



*Administrator*  
Washington, DC 20201

**JUL 02 2008**

The Honorable Saxby Chambliss  
United States Senate  
Washington, DC 20510

Dear Senator Chambliss:

I am writing to let you know what actions the Centers for Medicare & Medicaid Services (CMS) is taking to ameliorate the impact on beneficiaries and providers resulting from the Medicare physician fee schedule payment reductions scheduled to go into effect on July 1, 2008. CMS intends to work within the parameters of the law to minimize program disruptions to beneficiaries and physicians and other suppliers.

**Claims for Physician Fee Schedule Services Furnished Prior to July 1 Will Be Paid at Rates that Are Not Reduced and Will Be Paid On Time**

Current law requires Medicare pay for services based on the date that the service is furnished. Medicare payment is not made based on the date the claim is received by the contractors that process Medicare claims.

All claims for services furnished on or before June 30 will be processed under normal procedures. Payments for these claims will not be reduced even if the claim is paid in July. Payments will be made according to the current law payment time frames.

**Claims for Physician Fee Schedule Services Furnished On or After July 1 Will Be Held for 10 Days Before Being Processed, But Will Be Paid According to Statutory Payment Time Frames**

CMS has instructed its contractors to hold claims for services furnished on or after July 1 for the first 10 business days of July. This means that, instead of processing the claims and then holding them to be paid within the statutory claims payment time frame, the contractors will hold the claims for a short period of time before processing them.

This approach should have minimal impact on physicians and other health care providers' Medicare cash flow because, under current law, electronic claims generally must be paid between the 14<sup>th</sup> and 30<sup>th</sup> day following their receipt (for paper claims, the statutory payment window is between the 29<sup>th</sup> and 30<sup>th</sup> day after receipt). If claims are paid after the 30<sup>th</sup> day following their receipt, they may be eligible for interest payments. Further,

holding claims at the front-end of the claims processing system should help minimize additional workload requirements on physicians and CMS should a new law be enacted with a retroactive effective date. This approach avoids reprocessing claims by the Medicare contractors and could avoid resubmission of claims by physicians and the other health care providers.

**No Physician Fee Schedule Claims for Services Furnished During July Will Be Paid At The Reduced Rates Before July 15 At the Earliest**

As noted above, current law requires that Medicare pay claims no earlier than a specified number of days after they are received by the contractors that process the claims. For claims submitted electronically, current law requires claims be paid no earlier than 14 days after they are received. For paper claims, current law requires that they be paid no earlier than 29 days after they are received. In both cases, current law requires that most claims be paid no later than 30 days after their receipt by Medicare contractors, or interest is payable on them.

Even if an electronic claim for a service that is furnished on July 1 is received by a Medicare contractor on July 1, because of the statutory time frame for payment of claims, the earliest that payment could be made for that claim is July 15. A paper claim for a service furnished on July 1 and received by a Medicare contractor on July 1 cannot be paid earlier than July 30.

There is usually some lag between the date of service and the date the claim for that service is submitted to Medicare. The number of days between the date of service and the date the claim is received by Medicare contractors will generally determine how long after July 15 the claim will be paid.

**Minimizing Reprocessing and Resubmission of Physician Fee Schedule Claims if Legislation is Enacted Eliminating the Payment Reduction**

Medicare contractors receive about 15 million physician fee schedule claims per week. Because of claims volume, they can hold only about 10 days of claims. After 10 business days, absent legislation contractors will begin processing claims under the reduced physician fee schedule rates. If a new law is enacted which eliminates the payment reduction, retroactive to July 1, CMS is prepared to automatically reprocess those claims which have already been processed without the provider resubmitting the claim.

CMS contractors will implement a “rolling” 10-day hold on claims, based on the date of receipt. This means that the earliest received claims will be paid at the lower rates, but later received claims will be held before being processed. This will minimize the number of claims that must be reprocessed if a law is enacted to eliminate the payment reduction.

To the extent possible, health care providers may choose to hold their own claims until it becomes clearer as to whether new legislation will be enacted. This will reduce the need for providers to reconcile two payments (i.e., the initial claim and the reprocessed claim), and it will simplify calculations of beneficiary coinsurance and payments for payers which are secondary to Medicare in the event that legislation is enacted eliminating the payment reduction.

Under the statute, Medicare pays the lower of submitted charges or the Medicare physician fee schedule amount. Some physicians set their submitted charge to be equal to the currently applicable physician fee schedule amount. If a law is enacted that, retroactively to July 1, eliminates the physician payment reduction, then the Medicare contractors will automatically reprocess claims with dates of service July 1 and later that are billed with a submitted charge that is equal to at least the level of the fee schedule in effect between January 1 and June 30, 2008. However, claims that contain a submitted charge that is less than the level of the fee schedule without the payment reduction will likely need to be resubmitted as revised claims in the event of a retroactive elimination of the payment reduction.

### **Therapy Cap Exception**

Therapy caps are annual per beneficiary caps on incurred expenses for outpatient therapy services. They do not apply to outpatient therapy services furnished in hospital outpatient departments or to therapy services paid under Part A, such as services furnished in a covered inpatient or skilled nursing facility stay. There are two separate caps each of \$1,810, one for physical therapy and speech-language pathology services, and another for occupational therapy services. An exceptions process has been in effect through June 30, 2008 that allows Medicare to pay for services in excess of the cap if the services are determined to be medically necessary. Providers use modifiers to indicate on claims when therapy services may meet the criteria for an exception.

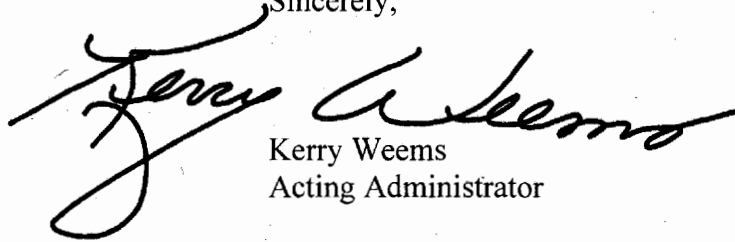
The exceptions process expires for services furnished after June 30, 2008. Pursuant to current law, the therapy caps will be implemented without the exceptions process. Since these services are paid under the physician fee schedule, the 10-day hold on claims discussed above will apply to these services. Providers should no longer use the modifiers when billing for therapy services. Beneficiaries may continue to receive therapy services if they have exceeded the cap, but will be financially liable for charges unless there is a statutory change to the caps with a retroactive effective date.

I want to assure you that as CMS follows the law, we are also taking every possible step to ameliorate the impact on beneficiaries and providers. We will continue to identify and address issues as they arise and maintain open lines of communication with the

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beneficiary and provider communities, as well as other stakeholders including Congress.  
Please let me know if you have any further questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry Weems". The signature is written in a cursive style with a large, looping initial "K".

Kerry Weems  
Acting Administrator