IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201227 JULY 24, 2012

Home health rates for State Fiscal Year 2013 are effective July 1, 2012

Pursuant to *Indiana Administrative Code (IAC) 405 IAC 1-4.2-4*, the standard statewide reimbursement rates for the Indiana Health Coverage Programs (IHCP) home health services for State Fiscal Year (SFY) 2013 are effective July 1, 2012, through June 30, 2013. The rates are calculated based on the most recently completed Medicaid cost reports required from all home health providers billing the IHCP for services.

During SFY 2012, the Office of Medicaid Policy and Planning (OMPP) promulgated an emergency rule (LSA Document #11-381(E)) to avoid an anticipated budgetary shortfall and to remain within the available Medicaid appropriation. The result was a 5% reduction of the Medicaid home health rates effective July 1, 2011, through June 30, 2013. The rate table on the next page reflects this reduction.

Computation of the reimbursement rates

Pursuant to *405 IAC 1-4.2-4*, all providers' hourly staffing rates for each discipline and overhead cost rates are each arrayed high to low. The providers' historical costs in each array are inflated from the midpoint of the cost report period to

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the midpoint of the projected rate period, using the Centers for Medicare & Medicaid Services (CMS) Home Health Agency Market Basket inflation index. From the statewide arrays, a median rate for each staffing discipline and for overhead costs is calculated. The statewide Medicaid rates for home health agencies are set at 95% of the median rate. The 5% reduction is then applied to the statewide Medicaid Home Health rates.

Overhead cost rate

The overhead cost-per-visit rate for each home health provider is based on total patient-related costs, less the direct staffing and employee benefit costs, less the semivariable costs, divided by the total number of home health agency visits during the Medicaid reporting period for that provider. The cost-per-visit rate for each home health provider is included in the statewide array of overhead costs. The semivariable costs removed from the overhead cost rate calculation are included in each staffing cost rate calculation, based on hours worked within each discipline.

Staffing cost rate

The staffing cost-per-hour rate for each discipline in the home health agency is based on the total patient-related direct staffing and employee benefit costs, plus the semivariable costs, divided by the total number of home health agency hours worked, as associated with each discipline. The cost-per-hour rate for each home health provider is included in the statewide array of staffing costs for each discipline.

The following table specifies the home health rates for SFY 2013.

Home health rates for SFY 2013, effective July 1, 2012, through June 30, 2013

Cost/procedure code	Billing unit	SFY 2013 95% of median	Less 5%	SFY 2013 rate
Overhead	One unit per recipient per day	$35.82	($1.79)	$34.03
Registered Nurse (RN) – 99600 TD	Hourly	$42.82	($2.14)	$40.68
Licensed Practical Nurse (LPN) – 99600 TE	Hourly	$28.32	($1.42)	$26.90
Home Health Aide – 99600	Hourly	$20.71	($1.04)	$19.67
Physical Therapist – G0151	15-minute increments	$17.37	($0.87)	$16.50
Occupational Therapist – G0152	15-minute increments	$16.48	($0.82)	$15.66
Speech Pathologist – G0153	15-minute increments	$17.65	($0.88)	$16.77

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Billing and repayment

The rates listed in the previous table are effective for dates of service on or after July 1, 2012, through June 30, 2013. Claims submitted and paid at the previous rate for these dates of service will be automatically reprocessed through a mass adjustment. Providers will be notified when the mass adjustment will take place. Providers may choose to complete claims adjustments before the automatic reprocessing occurs.

The mass adjustment will pay claims at the new rates. Mass-adjusted claims are identified on the Remittance Advice (RA) by internal control numbers (ICNs) that begin with 56. If a claim submitted for dates of service on or after July 1, 2012, 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, 2012, was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

Billing procedures remain the same. As a reminder, to ensure appropriate reimbursement, submit Traditional Medicaid home health claims online via Web interChange, or use the UB-04 paper claim form. Both Web interChange and the UB-04 claim form include fields for reporting overhead amounts and procedure codes applicable to the service provided. For convenience, the procedure codes related to each home health discipline are included in the previous rate table. Submit Home and Community Based Services (HCBS) Waiver claims online via Web interChange or use the CMS-1500 paper claim form. Additionally, if providing services under both an HCBS Waiver and the Traditional Medicaid programs, please indicate the Legacy Provider Identifier (LPI) on waiver claims and the National Provider Identifier (NPI) on claims for Traditional Medicaid members.

QUESTIONS?

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