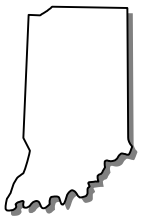
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200349 JULY 17, 2003

To: All Providers

Subject: Change in Reimbursement Rates for Home Health Providers

Overview

This bulletin notifies all home health providers of new Indiana Health Coverage Programs (IHCP) rates for reimbursement of home health services effective July 1, 2003.

Reimbursement Rates

Pursuant to Indiana Administrative Code (IAC) *405 IAC 1-4.2*-4, the standard statewide reimbursement rates for home health services were calculated and are effective July 1, 2003. The 2002 rates are applicable through June 30, 2003. The new rates are calculated based on the most recently completed Traditional Medicaid cost reports that were required to be filed by all home health providers billing the IHCP for services.

To determine prospective allowable costs, each provider's costs from the most recently completed Medicaid cost report were adjusted for inflation using the *Centers for Medicare & Medicaid Services (CMS) Home Health Agency Market Basket*. The inflation adjustment was applied from the midpoint of the annual cost report period to the midpoint of the 2003 rate period.

If a provider did not submit a cost report for the most recent fiscal period, the costs from the most recently submitted and reviewed cost report were adjusted for inflation. Also, if a provider did submit a cost report, but the data could not be reviewed because the provider did not submit the requested additional documentation, the costs from the most recently submitted and reviewed cost report were adjusted for inflation.

Computation of the Total Reimbursement Rate

The following is the computation of the total reimbursement rate:

- The overhead cost rate; plus
- The staffing cost rate multiplied by the number of hours spent performing billable patient care activities.

Each component of the total home health reimbursement rate is based on statewide weighted median costs calculated for each component. The statewide weighted median rate for each component is determined by calculating the per visit or per hour cost of each component for each home health agency. These costs are ranked from the highest to the lowest, calculating the cumulative number of Medicaid visits or hours, and locating the point on the array in which half of the respective Medicaid visits or hours were provided by agencies with a higher cost and half were provided by agencies with a lower cost.

Overhead Cost Rate

The overhead cost rate per visit for each home health provider is based on total patient-related costs, less the direct staffing and employee benefit costs, less the semi-variable costs, divided by the total number of home health agency visits during the Traditional Medicaid reporting period for that provider. The result of this calculation is the overhead cost per visit for each home health provider that was included in the statewide overhead array.

The semi-variable cost was removed from the overhead cost rate calculated, and included in the staffing cost rates calculated in Table 1.1 based on hours worked.

Staffing Cost Rate

The staffing cost rate per hour for each discipline in the home health agency is based on the total patient-related direct staffing and employee benefit costs, plus the semi-variable cost divided by the total number of home health agency hours worked. The result of this calculation is the staffing cost rate per hour per discipline for each home health agency.

Billing and Repayment

Use the new rates listed in Table 1.1 for services billed on or after July 1, 2003. If a provider has billed and been paid at the old rate for these dates of service, the provider can choose to wait for EDS to automatically reprocess the claims through a mass adjustment. Providers will be notified of the mass adjustment. Providers are not prohibited from completing adjustment forms prior to the automatic reprocessing.

The mass adjustment will pay the claims at the new rates. Mass adjusted claims are identified on the remittance advice (RA) with region number 56 as the first two digits of the internal control number (ICN). If a claim submitted for dates of service on or after July 1, 2003, was underpaid, the net difference is paid and reflected on the RA. If a claim submitted for dates of service on or after July 1, 2003, was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100 percent from future claims paid to the respective provider number. .

Billing procedures remain the same;however, to ensure appropriate reimbursement, Traditional Medicaid home health claims must be submitted using the UB-92 claim form. The UB-92 claim form includes fields for the reporting of overhead amounts and Healthcare Common Procedure Coding System (HCPCS) codes applicable to the service provided. For convenience, the HCPCS codes related to each home health discipline are outlined in Table 1.1. Additionally, if providing services under both the IHCP waiver and Traditional Medicaid programs, the appropriate provider number should be indicated on claim forms. Table 1.1 summarizes rates effective January 1, 2002, and July 1, 2003.

Table 1.1 – Billing Service Rates Effective July 1, 2003

Discipline	Procedure Code	Rates Effective January 1, 2002	Rates Effective July 1, 2003
Registered Nurse	Y0601	$28.76	$27.51
Licensed Practical Nurse	X3069	$23.05	$22.28
Home Health Aide	Y0501	$14.13	$14.10
Physical Therapist	W6503	$57.93	$55.04
Occupational Therapist	W7402	$53.08	$54.30
Speech Pathologist	W9083	$59.07	$50.29
Overhead	N/A	$21.97	$19.60

Refer questions about billing procedures to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.