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M E M O R A N D U M

TO: RHCF and Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: July 2, 2008

SUBJECT: **Important Update on Therapy Caps and Physician Payments**

ROUTE TO: Administrator, CFO

ABSTRACT: Update on Medicare therapy caps and physician reimbursement.

Introduction

In December of 2007, Congress passed the *Medicare, Medicaid, and SCHIP Extension Act of 2007* (the "ACT"), which included provisions to override the then proposed 10.1 percent reduction in the Medicare Physician Fee Schedule (MPFS) and extend the exceptions process for the financial limitation on outpatient therapy services (the "therapy caps"). Both of these provisions, however, expired as of June 30, 2008.

NYAHSA is still hopeful that Congress will eventually act to correct the current situation. However, in the meantime, providers need to determine how best to manage their claims submissions.

Therapy Caps

The current outpatient therapy caps for calendar year 2008 are $1,810 per beneficiary for occupational therapy and $1,810 per beneficiary for physical therapy and speech language pathology combined. For the latest information on the therapy caps, please refer to the Centers for Medicare and Medicaid Services' (CMS) Medlearn Matters article # 5871.

Because Congress has never authorized the therapy caps exceptions process for more than limited time periods, the legislation has to be continually renewed. Providers have been in the

situation in the past where the caps have been in place with no authorized exceptions process. This puts providers in the difficult situation of having to provide therapy services with the potential that the caps are exceeded and Medicare payment is not available. At this time, CMS is offering the following guidance:

Subject: News from CMS: Expiration of Therapy Cap Exceptions

The exceptions to outpatient therapy caps expire on June 30, 2008. Outpatient therapy service providers should not submit claims with the KX modifier for services furnished on or after July 1, 2008. To the extent possible, CMS is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of outpatient physical therapy, occupational therapy and speech-language pathology claims for services furnished by physicians, non-physician practitioners, and therapists paid under the physician fee schedule, beginning July 1.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Therapy cap accruals began on January 1, 2008, and some patients may have reached the annual limits by June 30, 2008.

Providers may access the accrued amount or remaining amount of therapy services from the Medicare beneficiary eligibility inquiry and response transactions. Specifically:

- *For CWF users, the system returns the "applied" amount. See CR4115 at http://www.cms.hhs.gov/transmittals/downloads//R759CP.pdf;*

- *For users of the HETS 270/271, the system returns the "remaining" amount. See the page 18 of the 270/271 user guide at http://www.cms.hhs.gov/HETSHelp/Downloads/HETS%20270-271%20User%20Companion%20Guide.pdf ; and*

- *The Medicare contractors' Interactive Voice Response units (IVR) return either the remaining or applied amounts based upon contractor programming. For those few contractors that do not provide this information on their IVRs, providers can call the contractors' customer service representatives.*

For additional information, Providers and Suppliers should also read the Medicare Claims Processing Manual, chapter 5, section 10. 2 at: http://www.cms.hhs.gov/manuals/downloads/clm104c05TXT.pdf.

Patients Who Have Reached Their Limit(s) on Outpatient Therapy Services:

Note that patients who have reached their limit(s) on outpatient therapy services, other than those who reside in a Medicare-certified part of a skilled nursing facility, may obtain medically necessary therapy services that exceed the caps if the services are furnished and billed by the outpatient department of a hospital. In other settings, outpatient therapy services in excess of the caps are not covered, and the therapy provider may charge for those

services. An Advance Beneficiary Notice is recommended, but not required for services that exceed therapy caps. An ABN is available at the following link: http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage (click on ABN-CMS-R-131 Form). In the box titled "Reason Medicare will not pay" the following language is suggested Medicare will not pay more than $1810 for expenses incurred for physical therapy and speech-language pathology services combined or for occupational services in 2008.

Patients may be referred to this website for further information: http://www.medicare.gov/Publications/Pubs/pdf/10988.pdf.

CMS will continue to be in communication with you with further information about payment of Medicare physician fee schedule claims. In addition, be on the alert for more information about other legislative provisions which may affect you.

Source: CMS News Release 7/1/2008

MPFS

A similar dilemma confronts providers regarding claims submissions under the Medicare Part B program where the scheduled reduction in the MPFS is now 10.6 percent. CMS has issued the following guidance to the fiscal intermediaries:

CMS Joint Signature Memorandum (JSM/TDL-08382) (06-30-08)

To the extent possible, The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare physician fee schedule, beginning July 1. In this regard, CMS has instructed its contractors to hold these claims for the first ten business days of July, for dates of service in July.

This should have minimum impact on provider cash flow because, under current law, electronic claims are not paid any sooner than 14 days (29 days for paper claims) after the date of receipt.

Meanwhile, all claims for services delivered on or before June 30 will be processed and paid under normal procedures. After ten business days, contractors will begin releasing claims into processing under the fee schedule which implements current law. This, of course, could result in claims being processed with the negative 10.6 percent update. If a new law is enacted which changes the negative 10.6 percent update, retroactive to July 1, CMS is prepared to automatically reprocess most of those claims which have already been processed.

Under the Medicare statute, Medicare pays the lower of submitted charges and the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1-June 30, 2008, fee schedule will be automatically reprocessed, if Congress retroactively reinstates the update that was in effect for that time

period. Any lesser amount will likely require providers to re-submit a revised claim.

To the extent possible, providers may hold claims in-house until it becomes clearer as to whether new legislation will be enacted or until cash flow becomes problematic. This will reduce the need for providers to reconcile two payments (i.e., the initial claim and the reprocessed claim), and it will simplify provider billings of beneficiary coinsurance and payment calculations for payers which are secondary to Medicare.

In addition, be on the alert for more information about other legislative provisions which may affect you.

Legislative Update and Call to Action

Based upon the above information from CMS, it appears advisable that providers hold off on submitting claims until such time as Congress and the White House have additional opportunity to resolve both of these issues.

According to the latest information from AAHSA, on June 24th, by a 355-59 vote, the House passed *HR 6331, the Medicare Improvements for Patients and Providers Act*, which would cancel the 10.6 percent Medicare pay cut for physicians scheduled to take effect July 1st. This bill would also continue the therapy caps exceptions process. Unfortunately, the Senate failed to reach cloture (60 votes) on identical legislation. There are rumors that a thirty-day extension is being worked out (which thus far includes a thirty-day extension of the therapy cap exceptions process), but as of now, we are unsure. This means that the therapy caps are in effect as of July 1st, as is the 10.6 percent physician payment cut. Senate Majority Leader Reid changed his vote to "No" (final vote 58-40) so that he can bring the bill up again when they return on July 7th.

Therefore, we are looking at a minimum of another week before Congress acts, and then, of course, the President has to sign the legislation. This same legislation contains a moratorium on the Durable Medical Equipment Competitive Acquisition Program (DME CAP). The White House opposes the DME CAP moratorium, leaving it unclear as to whether the President will sign the bill. It would be helpful if the Senate could establish a veto-proof majority on the bill.

Member support of AAHSA's advocacy efforts in this area remains critical. There is still time to contact your Congressional representatives and help build support for *the Medicare Improvements for Patients and Providers Act*, especially in the Senate. As always, NYAHSA members can go to http://capwiz.com/aahsa/home/ in order to contact Congress.

Please contact me with any questions at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.