

To: HBMA Members
From: HBMA Government Relations Committee

President Obama Signs the *Medicare and Medicaid Extenders Act of 2010*; New Law Includes SGR Fix through December 2011

On Wed Dec 15, 2010, President Obama signed into law the *Medicare and Medicaid Extenders Act of 2010 (MMEA)*. This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. The Centers for Medicare & Medicaid Services (CMS) is pleased that this law has addressed key issues for beneficiaries and providers and we are actively engaged in implementing these changes.

CMS is also working to implement several important new provisions for Medicare beneficiaries made possible by the Affordable Care Act - the health reform law. In 2011:

- Beneficiaries who reach the prescription drug coverage gap, known as the donut hole, will receive a 50-percent discount when buying Part D-covered brand-name prescription drugs.
- Virtually all Medicare beneficiaries are eligible to receive many free preventive care services and a free annual wellness visit.

These provisions will improve care for Medicare beneficiaries and we encourage you to share this information with your patients. More information on these Affordable Care Act provisions can be found at www.Medicare.gov and at www.healthcare.gov; healthcare.gov also contains a timeline and other key information about the new law and a highly praised insurance finder for coverage options in public and private insurance programs, which family members and friends of Medicare beneficiaries may find useful.

Below please find technical summaries of key provisions of the MMEA along with some information about how these changes may affect providers and provider billing.

- **Physician Payment Update -**
 - Section 101 of the MMEA prevents a payment cut for

physicians that would have taken effect on Sat Jan 1, 2011. While the physician fee schedule update will be zero percent, other changes to the relative value units (RVUs) used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2011. CMS is currently developing the 2011 Medicare Physician Fee Schedule (MPFS) to implement the zero percent update, and we expect all 2011 claims to be processed timely, in compliance with the new legislation.

- **Extension of Medicare Physician Work Geographic Adjustment Floor -**
 - Current law requires payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 103 of the MMEA extends the existing 1.0 floor on the "physician work" geographic practice cost index, through Sat Dec 31, 2011. As with the physician payment update, this change will be accomplished through a revised 2011 MPFS.

- **Extension of Physician Fee Schedule Mental Health Add-On Payments -**
 - For calendar year 2010, certain mental health services' payment rates continued to be increased by five percent. Section 107 of the MMEA extends the five percent increase in payments for these mental health services, through Sat Dec 31, 2011. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2011 MPFS.

- **Extension of Medicare Modernization Act Section 508 Reclassifications**
 - Section 102 of the MMEA extends Section 508 and special exception hospital reclassifications from Fri Oct 1, 2010, through Fri Sep 30, 2011. Effective Fri Apr 1, 2011, Section 102 also requires removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by Section 102 of the MMEA shall be assigned an individual special wage index effective Fri Apr 1, 2011. If the Section 508 or special exception hospital's wage index applicable for the period beginning on Fri Oct 1, 2010, and ending on Thu Mar 31, 2011, is lower than the period beginning on Fri Apr 1, 2011, and ending on Fri Sep 30, 2011, the hospital shall be paid an

additional amount that reflects the difference between the wage indices. The provision applies to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception hospital's reclassified wage index will be applicable from Sat Jan 1, 2011, through Sat Dec 31, 2011.

- **Extension of Exceptions Process for Medicare Therapy Caps -**
 - Section 104 of the MMEA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after Sat Jan 1, 2011, through Sat Dec 31, 2011. The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on Sat Jan 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.
- **Extension of Moratorium On Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients -**
 - In the final physician fee schedule regulation published in the *Federal Register* on Nov 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. Although the previous extension of the moratorium expired at the end of 2010, the MMEA restores the moratorium through 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after Sat Jan 1, 2011, through Sat Dec 31, 2011.
- **Extension of Ambulance Add-On Payments -**
 - The provisions that were extended by Section 106 of the MMEA are: [1] the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas; [2] the provision relating to air ambulance services that considers any area that was designated as a rural area as of Dec 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and [3] the provision relating to payment for ground ambulance services where the base rate is increased

when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. All of these payment provisions are extended through Sat Dec 31, 2011.

- **Extension of Outpatient Hold Harmless Provision -**
 - Section 108 of the MMEA extends the Outpatient Hold Harmless provision, effective for dates of service on and after Sat Jan 1, 2011, through Sat Dec 31, 2011, to rural hospitals with 100 or fewer beds and to all sole community hospitals and Essential Access Community Hospitals regardless of bed size.

- **Extension of Medicare Reasonable Cost Payment for Clinical Lab Tests Furnished to Hospital Patients in Certain Rural Areas -**
 - Section 109 of the MMEA extends the reasonable cost payment for clinical lab tests furnished by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after Fri July 1, 2011, through Sat June 30, 2012. This could affect services furnished as late as June 30, 2013. If your hospital qualifies under Section 109, you do not need to take any action. Your hospital will receive reasonable cost reimbursement for an entire year, starting with the facility cost reporting period beginning on or after Fri July 1, 2011.

- **Repeal of the Delay of RUG-IV -**
 - Section 202 of the MMEA repeals the delay of the Skilled Nursing Facility (SNF) PPS RUG-IV classification system. Therefore, RUG-IV will continue to remain in effect from Fri Oct 1, 2010, as previously implemented by the final SNF payment regulation for FY2011. All claims processing activities shall proceed in accordance with the existing instructions.

Please be on the alert for more information pertaining to the Medicare and Medicaid Extenders Act of 2010. Finally, as a reminder, beginning on Mon Jan 3, 2011, eligible professionals, eligible hospitals, and critical access hospitals can register for the Medicare and Medicaid Electronic Health Records Incentive Programs. For more information, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Sebelius and Holder Announce New Tools to Prevent and Fight Fraud at Boston Regional Healthcare Fraud Prevention Summit

As part of the Obama Administration's ongoing efforts to prevent and fight fraud in our nation's health care system, US Department of Health & Human Services Secretary Sebelius and Attorney General Eric Holder today announced that the Centers for Medicare and Medicaid Services would be acquiring new state-of-the-art fraud fighting analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid and the Children's Health

Insurance Program.

Sebelius and Holder made the announcement at the University of Massachusetts, Boston at the fourth regional health care fraud prevention summit. The Attorney General and the HHS Secretary have crisscrossed the country this year bringing together a wide array of federal, state, and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud within the US health care system.

As part of today's summit, CMS will issue today a solicitation for state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. These tools will integrate many of the Agency's pilot programs into the National Fraud Prevention Program and complement the work of the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT).

The recently-enacted Affordable Care Act provides additional tools and resources to fight fraud in the health care system by providing an additional \$350 million over the next ten years through the Health Care Fraud and Abuse Control Account. The Act toughens sentencing for criminal activity, enhances screenings and enrollment requirements, encourages increased sharing of data across government, expands overpayment recovery efforts, and provides greater oversight of private insurance abuses. For information on the 2009 Health Care Fraud and Abuse Control Program Report, please visit <http://www.justice.gov/dag/pubdoc/hcfacreport2009.pdf>.

To read the entire HHS Release issued on Thu Dec 16, please visit <http://www.hhs.gov/news/press/2010pres/12/20101216a.html>.

Reminder: Important Information on the Timely Claims Filing Requirement

The Centers for Medicare & Medicaid Services would like to remind Medicare Fee-For-Service physicians, providers, and suppliers submitting claims to Medicare for payment that, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after Jan 1, 2010, MUST be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service - or Medicare will deny those claims.

If you have Medicare Fee-For-Service claims with service dates from Thu Oct 1, 2009, through Thu Dec 31, 2009, those claims MUST be filed by Fri Dec 31, 2010, or Medicare will deny those claims. Claims with service dates from Thu Jan 1, 2009, to

Thu Oct 1, 2009, keep their original Fri Dec 31, 2010 deadline for filing.

For claims for services that require reporting a line item date of service, the line item date will be used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

For additional information about the new maximum period for claims

submission filing dates, contact your Medicare contractor or review the following MLN Matters articles related to this subject:

- *MM6960 - "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" -*
<http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf>
- *MM7080 - "Timely Claims Filing: Additional Instructions" -*
<http://www.cms.gov/MLN MattersArticles/downloads/MM7080.pdf>

A podcast on this subject is also available at
http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp.