Medicare payment adjustments made for 2010

Medicare contractors received new files on May 10 that will make significant payment changes for some services and geographic regions. These include certain corrections in the final 2010 physician fee schedule rule, as well as implementation of several provisions in the Patient Protection and Affordable Health Care Act enacted earlier this year.

All the changes are retroactive to Jan. 1, and all contractors must implement them by May 31. However, the new rates contained in the files do not reflect the 21.3 percent conversion factor cut that is scheduled to take effect on June 1. If Congress does not act this month, the new payment files could have a very short shelf life.

The six Patient Protection and Affordable Health Care Act provisions implemented in the new file would:

- Extend the 1.0 work geographic practice cost index (GPCI) floor that expired on Dec. 31, 2009
- Raise practice expense GPCIs in low-cost areas by reflecting only half the geographic wage and rent cost differences in their calculation
- Extend the current 5 percent add-on payment for specified psychiatry services
- Increase payments for bone density tests
- Extend the therapy cap exception that expired on April 1
- Extend a provision allowing independent labs to bill for the technical component of physician pathology services

The corrections to the final 2010 rule involve a number of cardiology codes that were undervalued by the Centers for Medicare & Medicaid Services (CMS) due to errors in the calculation of the practice expenses associated with myocardial perfusion imaging and professional liability insurance expenses for invasive cardiology procedures.

The AMA had pressed CMS to make these corrections, which will lead to payment increases of 40 percent or more for some codes. These changes will be implemented in a budget neutral manner and lead to very minor payment rate changes for other services.

Once the contractors have the new files in place, all claims going forward will be processed at the revised rates. However, CMS is still discussing the best way to handle the millions of 2010 claims that were paid at the rates in effect before these corrections and health reform changes were

made. With many different changes occurring at the same time, the situation is complicated and the process for adjusting previously paid claims may vary by service, geographic area or other factors.

Additional information will be made available once CMS has determined the best way to proceed. Until then, physicians may want to hold off on resubmitting previously processed claims affected by the payment changes. These resubmissions will likely be denied as duplicate claims. The AMA will continue to monitor the situation and work with CMS to make this process as smooth as possible.