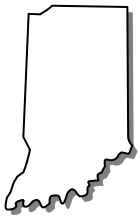
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: IHCP-enrolled Home Health Providers

Subject: Home Health Rates for State Fiscal Year 2009

Overview

The Office of Medicaid Policy and Planning (OMPP) previously informed home health providers in provider bulletin *BT200716* that the OMPP was making changes to the home health reimbursement methodology that will impact home health rates for fiscal years 2008 and 2009. This bulletin specifically addresses the rule changes that will impact home health rates for fiscal year 2009 as outlined in *405 IAC 1-4.2-4*. This bulletin provides the following:

- Rates for State fiscal year 2009
- Billing instructions for the overhead cost
- Clarification of billing policy for multiple units of service and multiple visits

Home Health Rule Changes

Pursuant to *405 IAC 1-4.2-4 (a) (1)* home health agency reimbursement for State fiscal year 2009 forward will result in one overhead cost rate per provider, per recipient, per day.

Home health agency rates for State fiscal year 2009 and forward will be based on a new rate-setting methodology that is based on 95 percent of the unweighted median as the basis for rates. See *405 IAC 1-4.2-4 (b)*. The State fiscal year 2008 reimbursement methodology expires June 30, 2008. (LSA Document #07-31, Section 5.) This bulletin specifies the rates established for State fiscal year 2009.

State Fiscal Year 2009 Rates

Table 1 specifies the home health rates for State fiscal year 2009.

Table 1 – Home Health Rates for State Fiscal Year 2009

Service	Rate
Overhead	$29.05
Registered Nurse (RN) – 99600 TD	$38.96
Licensed Practical Nurse (LPN) – 99600 TE	$26.79

Service	Rate
Home Health Aide – 99600	$20.07
Physical Therapy – G0151	$15.18 per 15-minute increments
Occupational Therapy – G0152	$15.12 per 15-minute increments
Speech Therapy – G0153	$15.70 per 15-minute increments

Changes to Billing Overhead Occurrence Codes 62 – 66

Providers may only bill one overhead per provider, per recipient per day. Effective for claims with dates of service on or after July 1, 2008, occurrence codes 62 - 66, are no longer active. Home health claims billed with occurrence codes 62 – 66, and a date of service on or after July 1, 2008, will be denied with the following Explanation of Benefit (EOB) code:

0515 - The overhead fee is not on file for the dates of service indicated or the home health occurrence code is invalid for the date of service. Please verify and resubmit.

Occurrence codes 62 – 66 are active for claims that are billed or adjusted with dates of service through June 30, 2008.

Billing Multiple Visits and Units of the Same Day

Below is a clarification of the information published in Chapter 8, of the *IHCP Provider Manual*, dated December 2006.

Unit of Service

Each line item identifies services billed using Healthcare Common Procedure Coding System (HCPCS) codes and service dates. Providers must bill each date of service as a separate line item and bill each level of service, such as registered nurse (RN) or licensed practical nurse (LPN), provided on the same date as a separate line item. The procedure code description defines the unit of service. When home health providers perform the same service, such as multiple RN visits on the same date of service, they must bill those services on the same claim form and on one detail with the total number of units of services provided. Billing separate lines for the same service with the same date of service causes them to be denied as an exact duplicate. The OMPP sets the rate for each procedure code.

Multiple Visit Billing

When providers make multiple visits for the same prior authorized service to a member in one day, providers should bill all visits on the same claim form and on one detail with the total number of units of services provided. If providers bill these services on separate claim forms and/or on separate claim details, the IHCP denies one or more of the services as a duplicate service.

In the event additional hour(s) of the same service are identified after a claim has been adjudicated and paid, providers must submit a paid claim adjustment. Procedures for submitting a paid claim adjustment are in Chapter 11 of the *IHCP Provider Manual*.

Home health agency providers should be aware that rotating personnel in the home merely to increase billing is not appropriate.

Example

A Home Health Agency sent an RN to a member's home in the morning and an LPN to the same home in the evening of July 15, 2008. The nurse performed two hours of RN services in the morning and a second nurse performed two hours of LPN services in the evening of July 15, 2008.

Detail 1: Revenue Code 552 with HCPCS 99600 TD. Date of Service is 7/15/08 and 2 in the units of service.

Detail 2: Revenue Code 552 with HCPCS 99600 TE. Date of Service is 7/15/08 and 2 in the units of service.

Note:	*In this example, providers will bill for only one overhead by entering a 61 occurrence code with a corresponding date of 7/15/08, in Fields 31a – 34b and 35a-36b on the UB-04* claim form.

Contact Information

If you have questions about the content of this bulletin, contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll free at 1-800-577-1278.

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