HFMA WISCONSIN CHAPTER - BOARD OF DIRECTORS' MEETING
Medicare Issues Committee Report

Recent Developments – Since November 13, 2009

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Reimbursement and Payment Developments

Congress Delays Medicare Physician Fee Schedule Fee Cut

Congress passed the Department of Defense Appropriations Act for fiscal year 2010 in late December 2009, which, in part delayed a 21.2 percent fee cut to the Medicare Physician Fee Schedule until March 1, 2010. The Centers for Medicare and Medicaid Services ("CMS") implemented the fee cut in the Medicare Physician Fee Schedule Final Rule for calendar year 2010, when it finalized an update of -21.1 percent, as required by the sustainable growth rate formula. As a result of the Congressional delay, Medicare payment rates to physicians will remain at 2009 levels through Feb. 28, 2010.

A copy of the Department of Defense Appropriations Act may be accessed at: http://thomas.loc.gov/cgi-bin/query/D?c111:8:./temp/~c111mX3vj5.

Fraud and Abuse Developments

No Change in Stark Non-Monetary Compensation, Medical Staff Incidental Benefit Amounts for CY 2010

CMS recently updated the compensation limits for the non-monetary compensation and medical staff incidental benefits exceptions under the federal physician self-referral law, also known as the "Stark" law. These amounts are adjusted each year in line with the Consumer Price Index - Urban All Item ("CPI-U").

According to CMS, the CPI-U decreased 1.3 percent for the period ending September 30, 2009. For this reason, the dollar amount limits applicable to these two exceptions are unchanged from the amounts for CY 2009. Specifically, as of January 1, 2010, the non-monetary compensation limit is $355 dollars per year, while the medical staff incidental benefit limit is less than $30 dollars per occurrence of the benefit. Notably, all other requirements of the Stark law's exception for non-monetary compensation and medical staff incidental benefits still must be met.

Information regarding the CPI-U updates is available at http://www.cms.hhs.gov/PhysicianSelfReferral/10_CPI-U_Updates.asp.

CMS Announces Changes to Medical Record Request Limits for RAC DRG Validation Audits

Responding to industry concerns over the prior method of calculating limits on medical record requests for Recovery Audit Contractor ("RAC") audits, CMS announced on December 1, 2009 that it has decided to modify the limits for FY 2010 for RAC DRG validation audits. The new limits will be set annually, on a per tax ID, per campus basis. Previously, the limits were tied to NPI numbers which would have negatively impacted the many providers with multiple NPIs.

Under the new policy, medical record request limits will be based on the provider's tax ID number, and the "campus" will be defined as a provider's physical locations that share the first three digits of a zip code. For example, a provider with two locations in zip codes 12345 and 12356 would constitute a single campus and would have a single documentation limit; if the provider's two locations were in zip codes 12345 and 12456, each location would have its own documentation limit.

The limits for FY 2010 will be set at 1% of all claims submitted for the previous calendar year (2008) divided into 8 periods of 45 days. The limit will apply to all claim types, including professional services. For example, the documentation limit for a provider that billed 200,000 claims in 2008 would be 250 records per 45 days (200,000*.01)/8=250. CMS explained that through March 2010, the agency will continue to set a limit of 200 requests per 45 days for all provider types. From April through September 2010, the cap will rise to 300 requests per 45 days for providers that bill in excess of 100,000 claims per tax ID. In the above example, then, the provider's limit would be 200 every 45 days through March 2010; the limit would rise to 250 records every 45 days, beginning in April 2010.

The RACs may request permission to exceed the cap after the first six months of the fiscal year. Approval will be considered on a case-by-case basis, and if approved, the provider will be notified of the expanded limits before receiving additional record requests.

Miscellaneous Developments

CMS and ONC Issue Regulations Proposing Definition of Meaningful Use and Setting Standards

CMS and the Office of the National Coordinator for Health Information Technology ("ONC") issued proposed regulations on Thursday, December 30, 2009 aimed at further implementing electronic health record ("EHR") incentives under the American Recovery and Reinvestment Act of 2009 ("ARRA").

The proposed rule issued by CMS addresses eligibility requirements in order to qualify for incentive payments under Medicare and Medicaid, including what constitutes meaningful use, and how to calculate the incentive payment amounts. The CMS proposed rules are found at 42 C.F.R. Parts 412, 413, 422 and 495 and CMS is seeking comment on these rules within 60 days. ONC issued a closely related interim final rule ("IFR") to specify a set of standards, implementation specifications and certification criteria for EHRs for the federally funded

programs. The ONC interim final rule is found at 45 C.F.R. Parts 170 (Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology) which sets forth standards required for certified EHRs to support meaningful use. The interim final rule is effective 30 days after publication in the Federal Register. ONC is also seeking comments within 60 days after publication in the Federal Register. A third set of regulations is expected from ONC to be used in conjunction with these two sets of regulations.

A copy of the proposed rule by CMS can be accessed at: http://www.cms.hhs.gov/Recovery/11_HealthIT.asp. Fact Sheets prepared by CMS for the proposed rule can be accessed at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

ONC's interim final rule may be viewed at http://healthit.hhs.gov/portal/server.pt?open=512&objID=1153&mode=2.