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PRESIDENT OBAMA SIGNS THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" INTO LAW, SEE PAGES 2 AND 3 FOR DETAILS

States Set to Receive Federal Matching Funds for EHR Incentive Programs

In another key step to further states' role in developing a robust U.S. health information technology (HIT) infrastructure, CMS announced that several states' Medicaid programs will receive federal matching funds for state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

EHRs will improve the quality of health care and make care more efficient. The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care. Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

The Recovery Act provides a 90 percent federal match for state planning activities to administer the incentive payments to Medicaid providers, to ensure their proper payments through audits, and to participate in statewide efforts to promote interoperability and meaningful use of EHR technology statewide and, eventually, across the nation.

The states receiving these funds will use them for planning activities that include conducting a comprehensive analysis to determine the current status of HIT activities in those states. As part of that process, states will gather information on issues such as existing barriers to their use of EHRs, provider eligibility for EHR incentive payments, and the creation of State Medicaid HIT Plans, which will define the states' vision for their long-term HIT use.

The list below shows the states that have received these funds and the amounts as of April 30, 2010:

AK	$900,000	NE	$894,000
AL	$269,000	NM	$405,000
AR	$815,000	NV	$1.05 mil
AZ	$2.89mil	NY	$5.91mil
CA	$2.48mil	OK	$587,000
CO	$798,000	OR	$3.53mil
FL	$1.69mil	PA	$1.42mil
GA	$3.17mil	PR	$1.80mil
IA	$1.16mil	SC	$1.48mil
ID	$142,000	TN	$2.7mil
IL	$2.18mil	TX	$3.86mil
KS	$1.70mil	UT	$396,000
KY	$2.60mil	VA	$1.66mil
ME	$1.40mil	VI	$232,000
MI	$1.52mil	VT	$294,000
MO	$1.53mil	WA	$967,000
MS	$1.47mil	WI	$1.37mil
MT	$239,000	WY	$596,000
NC	$2.29mil		

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Physician Fee Schedule Frozen Until May 31, 2010

On April 15, 2010, President Obama signed into law the "Continuing Extension Act of 2010." This law extends through May 31, 2010, the zero percent update to the Medicare physician fee schedule (MPFS) that was in effect for claims with dates of service January 1, 2010 through March 31, 2010. The law is retroactive to April 1, 2010. Consequently, effective immediately, claims with dates of service April 1, 2010 and later, which were being held by Medicare contractors, have been released for processing and payment. Please keep in mind that the statutory payment floors still apply and, therefore, clean electronic claims cannot be paid before 14 calendar days after the date they are received by Medicare contractors (29 calendar days for clean paper claims).

Given the uncertainty regarding MPFS claims with dates of service June 1, 2010, and later, please watch your listservs and your contractor's website for more information.

CMS Website News...New Address and New Look!

The Centers for Medicare & Medicaid Services (CMS) changed its provider website address from "www.cms.hhs.gov" to www.cms.gov. Existing bookmarks and links from other websites will continue to work following this address change.

Also, the beneficiary-focused website www.medicare.gov has a new look. Please visit the site at the above link and refer your Medicare beneficiary population to the new easy-to-navigate website.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Patient Protection and Affordable Care Act

New Timely Filing Requirements for Claims

Section 6404 of the PPACA amends the timely filing requirements to reduce the maximum time period for submission of all Medicare fee-for-service claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing requirements. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010. The new provision also permits the Secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Extension of Outpatient Hold-Harmless Provision

PPACA extends the outpatient hold-harmless provision, effective for dates of service on and after January 1, 2010, through December 31, 2010, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals, regardless of bed size.

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Extension of Ambulance Add-ons for Ambulance Services

PPACA Sections 3105 and 10311 impact certain ambulance payment provisions. It should be noted that PPACA Section 3105 establishes the implementation date as April 1, 2010. PPACA Section 10311 revises Section 3105 and changes the implementation date retroactive to January 1, 2010.

The PPACA extends the increases in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by 3 percent, and for covered ground ambulance transports which originated in urban areas by 2 percent retroactive to January 1, 2010, through December 31, 2010. The new law similarly extends the provision for air ambulance services provided in any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for services furnished on December 31, 2006. Finally, the PPACA extends retroactive to January 1, 2010, and through December 31, 2010, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which established the super rural bonus.

CMS is working to expeditiously implement these three ambulance provisions of the PPACA. Be on the alert for more information about these ambulance provisions and their impact on your past and future claims.

Home Health Service in Rural Areas to Receive Add-on Payment

Section 3131(c) of PPACA creates a 3 percent add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through December 31, 2016. Similar to temporary rural add-on provisions in the past, claims that report a rural state code (code beginning with 999) as the Core Based Statistical Area (CBSA) code for the beneficiary's residence will receive the additional 3 percent payment. The CBSA code is reported associated with value code '61' on home health claims. CMS is working to expeditiously implement the home health rural add-on provision.

Reasonable Cost Payments for Lab Tests in Some Rural Hospitals

Section 3122 of the PPACA re-institutes reasonable cost payment for clinical lab tests performed 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 July 1, 2010, through June 30, 2011. This could affect services performed as late as June 30, 2012.

If you are a hospital that qualifies under Section 3122, you do not need to take any action. You will receive reasonable cost reimbursement for an entire year, starting with your cost reporting period beginning on or after July 1, 2010.

The Patient Protection and Affordable Care Act

Click here to read the entire text of the legislation signed into law by President Obama on March 23, 2010.

The Patient Protection and Affordable Care Act

Billing for the Technical Component of Pathology Services

Section 3104 extends the moratorium that allows independent laboratories to bill for the technical component (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 PPACA 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.

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PPACA Provisions Impacting Institutional Medicare Providers

PPACA Sections 3401 and 3137 contain a number of provisions affecting institutional providers. The 3401 sections discussed below are effective April 1, 2010, while Section 3137(a) has October 1, 2009, and April 1, 2010 effective dates. CMS is working to expeditiously implement these important provisions of PPACA. Providers will begin seeing payments under these provision in the late April/early May time frame.

Inpatient Acute Hospitals (Section 3401(a))

Section 3401(a) of PPACA imposes a 0.25 percentage point reduction to the Inpatient Prospective Payment System (IPPS) hospital's market basket for fiscal year (FY) 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect IPPS rates for discharges occurring on or after April 1, 2010, through September 30, 2010.

Long-Term Care Hospitals (Section 3401(c))

Section 3401(c) of PPACA imposes a 0.25 percentage point reduction to the Long Term Care Hospital's (LTCH) market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect LTCH rates for discharges occurring on or after April 1, 2010, through September 30, 2010.

Inpatient Rehabilitation Facilities (Section 3401(d))

Section 3401(d) of PPACA imposes a 0.25 percentage point reduction to the Inpatient Rehabilitation Facility market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction is also resulting in changes to the standard payment conversion factor, payment rates, and the outlier threshold amount.

Extension of Section 508 Hospital Reclassifications (Sections 3137(a) and 10317)

Sections 3137(a) and 10317 extend section 508 and special exception hospital reclassifications from October 1, 2009, through September 30, 2010. Effective April 1, 2010, section 3137(a) and 10317 also require 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 sections 3137(a) and 10317 will be assigned an individual special wage index effective April 1, 2010. If the section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, is lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, the hospital will be paid an additional amount that reflects the difference between the wage indices. The provision applies to both inpatient and outpatient hospital payments.

Exceptions Process for Therapy Caps Extended Through 2010

Section 3103 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.

The 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 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.

Physician Supervision Requirements in CAHs Relaxed

In the 2010 hospital outpatient prospective payment system and ambulatory surgical center rule (CMS-1413-FC), CMS detailed physician supervision requirements for outpatient therapeutic services by hospitals and critical access hospitals (CAHs). The physician supervision requirements for outpatient therapeutic services (excluding physical therapy, occupational therapy, and speech pathology, as well as programs for cardiac rehab, intensive cardiac rehab, and pulmonary rehab services) prompted some concern among CAHs, many of which do not have physicians or mid-level practitioners onsite 24 hours a day, seven days a week.

Accordingly, in a March 15, 2010, posting on the CAH center of the CMS website, CMS indicated it will instruct all of its Medicare contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in CAHs from January 1 through December 31, 2010. CMS plans to revisit the issue of supervision for therapeutic services provided to hospital outpatients in CAHs through the annual rulemaking cycle in 2011. CMS continues to expect CAHs to fulfill all other Medicare program requirements when providing services to Medicare beneficiaries and when billing Medicare for those services. CMS continues to emphasize quality and safety for services provided to all patients in CAHs.

Philly RO Hosts SHIP Directors

On April 7 and 8, 2010, Region III hosted a regional State Health Insurance Program (SHIP) Directors Meeting in the Philadelphia Regional Office. The SHIP Directors from all six of the region's SHIP programs attended. The purpose of the meeting was to discuss SHIP activities and experiences over the past year and planning for the coming grant year. Issues concerning the SHIP grants were discussed and the terms and conditions for this year's grant were reviewed.

Throughout the meeting, information was exchanged regarding key program activities including partnership development and maintenance, quality assurance activities, and reaching diverse populations. Breakout sessions were held where more specific discussions about the political landscape, program infrastructure and outreach focus in each state took place. The RO looks forward to building upon the existing spirit of cooperation and collaboration among the SHIP Directors in our region.

Medicare Expands Coverage for Treating Facial Lipodystrophy Syndrome in People Living with HIV

On March 23, 2010, CMS announced its decision to cover facial injections for Medicare beneficiaries who experience symptoms of depression due to the stigmatizing appearance of severely hollowed cheeks resulting from the drug treatment for Human Immunodeficiency Virus (HIV). This decision is effective immediately.

Facial lipodystrophy (LDS) is a localized loss of fat from the face, causing an excessively thin appearance in the cheeks. In some cases, facial LDS may be a side effect of certain kinds of medications (antiretroviral therapies) that individuals receive as part of an HIV infection treatment regimen.

The facial LDS can leave people living with HIV looking gaunt and seriously ill, which may stigmatize them as part of their HIV-infection status. Individuals who take these medications and experience facial LDS side effects may suffer psychological effects related to a negative self-image. These effects may lead people living with HIV to discontinue their antiretroviral therapies. The new decision allows for treatment of individuals who experience symptoms of depression due to the appearance changes from facial LDS.

The injections included in this coverage decision are "fillers" that have been approved by the U.S. Food & Drug Administration to be injected under the skin in the face to help fill out its appearance specifically for treatment of facial LDS. Data show that these injections can improve patient self-image, relieve symptoms of depression, and may lead to improved compliance with anti-HIV treatment.

"Today's decision marks an important milestone in Medicare's coverage for HIV-infection therapies," said Barry M. Straube, M.D., CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards & Quality. "Helping people living with HIV improve their self-image and comply with anti-HIV treatment can lead to better quality of life and, ultimately, improve the quality of care that beneficiaries receive."

The final decision is posted on the CMS Website.
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CMS Awards Banking Contracts to U.S. Bank and JP Morgan Chase

CMS recently awarded new banking contracts to U.S. Bank and JP Morgan Chase. Medicare providers do not have to take any action. However, providers should be aware that the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

The following Medicare claims processing contractors will remain with JP Morgan Chase: Cahaba Government Benefit Administrators, Pinnacle Business Solutions, First Coast Service Options, Palmetto GBA (except for A/B MAC Jurisdiction 1), and Wisconsin Physician Service. Providers who bill to these contractors will not experience any change.

The following Medicare claims processing contractors will transition to JP Morgan Chase on June 1, 2010: Palmetto A/B MAC Jurisdiction 1 and Trailblazer.

The following contractors will transition to U.S. Bank on June 1, 2010, CIGNA Government Services, Highmark Medicare Services, National Government Services, NHIC and Noridian Administrative Services.