

a diagnosis. Other clinical situations where flow cytometry tests have some value include stem cell transplantation, paroxysmal nocturnal hemoglobinuria, immune deficiency disorders, etc.

When flow cytometry is performed to diagnose lymphoma or leukemia, there is a single interpretation based on the quantification of all markers tested. There is not an interpretation of each marker individually.

Moreover, for a given clinical indication (for example, diagnosis of lymphoma based on lymph node examination) there is variation in the number of markers performed. The number of markers that are necessary depends, in part, on the pathologic information available to the pathologist at the time he/she orders flow cytometry. Therefore, for a given clinical indication (for example, diagnosis of lymphoma from a lymph node) a pathologist who chooses to perform flow cytometry before performing a microscopic examination of the tissue specimen (for example, a lymph node) may order more markers than a pathologist who orders flow cytometry after performing a microscopic examination of the tissue specimen.

The current coding scheme (payment on a per marker basis) may encourage the performance of more markers than may be medically necessary because the pathologist determines what markers to perform and when to perform them.

Our review of flow cytometry reports confirms that markers are interpreted (and reported) on a panel basis. From our review, physicians do not typically interpret individual markers. This is consistent with most of the clinical indications for flow cytometry that require performance of several markers to make a diagnosis. There may also be clinical situations where no professional component is performed although it is appropriate to perform the technical component (TC) (for example, monitoring of HIV infected patients, monitoring of solid organ transplantations).

The fact that markers are generally analyzed on a "panel" basis, not an "individual" basis, means that the current practice and use of flow cytometry is not appropriately reflected by the PC of CPT code 88180.

However, we do believe that it is appropriate to pay for the TC of each marker separately, although at a lower rate of payment (due to economies of scale) when multiple markers are performed. A coding scheme that pays per marker for the TC and per panel for the PC would more accurately reflect the actual practice of flow cytometry.

The laboratory community is aware of our concerns about the coding of flow cytometry and will review this issue and consider whether changes should be made to the current coding for the procedure. If no changes in coding are forthcoming, we would consider creating HCPCS codes for flow cytometry. We welcome comments and recommendations on appropriate values for the procedure that we could use in developing any future proposal.

#### 5. Create G Codes for Dialysis Patient Seeing the Doctor

We have reviewed our current payment policy for the monthly dialysis capitation, CPT codes 90918 through 90921 in response to concerns that have been raised over whether our payment policy is consistent with current medical practice.

Specifically, we understand that physician involvement in dialysis for end stage renal disease (ESRD) varies based on a patient's condition, response to dialysis, and comorbidities. A physician involvement for a single patient may also vary from month to month. It is our intent to ensure that beneficiaries with ESRD receive the highest quality dialysis care available and that physician involvement in dialysis for ESRD patients is appropriate and consistent with the needs of the patient in any month.

Observers of the quality of care for dialysis patients have noted that some dialysis patients may benefit from being evaluated by their physician frequently. A recent international comparison study suggested that longer physician-patient contact time in hemodialysis facilities was associated with lower mortality risk.

To align the payment incentives with the frequency of the physician personally evaluating the dialysis patient, we are proposing to make CPT codes 90918, 90919, 90920, 90921 invalid for Medicare and to create G codes. We are proposing to create 3 new G codes in place of each CPT code with higher payments associated with providing more visits within each month to an ESRD patient. Under our proposal, there will be separate codes when the physician provides 1 visit per month, 2–3 visits per month and 4 or more visits per month. The code for 1 visit per month will have the lowest payment while a higher payment will be provided for 2 to 3 visits per month and the highest payment for 4 or more visits per month. Our methodology for determining payment is described below. These new codes will be reported once per month for services performed in an outpatient setting and

related to the patient's ESRD. These physician services will continue to include the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management, provided during a full month. These codes would not be used if a hospitalization occurred during the month.

**GXXX5—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.**

**GXXX6—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.**

**GXXX7—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.**

**GXXX8—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.**

**GXXX9—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.**

**GXX10—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.**

**GXX11—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and**