Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and NCPDP, version D.0, standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses and billing services to schedule testing with their local MAC as soon as possible. Medicare also encourages you to stay current on 5010/D.0 news and helpful tools by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html on its website. Test early, Test often!

MLN Matters® Number: MM7300 Revised
Related Change Request (CR) #:7300
Related CR Release Date: January 7, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R833OTN
Implementation Date: No later than January 14, 2011

Emergency Update to the CY 2011 Medicare Physician Fee Schedule Database

Note: This article was updated on September 4, 2012, to reflect current Web addresses. Previously, this article was revised on March 20, 2011, to reflect a new CR. That CR corrected the implementation date. The transmittal number, release date and web address of the CR was also changed. All other information remains the same.

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS Final Rule. This CR also reinstates three Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background

Payment files were issued based upon the Calendar Year (CY) 2011 MPFS Final Rule, issued on November 2, 2010, and published in the "Federal Register" on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS Final Rule Correction Notice, issued in December 30, 2010, (http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1) to be published in the "Federal Register" on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare Physician Fee Schedule Revisions and Updates

Some physician work, Practice Expense (PE) and Malpractice (MP) Relative Value Units (RVUs) published in the CY 2011 MPFS Final Rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS Final Rule Correction Notice public use data files located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.htmlon the Centers for Medicare & Medicaid Services (CMS) website. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R833OTN.pdf on the CMS website.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS Final Rule has been revised. This CF will be published in the CY 2011 MPFS Final Rule Correction Notice.Legislative changes subsequent to issuance of the CY 2011 MPFS Final Rule have led to the further revision of the values published in the CY 2011 MPFS Final Rule Correction Notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

1. Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee

schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS Final Rule policy of a 25 percent Multiple Procedure Payment Reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Secrutiy Act. This change is detailed in recently released CR7050. CMS published MLN Matters® article 7050, related to CR 7050, which may be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf on the CMS website. This Act also made the therapy MPPR not budget neutral under the Physician Fee Schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

2. Medicare and Medicaid Extenders Act (MMEA) of 2010

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare Fee-For-Service program policies. A summary of MPFS-related provisions follows.

- Physician Payment Update

Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is $33.9764.

The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 Conversion Factor		**$36.8729**
MMEA "Zero Percent Update"	**0.0 percent (1.000)**	
CY 2011 RVU Budget Neutrality Adjustment	**0.4 percent (1.0043)**	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	**-8.3 percent (0.9175)**	
CY 2011 Conversion Factor		**$33.9764**

The revised CY 2011 MPFS payment files will reflect this conversion factor.

- Extension of Medicare Physician Work Geographic Adjustment Floor

Current law requires the 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 3102 of the Affordable Care Act extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished though December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs can also be found in the attachment to CR 7300 as noted previously.

- Extension of MPFS Mental Health Add-On

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy can also be found in the attachment to CR 7300.

- Extension of Exceptions Process for Medicare Therapy Caps

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. 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, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 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 That Allowed Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 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 January 1, 2011, through December 31, 2011.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMPOS) Updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Abduct restrainer canvas &web);
- L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Acromio/clavicular canvas & web); and
- L3675 SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, and PREFABRICATED INCLUDES FITTING AND ADJUSTMENT (SD: Canvas vest SO).

These three "L" codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three "L" codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	$85.06	$118.57	$145.25
AR	D	PO	$85.06	$97.17	$145.24
AZ	D	PO	$100.69	$124.79	$141.00
CA	D	PO	$100.69	$124.79	$141.00
CO	D	PO	$111.02	$93.60	$146.04
CT	D	PO	$113.42	$93.60	$141.00
DC	D	PO	$85.06	$112.42	$141.00
DE	D	PO	$85.06	$112.42	$141.00
FL	D	PO	$85.06	$118.57	$145.25
GA	D	PO	$85.06	$118.57	$145.25
IA	D	PO	$106.53	$124.79	$143.74
ID	D	PO	$85.06	$97.28	$141.00
IL	D	PO	$85.06	$93.60	$144.48

	JURIS	CATG	L3660	L3670	L3675
IN	D	PO	$85.06	$93.60	$144.48
KS	D	PO	$106.53	$124.79	$143.74
KY	D	PO	$85.06	$118.57	$145.25
LA	D	PO	$85.06	$97.17	$145.24
MA	D	PO	$113.42	$93.60	$141.00
MD	D	PO	$85.06	$112.42	$141.00
ME	D	PO	$113.42	$93.60	$141.00
MI	D	PO	$85.06	$93.60	$144.48
MN	D	PO	$85.06	$93.60	$144.48
MO	D	PO	$106.53	$124.79	$143.74
MS	D	PO	$85.06	$118.57	$145.25
MT	D	PO	$111.02	$93.60	$146.04
NC	D	PO	$85.06	$118.57	$145.25
ND	D	PO	$111.02	$93.60	$146.04
NE	D	PO	$106.53	$124.79	$143.74
NH	D	PO	$113.42	$93.60	$141.00
NJ	D	PO	$87.06	$110.96	$141.00
NM	D	PO	$85.06	$97.17	$145.24
NV	D	PO	$100.69	$124.79	$141.00
NY	D	PO	$87.06	$110.96	$141.00
OH	D	PO	$85.06	$93.60	$144.48
OK	D	PO	$85.06	$97.17	$145.24
OR	D	PO	$85.06	$97.28	$141.00
PA	D	PO	$85.06	$112.42	$141.00
RI	D	PO	$113.42	$93.60	$141.00
SC	D	PO	$85.06	$118.57	$145.25
SD	D	PO	$111.02	$93.60	$146.04
TN	D	PO	$85.06	$118.57	$145.25
TX	D	PO	$85.06	$97.17	$145.24

	JURIS	CATG	L3660	L3670	L3675
UT	D	PO	$111.02	$93.60	$146.04
VA	D	PO	$85.06	$112.42	$141.00
VT	D	PO	$113.42	$93.60	$141.00
WA	D	PO	$85.06	$97.28	$141.00
WI	D	PO	$85.06	$93.60	$144.48
WV	D	PO	$85.06	$112.42	$141.00
WY	D	PO	$111.02	$93.60	$146.04
AK	D	PO	$100.22	$148.35	$141.00
HI	D	PO	$107.12	$158.62	$141.00
PR	D	PO	$82.83	$105.08	$169.21
VI	D	PO	$87.06	$110.96	$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html on the CMS website.

Additional Information

The official instruction, CR7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R833OTN.pdf on the CMS website.

If you have any questions, please contact your carrier, RHHI, FI, A/B MAC, or DME 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 on the CMS website.