DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of Media Affairs

MEDICARE FACT SHEET

FOR IMMEDIATE RELEASE
July 16, 2008

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MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT, 2008

Background

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted, making changes to the Medicare program. Information about some of the changes is outlined below. Detailed instructions about these changes have been communicated via listserv to CMS providers and other affected parties. CMS will be implementing other provisions of the legislation in the coming months and will announce additional information as it becomes available.

Physician Pay

As a result of the new law, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate reduction of -10.6 percent is retroactively replaced with the fee schedule rates in effect from January – June, 2008, which reflected a 0.5 percent update from 2007 rates. In addition, MPFS payment rates are being revised to increase the fee schedule amounts for certain mental health services.

Effective immediately, CMS has instructed its contractors to implement the new law. However, it may take up to 10 business days to implement these changes. To minimize physician disruption during this transition, CMS will post the new physician fee schedule as soon as possible and will continue its rolling 10 day hold and release of claims. This means that, until the new fee schedule rates are implemented, some claims may still be paid at the lower rates that were in effect between July 1st and July 15th. To the extent possible, contractors will begin to automatically reprocess any claims paid at the lower rates in a timely manner. CMS will issue guidance about the collection of corrected co-insurance payments in the next few days.

More information on physician pay issues is available at http://www.cms.hhs.gov/PhysicianFeeSched/

Therapy Caps

The law also reinstated the therapy caps exceptions process as of July 1st. Therefore, medically necessary therapy services, in excess of the therapy caps, will continue to be paid by Medicare in accordance with the exceptions process. Claims submitted with the therapy cap exception modifier will be processed as soon as the payment rates have been activated. Claims submitted without the

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modifier, and rejected or denied, can be resubmitted with the modifier for reimbursement. To the extent possible, claims under the therapy cap limit, which were paid at the lower rate, will be reprocessed automatically. More information on therapy caps is available at http://www.cms.hhs.gov/TherapyServices/

DME

The Durable Medical Equipment Competitive Bidding Program, which affects only Medicare beneficiaries in traditional fee-for-service in 10 competitive bidding areas, has been delayed. Medicare beneficiaries may use **any** Medicare-approved supplier for Durable Medical Equipment. If a beneficiary changed suppliers when this new program started (July 1, 2008), they can either continue to use the new supplier or choose another supplier. The original DME payment rates in effect prior to July 1 are reinstated retroactively. All Medicare households in the 10 competitive bidding areas will be notified of this change directly in a letter from CMS within two weeks.

The DME Competitive Bidding areas are: (1) Charlotte-Gastonia-Concord, NC-SC, (2) Cincinnati-Middletown, OH-KY-IN, (3) Cleveland-Elyria-Mentor, OH, (4) Dallas-Fort Worth-Arlington, TX, (5) Kansas City, MO-KS, (6) Miami-Fort Lauderdale-Miami Beach, FL, (7) Orlando-Kissimmee, FL, (8) Pittsburgh, PA, (9) Riverside-San Bernardino-Ontario, CA, and (10) San Juan, PR. Information on payment rates and claims processing will be communicated to DME suppliers in the coming days.

More information on DME is available at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/

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