



**News Flash** – The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare Fee-for-Service (FFS) contractor that processes and pays your Medicare claims. CMS is preparing to conduct the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey. Providers and suppliers can complete the survey on the Internet via a secure website or by mail, fax, or telephone. To learn more about the MCPSS, please visit <http://www.cms.gov/MCPSS> on the CMS website.

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## **Sections 3103 and 3104 of the Patient Protection and Affordable Care Act (PPACA) Extends Certain Payment Provisions Under the Medicare Program Related to Therapy Cap Exceptions and the Billing by Independent Laboratories for the Technical Component of Physician Pathology Services Furnished to Hospital Patients**

**Note:** This article was revised and re-issued on April 1, 2010, to reflect the impact of the PPACA on the therapy caps exceptions process and on billings by independent laboratories for the technical component of physician pathology services furnished to hospital patients.

### **Provider Types Affected**

All Medicare providers should take note of this article.

### **Provider Action Needed**

This special edition article is being re-issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare

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payment provisions, such as the Therapy Cap Exceptions Process and Allowing Independent Laboratories to Bill for the Technical Component of Physician Pathology Services Furnished to Hospital Patients, have been extended as a result of the Patient Protection and Affordable Care Act (PPACA). Previously, these provisions were to sunset as of December 31, 2009.

#### **Extension of Moratorium That Allows Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients**

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act*, which extends the moratorium that allows independent laboratories to bill for the TC of physician pathology services furnished to patients in hospitals, effective for claims with dates of service on and after January 1, 2010, through December 31, 2010.

In the final physician fee schedule regulation published in the Federal Register on November 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 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 2009, Section 3104 of the *Patient Protection and Affordable Care Act* restored the moratorium retroactive to January 1, 2010. Therefore, independent laboratories may now 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 January 1, 2010, through December 31, 2010. If an independent laboratory previously submitted a claim for services covered by this provision and the claim was denied, the laboratory may contact its Medicare contractor for further instructions.

#### **Extension of Therapy Cap Exceptions Process**

Section 3103 of the *Patient Protection and Affordable Care Act* 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 January 1, 2010, through December 31, 2010.

Therapy caps are determined on a calendar year basis, so all patients began a new cap year on January 1, 2010. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,860. For

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occupational therapy services, the limit is \$1,860. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Please be on the alert for more information pertaining to the *Patient Protection and Affordable Care Act*.

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