



## Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018

MLN Matters Number: MM10531

Related Change Request (CR) Number: 10531

Related CR Release Date: March 20, 2018

Effective Date: January 1, 2018

Related CR Transmittal Number: R2047OTN

Implementation Date: April 2, 2018 – date to begin reprocessing claims

### PROVIDER TYPE AFFECTED

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This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### WHAT YOU NEED TO KNOW

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Change Request (CR) 10531 provides direction to MACs to reprocess claims related to several provisions of the Bipartisan Budget Act of 2018, referred to as Medicare Extenders. Specifically, the CR provides guidance to MACs regarding Medicare Fee For Service (FFS) claims reprocessing requirements and timeframes. Make sure your billing staffs are aware of these changes.

### BACKGROUND

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On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 which contains a number of provisions that extend certain Medicare FFS policies, including Ambulance add-on payment provisions, the Work Government Practice Cost Index (GPCI) Floor, and the three percent Home Health (HH) Rural Add-on Payment. In addition, the Act permanently repeals the outpatient therapy caps beginning on January 1, 2018, while retaining the requirement to submit the KX modifier for services in excess of the prior cap amounts. Due to the retroactive effective dates of these provisions, your MAC will reprocess various Medicare FFS claims impacted by this legislation.

Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 50208 of the Social Security Act, provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Social Security Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2019. The statute waives budget neutrality related to this provision.

As a result of the Work GPCI floor changes, certain Federally Qualified Health Center (FQHC) Geographic Adjustment Factors (GAFs) will change, which may result in a change to some FQHC payments. For Inpatient Prospective Payment System (IPPS) hospitals, temporary changes to the low-volume hospital payment adjustment and the Medicare-Dependent Hospital (MDH) program have been extended. In addition, for the Long-Term Care Hospital Prospective Payment (LTCH PPS), the blended payment rate for site neutral payment rate cases is extended for certain LTCH hospital discharges. Separate instructions addressing these payment updates are forthcoming.

On January 25, 2018, the Centers for Medicare & Medicaid Services (CMS) instructed MACs to release for processing held therapy claims with the KX modifier with dates of receipt January 1-10, 2018. CMS also instructed the MACs to institute a “rolling hold” for all new therapy claims with the KX modifier. On February 12, 2018, CMS provided direction regarding new Medicare Physician Fee Schedule (MPFS) files and abstract files due to the extension of the Work GPCI Floor, as well as a revised 2018 Ambulance Fee Schedule (AFS) file. CMS also instructed the MACs to ensure legislative effective indicators were set correctly in Medicare systems to apply therapy policies. Given that legislation has been enacted, CMS is instructing the MACs to reprocess effected claims that were processed using the previous MPFS files.

As stipulated in Section 421(a) of the MMA, the 3 percent rural add-on is applied to the national, standardized episode rate, national per-visit payment rates, Low-Utilization Payment Adjustment (LUPA) add-on payments, and the Non-Routine Supplies (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2019. Refer to Tables 1 through 4 of the attachment to CR10531 for the Calendar Year (CY) 2018 rural payment rates. CR10531 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf>.

Section 1848(e)(1)(E) of the Social Security Act stipulates that after calculating the work geographic index for purposes of MPFS payment for services furnished, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. This provision expired on December 31, 2017, and the locality-specific anesthesia conversion factors for CY 2018 were calculated without this work geographic index floor of 1.00 in place.

Section 50201 of the Bipartisan Budget Act of 2018 restored the work geographic index floor of 1.00 and retroactively dated this restoration to January 1, 2018. In accordance with the law, CMS has updated the locality-specific anesthesia conversion factors for CY 2018 to include the work geographic index floor of 1.00. These updated locality-specific anesthesia conversion factors also have a retroactive effective date of January 1, 2018.

CR10531 reminds the MACs to be aware that Section 1848(b)(4) of the Social Security Act limits MPFS payment for the technical portion of most imaging procedures to the amount paid under the Outpatient Prospective Payment System (OPPS) system. This policy applies to the technical component (and technical portion of global payment) of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. The MPFS payment rates

for some of these services does not reflect the most recent updates to the OPSS rates that were updated in December of 2017. CMS corrected these rates in new MPFS files and informed the MACs of the corrections on February 12, 2018. These MPFS files also contain the updates for the GPCI. This correction is unrelated to the passage of this Act, but CMS is taking the opportunity to address this issue now since new MPFS files are required as a result of the Act.

The instructions to the MACs to reprocess claims contain the following specifics:

- The MACs will reprocess therapy claims with the KX modifier containing Dates of Service in Calendar Year 2018, which were denied prior to the implementation of the updated legislative effective dates issued on January 25, 2018. NOTE: For institutional claims, these claims will include revenue codes 042x, 043x, or 044x and modifiers GN, GO, or GP.
- The MACs will reprocess therapy claims with the KX modifier which were denied due to an invalid date provided by CMS on February 12, 2018.
- The MACs will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to the attention of your MAC.
- The MACs reprocess MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018 – in CR10531.
- The MACs will reprocess 2018 MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018 which cannot be automatically reprocessed only if you bring such claims to your MAC's attention. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018.
- The MACs will reprocess ground AFS claims using the revised 2018 AFS file for Dates of Service in Calendar Year 2018.
- The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- MACs will reprocess home health claims with the following criteria:
  - Type of Bill 32X
  - Claim "Through" dates on or after January 1, 2018
  - Value code 61 amounts in the range 999xx
  - Receipt dates prior to the installation of the revised home health Pricer, which reflects the extension of the 3% rural add-on for CY 2018.
- MACs will automatically reprocess claims impacted by the OPSS cap for Dates of Service in Calendar Year 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- The MACs will automatically reprocess anesthesia claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.

- MACs shall ensure all reprocessing actions have been initiated within 6 months of the issuance of CR10531:
  - For therapy and MPFS adjustments
  - For ground ambulance service claims with a date of service on or after 1/1/2018
  - For OPFS adjustments
  - For anesthesia adjustments
- MACs shall ensure all reprocessing actions have been initiated within 6 months of the implementation date of the Pricer for HH rural add-on adjustments.

## ADDITIONAL INFORMATION

The official instruction, CR10531, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

## DOCUMENT HISTORY

Date of Change	Description
March 26, 2018	Initial article released.

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