimates based on code stacks published by Quest and LabCorp in 2012 and the 2012 Medicare CLFS.
Recent Developments in Molecular Diagnostics Reimbursement
The Palmetto MolDx Program Aims to Standardize Coverage and Payment of Molecular Diagnostics

The MolDx Program

- Lab registers test for a McKesson Z-code Identifier
- Lab submits clinical value dossier to Palmetto
- Palmetto conducts a technical assessment to determine coverage
- If the test is covered, Palmetto determines a payment rate

- Launched in 2012, the MolDx Program was designed to address Palmetto’s concerns around lack of transparency in billing and payment for molecular testing
- The program currently applies to Palmetto’s Jurisdiction 11 (WV, VA, NC, SC) and Noridian’s Jurisdiction E (CA, NV, HI)
- All labs submitting Medicare claims in these jurisdictions must participate in the MolDx program in order for their claims to be paid

Source: http://www.palmettogba.com/palmetto/MolDX.nsf/DocsCatHome/MolDx
The Protecting Access to Medicare Act (PAMA) of 2014 Affects Reimbursement for ALL Clinical Lab Services

- **Starting January 1, 2016**, all labs for which the majority of revenue comes from Medicare must **submit information to CMS on their private payer reimbursements**, including:
  - Payment amounts, reflecting all discounts and price concessions, for each test and each unique private payer
  - The volume of tests paid by each unique private payer

- This law applies to **all** clinical laboratory services paid under the CLFS or MPFS, including molecular diagnostics, chemistry, and cytopathology tests

<table>
<thead>
<tr>
<th>Date</th>
<th>Major Milestone</th>
</tr>
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<tr>
<td><strong>January 1, 2016</strong></td>
<td>Submission of laboratory private payer reimbursement data begins</td>
</tr>
<tr>
<td><strong>January 1, 2017</strong></td>
<td>CLFS payment rates determined through private payer reimbursement data take effect</td>
</tr>
</tbody>
</table>

Source: [http://beta.congress.gov/113/bills/hr4302/BILLS-113hr4302enr.pdf](http://beta.congress.gov/113/bills/hr4302/BILLS-113hr4302enr.pdf)
How PAMA Defines Advanced Diagnostic Laboratory Tests (ADLTs)

- Tests that are provided by a single source; **AND**
- Involve the analysis of multiple biomarkers combined with unique algorithms; **OR**
- Are FDA approved; **OR**
- Meet any other criteria established by CMS
PAMA Will Change the Rate-Setting Process for Clinical Laboratory Tests

Medicare rate-setting for clinical laboratory tests performed on or after January 1, 2017 will vary depending on the type of test:

- **ADLTs**
  - **Existing Tests**: Payment is based on the volume-weighted median of private payer reimbursement data that labs submit to CMS every year.
  - **New Tests**: Payment for the first three quarters of use will be based on the list price marketed to private payers.

- **Other Lab Tests**
  - **Existing Tests**: Payment is based on the volume-weighted median of private payer reimbursement data that labs submit to CMS every three years.
  - **New Tests**: Payment will be determined through either crosswalking or gapfilling.
PAMA provides the HHS Secretary with the authority to designate up to **four MACs** to establish coverage policies and/or process claims for clinical laboratory tests for the entire Medicare program.
Developing a Reimbursement Plan for Your Tests
Developing a Reimbursement Plan: Key Takeaways

**Coverage**
- If necessary, develop a publication plan to generate (clinical utility) evidence to support coverage
- Prepare materials and protocols to support appeals for denied claims

**Coding**
- Determine whether any existing CPT code(s) are appropriate for your test
- If not, consider using an unlisted code or applying for a new code

**Payment**
- Negotiate payment rates with your contracted private payers
- If applicable, work with your local MAC to determine payments for codes that are not on the CLFS
1. Which of the following types of evidence is most important to payers in evaluating coverage for a diagnostic test?
   a) Analytical validity
   b) Clinical validity
   c) Clinical utility
   d) All of the above

2. Which of the following code sets are organized into nine levels of increasing technical complexity and interpretive work?
   a) MoPath Tier 1 codes
   b) MoPath Tier 2 codes
   c) Multianalyte Assays with Algorithmic Analysis (MAAA) codes
   d) Next Generation Sequencing (NGS) codes
3. Which of these Medicare jurisdictions is/are currently subject to the requirements of the Palmetto MolDx program?
   a) J11 (NC, SC, VA, WV)
   b) JE (CA, HI, NV)
   c) J11 and JE
   d) None of the above

4. Under the Protecting Access to Medicare Act, starting in 2017, how would CMS set Medicare payment rates for new Advanced Diagnostic Laboratory Tests (ADLTs) in the first 3 quarters of availability?
   a) By crosswalking
   b) By gapfilling
   c) Based on the weighted median of private payer reimbursement amounts
   d) Based on the test’s list price
Thank you for your attention!

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