CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1058	**Date: March 14, 2012**
	Change Request 7767

SUBJECT: Emergency March 2012 Update (MCTRJCA) to the CY 2012 Medicare Physician Fee Schedule (MPFS) Database

I. SUMMARY OF CHANGES: On Wednesday, February 22, 2012, President Obama signed into law the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), extending the TPTCCA zero percent update to the end of the calendar year, December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service policies. This One-Time Notification addresses the specific changes to the payment files resulting from the MCTRJCA effective March 1, 2012. Included in the MCTRJCA are extensions to (1) the moratorium that allows certain pathologists and independent laboratories to bill for the Technical Component (TC) of physician pathology services furnished to hospital patients through June 30, 2012, (2) the exceptions process for Medicare Therapy Caps, and (3) the continuation of the Medicare Physician Work Geographic Adjustment Floor. Further, the MCTRJCA discontinues the (a) Minimum Payment for Bone Mass Measurement, and (b) Physician Fee Schedule Mental Health 5 percent Add-On Payments.

EFFECTIVE DATE: March 1, 2012
IMPLEMENTATION DATE: March 15, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1058	Date: March 14, 2012	Change Request: 7767

SUBJECT: Emergency March 2012 Update (MCTRJCA) to the CY 2012 Medicare Physician Fee Schedule (MPFS) Database

Effective Date: March 1, 2012

Implementation Date: March 15, 2012

I. GENERAL INFORMATION

A. Background: Payment files were issued to contractors based upon the CY 2012 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on November 28, 2011, as modified by the Final Rule Correction Notice, published in the Federal Register on January 4, 2012, and relevant statutory changes applicable January 1, 2012. On December 23, 2011, the ***Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)*** became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the Medicare Physician Fee Schedule from January 1, 2012 until February 29, 2012. On Wednesday, February 22, 2012, President Obama signed into law the ***Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA),*** extending the TPTCCA zero percent update to the end of the calendar year, December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service policies. This One-Time Notification addresses the specific changes to the payment files resulting from the MCTRJCA effective March 1, 2012.

B. Policy:
Medicare Physician Fee Schedule Revisions and Updates
Included in the MCTRJCA are extensions to (1) the moratorium that allows certain pathologists and independent laboratories to bill for the Technical Component (TC) of physician pathology services furnished to hospital patients through June 30, 2012, (2) the exceptions process for Medicare Therapy Caps, and (3) the continuation of the Medicare Physician Work Geographic Adjustment Floor. Further, the MCTRJCA discontinues the (a) Minimum Payment for Bone Mass Measurement, and (b) Physician Fee Schedule Mental Health 5 percent Add-On Payments.

(1) Under previous law, including, most recently, Section 305 of the *Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)*, a statutory moratorium allowed pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B MAC for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire on February 29, 2012. However, Section 3006 of the MCTRJCA extends the moratorium through June 30, 2012. Therefore, pathologists and independent laboratories that had an arrangement with a hospital that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for the TC to a carrier may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with Dates of Service (DOS) through June 30, 2012.

For background and policy information regarding payment to certain pathologists and independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to Change

Request (CR) 5347, Transmittal 1221, issued on April 18, 2007, and CR 5943, Transmittal 1440, issued on February 7, 2008.

(2) Section 3005 of the MCTRJCA extends the exceptions process for Medicare therapy caps, effective for dates of service on and after March 1, 2012, through December 31, 2012. Therapy providers may continue to request an exception to the cap by submitting therapy claims with KX modifiers for services during this period. The KX modifier should continue to be used by providers when they know that the therapy cap has already been met, and documentation exists to substantiate that the therapy services are medically necessary. Contractors shall continue to process claims containing the KX modifier.

Section 3005 also requires additional changes to outpatient therapy claims processing beginning October 1, 2012. These changes include (1) the temporary inclusion of therapies provided in outpatient hospital settings to the therapy cap and the exception process, (2) an additional threshold beyond which therapy services require manual medical review, and (3) the reporting of the National Provider Identifier of the physician that reviews the therapy plan of care. The Centers for Medicare & Medicaid Services will issue a separate Change Request detailing the requirements for these October 2012 changes.

(3) The MCTRJCA extends the TPTCCA continuation of the 1.0 floor on the physician work geographic practice cost index, through to the end of the calendar year, December 31, 2012. The March 1, 2012 MPFS database (MPFSDB) will reflect this extension.

(a) The MCTRJCA discontinues the Minimum Payment for Bone Mass Measurement, dual-energy x-ray absorptiometry (DXA) services described CPT codes 77080 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)) and 77082 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment), effective March 1, 2012. The Bone Mass Measurement payments will be calculated based on a standard PFS methodology for the March 1, 2012 update of the Physician Fee Schedule.

(b) The MCTRJCA discontinues the 5 percent Mental Health Add-On Payments effective March 1, 2012. The revised MPFS payment files no longer reflect this 5 percent add-on for certain mental health services.

A new MPFS database (MPFSDB) has been created and made available, to include all the MPFS policy and payment revisions described above, as well as all relevant statutory changes applicable to date. The March 1, 2012 MPFS payment file names are as follows:

Physician Fee Schedule: MU00.@BF12390.MPFS.CY12.RVM.C00000.V0301

Purchased Diagnostic File: MU00.@BF12390.MPFS.CY12.PURDIAG.V0301

FI Abstract Files:
MU00.@BF12390.MPFS.CY12.ABSTR.V0310.FI
MU00.@BF12390.MPFS.CY12.MAMMO.V0310.FI
MU00.@BF12390.MPFS.CY12.SNF.V0310.FI
MU00.@BF12390.MPFS.CY12.SUPL.V0310.FI
MU00.@BF12390.MPFS.CY12.V0310.RHHI
MU00.@BF12390.MPFS.CY12.PAYIND.V0310

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7767.1	Medicare contractors shall retrieve the revised payment files, as identified in this CR, from the CMS Mainframe Telecommunications System. Contractors will be notified via email when these files are available for retrieval.	X		X	X	X	X				
7767.2	Medicare contractors shall send notification of successful receipt via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (e.g., Medicare contractor carrier/fiscal intermediary name and number).	X		X	X	X					
7767.3	Medicare contractors are authorized, if necessary, to hold claims for up to ten business days to have tested and loaded the revised files into production, and shall use these files to begin to pay claims by March 1, 2012 but no later than March 15, 2012.	X		X	X	X					
7767.4	Contractors shall disclose the new MPFS fees on their Web sites as soon as possible, but no later than March 15, 2012. In addition, contractors shall notify providers via their Web site as to when the new fees are effective.	X			X						
7767.5	Medicare contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X		X	X	X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7767.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters"	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Larry Chan, larry.chan@cms.hhs.gov, (410) 786-6864; Charles Campbell, charles.campbell@cms.hhs.gov, (410) 786-7209; Sara Vitolo, sara.vitolo@cms.hhs.gov, (410) 786-5714.

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable; Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs)*****:**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.