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Important Information on the New Medicare Law – The Medicare Improvements for Patients and Providers Act of 2008

Note: **This article was revised on May 16, 2018, to update Web addresses. All other information remains the same.**

This article contains a compilation of messages that were issued on July 16, 2008.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. This legislation alters a number of Medicare policies, which have been the subject of a number of change requests (CRs) and MLN Matters articles published in recent months. The Centers for Medicare & Medicaid Services (CMS) is in the process of revising these previously issued CRs and MLN Matters articles as a result of this legislation. However, CMS feels it is important that physicians, providers and suppliers be aware of five critical issues immediately.

These five issues are:

- New 2008 Medicare Physician Fee Schedule (MPFS) payment rates effective for dates of service July 1, 2008 through December 31, 2008;

- Extension of the exceptions process for the therapy caps;
- A delay in the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program;
- Reinstatement of the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients; and
- Extension of the payment rule for Brachytherapy and Therapeutic Radiopharmaceuticals.

Be sure your billing staff is aware of these changes.

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. While MIPPA calls for numerous changes to the Medicare program, this special edition article covers five key provisions as noted above.

1. New 2008 Medicare Physician Fee Schedule (MPFS) Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008

As a result of this legislation, the mid-year 2008 MPFS rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less, for claims with dates of service on or after July 1, 2008. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims with dates of service on or after July 1, 2008, that have been on hold. These claims will be processed on a rolling basis (first in/first out) for payment at the -10.6% update level. After your Medicare contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Medicare contractor websites are being updated with the new rates and these should be available shortly. Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

2. Extension of Therapy Cap Exceptions

Another key provision of the MIPPA legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

3. Delay in the DMEPOS Competitive Bidding Program

This new law also has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding the new law's impact on this program will be forthcoming.

4. Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

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 technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the MPFS for the TC of physician pathology services for 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. As such, during this time, Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by Section 136 of MIPPA, retroactive to July 1, 2008.

A previous communication (MLN Matters article MM6088) indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

5. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

MIPPA extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the Outpatient Prospective Payment System (OPPS) rates that were in effect until MIPPA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing of affected claims will be complete by September 30, 2008.

Additional Information

Be on the alert for more information about other legislative provisions which may affect you.

If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html**.

Document History

- July 17, 2008 – Initial article released.
- May 16, 2018 – The article is revised to update Web addresses. All other information remains the same.