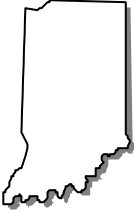

PROVIDER BULLETIN

BT200213 MARCH 29, 2002

To: **All Providers**

Subject: **Change in Reimbursement Rates for Home Health Providers**

Overview

This bulletin is to notify all home health providers of new Medicaid rates for reimbursement of home health services effective January 1, 2002.

Reimbursement Rates

The new rates were calculated using the Home Health Market Basket to inflate the cost reports used to establish the 2001 rates. In accordance with *405 IAC 1-4(g)*, cost reports were inflated from the mid point of the cost report period to the mid point of the 2002 rate period. The addition of 12 more months of inflation to the cost reports used to establish the 2002 rates resulted in an average rate increase of 4.4 percent.

All home health providers who bill the Indiana Health Coverage Programs (IHCP) Traditional Medicaid for services must file cost reports. The Center for Medicare and Medicaid Services (CMS) has extended the filing date for Medicare home health agency cost reports. Since the Medicare cost report is an integral component of the Medicaid rate setting process, the Office of Medicaid Policy and Planning (OMPP) has granted an extension of the Medicaid cost report due date prescribed by *405 IAC 1-4.2-3.1*. The current Medicaid cost report due dates are outlined in Table 1.1.

Table 1.1 – Medicaid Cost Report Extensions

Cost Reporting Year End Dates	Cost Report Due Dates
August 1, 2000 – September 30, 2000	May 27, 2002
October 1, 2000 – December 31, 2000	June 17, 2002
January 1, 2001 – March 31, 2001	July 8, 2002
April 1, 2001 – June 30, 2001	August 5, 2002
July 1, 2001 – September 30, 2001	September 2, 2002
October 1, 2001 – December 31, 2001	September 23, 2002
January 1, 2002 – March 31, 2002	October 14, 2002
April 1, 2002 – May 31, 2002	November 5, 2002

The unavailability of cost reports, due to filing delays outside the control of home health agencies and the OMPP, has lead to an update of prior year costs by applying an additional inflation adjustment to establish the January 1, 2002, rates.

Updated cost reports should be available for the calculation of rates subsequent to the 2002 rate period, at which time the most recently completed Medicaid cost report will be used in the home health rate setting process. Therefore, it is imperative that home health agencies file Medicaid cost reports accurately and timely.

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 performing 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 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 total 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 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 1.2 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 1.2 for billing services on or after January 1, 2002. If a provider has already billed and 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 adjustment. Providers will be notified when the mass adjustment occurs. Although a mass adjustment has been scheduled, 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 with region number 56 as the first two digits of the internal control number (ICN). If a claim for dates of service in 2002 was previously underpaid, the net difference is paid and reflected on the remittance advice. If a claim for dates of service in 2002 was previously overpaid, the net difference appears as an accounts receivable. The accounts 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, 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 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 1.2. Additionally, if providing services under both the Medicaid Waiver and Traditional Medicaid programs, the appropriate provider number should be indicated on claim forms. Table 1.2 summarizes rates effective January 1, 2001, and January 1, 2002.

Table 1.2 – Billing Service Rates Effective January 1, 2002

Discipline	Procedure Code	Rates Effective January 1, 2001	Rates Effective January 1, 2002
Registered Nurse	Y0601	$27.54	$28.76
Licensed Practical Nurse	X3069	$22.07	$23.05
Home Health Aide	Y0501	$13.53	$14.13
Physical Therapist	W6503	$55.47	$57.93
Occupational Therapist	W7402	$50.83	$53.08
Speech Pathologist	W9083	$56.56	$59.07
Overhead	N/A	$21.04	$21.97

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.

Note: For providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system please contact the appropriate MCO for billing and reimbursement information.

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