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Provisions in the Affordable Care Act of 2010 (ACA)

Note: This article was updated on August 21, 2012, to reflect current Web addresses. All other information remains the same.

Provider Types Affected

All providers that bill Medicare for services provided to Medicare beneficiaries

Provider Action Needed

Providers should be aware of these provisions and frequently visit the CMS website for updates on their implementation.

Background

The ACA, signed into law on March 23, 2010, includes a number of provisions designed to help physicians. Some of those changes are reflected in the Notice of Proposed Rule Making (NPRM), CMS-1503-P. (CMS is accepting comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010, that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.)

Provisions in the ACA

Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

The ACA extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (also known as the "Welcome to Medicare Visit"). Medicare will cover annual wellness visits where beneficiaries receive personalized prevention plan services.

Elimination of Deductible and Coinsurance For Most Preventive Services

Effective January 1, 2011, the ACA waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit. The ACA also waives the Part B deductible for colorectal cancer screening tests that become diagnostic.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The ACA authorizes CMS to make incentive payments equal to 10 percent of the provider's allowed charges for primary care services furnished by certain physician and non-physician specialties that are designated as primary care practitioners. This provision begins with calendar year 2011. Primary care practitioners are physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services.

Incentive Payments for General Surgery Services in Rural Areas

The ACA calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule – in Health Professional Shortage Areas (HPSAs) between January 1, 2011, and December 31, 2016. To be eligible for the incentive payment, you must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the payment for the surgical services furnished by the general surgeon occurring in a zip code that is located in an area designated as a primary care HPSA.

Revisions to the Practice Expense Geographic Adjustment *(PE GPCI) to Assist Rural Providers*

The ACA limits recognition of local differences in employee wages and office rents in the PE GPCIs for calendar years 2010 and 2011 as compared to the national average. Localities are held harmless to any decrease in 2010 and 2011 in their PE GPCIs that would result from this alternative methodology. The new law also establishes a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota), raising the rural area payment for physicians' services to be no less than the national average.

Physician Self-Referral for Certain Imaging Services

The ACA amends the in-office ancillary services exception to the self-referral law as applied to advanced imaging services, such as magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides.

Misvalued Codes Under the Physician Fee Schedule

The ACA requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. Building on this authority, the new rule identifies additional categories of services that may be misvalued, including codes with low work relative value units (RVUs) commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.

Modification of Equipment Utilization Factor for Advanced Imaging Services

The ACA adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment to more consistently reflect the typical actual use of the equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the ACA increases the established multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months

The ACA changes the time frame during which claims may be submitted for physicians' services to one year from the date of service, beginning with services furnished on or after January 1, 2010. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months and aims to improve prompt payment and improve program integrity.

Additional Information

If you have questions, please contact your Medicare contractor 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.

You can find information (as of June 11, 2010) on CMS published regulations, CMS policy instructions, key implementation dates, and other accomplishments that relate to ACA at http://www.cms.gov/Regulations-and-Guidance/Legislation/LegislativeUpdate/downloads/PPACA.pdf on the CMS website.

Many of the new provisions outlined in the ACA are reflected in the proposed Medicare Physician Fee Schedule regulation, which can be found at http://www.federalregister.gov/inspection.aspx on the Internet.