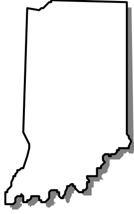

PROVIDER BULLETIN

BT200128 JULY 13, 2001

To: All Indiana Health Coverage Programs Home Health Providers

Subject: Change in Reimbursement Rates for Home Health Providers

Overview

This bulletin is to notify all home health providers of the NEW RATES for reimbursement of home health services **effective January 1, 2001.**

Reimbursement Rates

Pursuant to *405 IAC 1-4.2*-4, the standard statewide reimbursement rates for home health services effective January 1, 2001, have been calculated. The new rates are calculated based on the most recently completed Medicaid cost reports that were required to be filed by all home health providers who billed the Indiana Health Coverage Programs'(IHCP) Traditional Medicaid for services.

In determining prospective allowable costs, each provider's costs from the most recently completed Medicaid cost report were adjusted for inflation using the Health Care Financing Administration (HCFA) Home Health Agency Market Basket. The inflation adjustment was applied from the midpoint of the annual cost report period to the midpoint of the 2001 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. Likewise, 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 Per Visit Rate

The total reimbursement rate per visit is computed as follows:

1. The overhead cost rate; plus
2. The staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities.

Each component of the total home health reimbursement per visit 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, ranking these costs from the highest cost to the lowest cost, calculating the cumulative number of Traditional Medicaid visits or hours, and locating the point on the array in which half of the respective Traditional 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 the total patient-related costs, less 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

Please use the new rates listed in Table 1.1 for billing services on or after January 1, 2001. If a provider has already billed and has been paid at the old rates for these dates of service, the provider may choose to wait for EDS to automatically reprocess the claims through a mass claims adjustment. Providers will be notified when this mass claims adjustment will take place. Although a mass claims adjustment has been

scheduled, providers are not prohibited from completing adjustment forms prior to the automatic reprocessing.

The mass claims adjustment will repay the claims at the new rates. Mass-adjusted claims can be identified on the remittance advice by the assigned region number 56 as the first two digits in the internal control number (ICN). If a claim for dates of service in 2001 had been previously underpaid, the net difference will be paid and reflected on the remittance advice. If a claim for dates of service in 2001 had been previously overpaid, the net difference will appear as an account receivable. The account receivable will be recouped from future claims paid to the respective Indiana*AIM* provider number at the rate of 100 percent.

Billing procedures remain the same. However, to ensure appropriate reimbursement, please note that Traditional Medicaid home health claims should be submitted using the UB-92 claim form. The UB-92 claim form includes fields for the reporting of overhead amounts and home health procedure codes (HCPCS) applicable to the service provided. For convenience, the home health procedure codes related to each discipline are outlined in Table 1.1. Additionally, if providing services under both the Medicaid Waiver and Traditional Medicaid Programs, please be sure to indicate the appropriate provider number on claim forms.

Table 1.1 – Billing Service Rates Effective January 1, 2001

Description January 1, 2001	**Rate**	
Overhead	$21.04	
Discipline January 1, 2001	**Rate**	**Procedure Code**
Registered Nurse	$27.54	Y0601
Licensed Practical Nurse	$22.07	X3069
Home Health Aide	$13.53	Y0501
Physical Therapist	$55.47	W6503
Occupational Therapist	$50.83	W7402
Speech Pathologist	$56.56	W9083

If there are questions about billing procedures, please call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.