
WISCONSIN MEDICAID UPDATE

NOVEMBER 22, 1995

UPDATE 95- 49

TO:
Home Health Agencies

Home Health Reimbursement Limits and Other Changes

Wisconsin 1995-1997 Biennial Budget Provision

Wisconsin Act 27, Laws of 1995, the biennial budget, includes a provision that limits reimbursement for home health services. This is effective for dates of service on and after August 1, 1995.

Reimbursement Is Limited to The Lesser of Three Amounts

Effective for dates of service on and after August 1, 1995, Wisconsin Medicaid reimburses a home health agency the lesser of:

1. the Wisconsin Medicaid maximum allowable fee
2. the amount the federal Medicare program reimburses for a service, based on the agency's Medicare cost per visit
3. the agency's usual and customary charge

Attachment 1 contains the Home Health Services Terms of Reimbursement stating the new limits on reimbursement.

Highlights of this Update...

- ✓ Home health reimbursement changes
- ✓ Correction for home health ongoing assessment visits
- ✓ Electronic software use for billing

All Home Health Services Included in the Reimbursement Limit

The budget provision limits reimbursement for all home health services:

- ✓ skilled nursing (W9925, W9930, W9932, W9940)
- ✓ home health aide (W9931, W9941)
- ✓ physical therapy (W9919)
- ✓ occupational therapy (W9920)
- ✓ speech/language pathology (W9921)

Continue Billing Your Usual and Customary Charge

When billing Wisconsin Medicaid, continue billing your usual and customary charge for the service.

Wisconsin Medicaid Will Figure What Your Payment Is

For your convenience, Wisconsin Medicaid has a rate on file for your agency. This rate is the lesser of the Wisconsin Medicaid maximum allowable fee and your agency's Medicare cost per visit, adjusted for inflation. When claims for home health services are processed, Wisconsin Medicaid will compare your usual and customary charge on the claim to your rate on file. Wisconsin Medicaid will reimburse you the lesser of your usual and customary charge or your rate on file.

The methodology and process for implementation of the home health reimbursement limits were thoroughly discussed with by the Medicaid Committee of the Wisconsin Homecare Organization (WHO).

Enclosed Form Gives Your Rate on File

Enclosed with this Update is a one-page form that indicates:

- Column 1: Medicare's revenue code
- Column 2: Wisconsin Medicaid's procedure code
- Column 3: Wisconsin Medicaid's maximum allowable fee for that procedure

The Department of Health and Social Services (DHSS) determined Wisconsin Medicaid maximum allowable fees for home health services.

Column 4: your agency's Medicare average cost per visit for that procedure

United Government Services (UGS) determines Medicare average costs per visit for your home health agency. This is based on the most recent audited Medicare cost report on file with the Medicare fiscal intermediary.

Column 5: your agency's Medicare projected cost per visit, adjusted for inflation, for that procedure

This amount is calculated by UGS in the following manner:

The cost-per-visit amounts were inflated using the McGraw-Hill DRI Health Care Costs - Historical Data table showing quarterly inflation factors for the home health agency market basket.

The table is used in this way: the factor from the cost report date is subtracted from the factor from the projected date to get a new factor. The new inflation factor is then multiplied by the cost-per-visit amounts from the cost report to arrive at projected cost-per-visit amounts.

Although the effective date for this budget provision is extended to August 1, 1995, the cost reports are inflated to July 1, 1995.

The inflation factor used is shown on the form.

Column 6: your rate on file

Your rate on file is the lesser of the Wisconsin Medicaid maximum allowable fee (column 3) or the Medicare cost per visit, adjusted for inflation (column 5).

Rates for Home Health Agencies That Are Certified after this Update Is Issued

Home health agencies that are newly Wisconsin Medicaid-certified *and* who have not filed a Medicare cost report will have the Wisconsin Medicaid maximum allowable fee as their rate on file. Thus, reimbursement will be the lesser of the agency's usual and customary charge or the Wisconsin Medicaid maximum allowable fee.

If a newly certified Medicaid Home Health agency has a Medicare certification date greater than 12 months from the date of Wisconsin Medicaid certification, the agency might have a Medicare cost report. In this instance, Wisconsin Medicaid will have a rate on file for that agency.

Home Health Services Wisconsin Medicaid Maximum Allowable Fees <i>Effective 8/1/95</i>	
<u>Skilled Nursing</u>	
W9925, W9930 & W9940 - \$78.50	
<u>Home Health Aide</u>	
W9931 & W9941 - \$37.00	
<u>Physical Therapy</u>	<u>Occupational Therapy</u>
W9919 - \$75.00	W9920 - \$77.00
<u>Speech Pathology</u>	
W9921 - \$79.50	

Rates on File in Some Circumstances

If a home health agency is not certified with Wisconsin Medicaid to provide a therapy service, the rate on file is \$0.00. A certified home health agency may

provide a therapy service only when the Medicare certifying agency notifies the fiscal agent that the federal Health Care Financing Administration has approved the service.

If your last audited cost report shows no Medicare costs for therapy visits, but you are currently Medicare-certified for physical, occupational, or speech therapy, the rate on file is the Wisconsin Medicaid maximum allowable fee.

When multiple agencies merge, the rates on file for the resulting agency are those of the surviving provider.

When an agency has a change in ownership, the rates on file from the canceled provider number are used for the new provider.

Filing for Reconsideration of Rates on File

Home health agencies have until January 1, 1996, to notify the Bureau of Health Care Financing (BHCF) of any disagreement with the rates on file. After that date, Wisconsin Medicaid will use the rates on file for each discipline listed on the enclosed form.

Reconsideration requests will only be accepted if your rates on file are incorrect. Changes will not be considered, nor should they be requested, for disagreement with the statutes and implementation policy.

Include the following information in your written request for reconsideration:

- ✧ the date of the request
- ✧ the agency name and address
- ✧ Wisconsin Medicaid provider number
- ✧ the discipline(s) and rate(s) that you disagree with

- ✧ the reason for disagreement
- ✧ the rate(s) you believe is correct
- ✧ documentation to support the change

Send written requests for reconsideration to:

Attn: K. B. Piper, Director
 BHCF
 1 W. Wilson St, Room 250
 PO Box 309
 Madison, WI 53701-0309

Recoupments May Be Necessary

The new reimbursement limits are effective for dates of service on and after August 1, 1995. Early in 1996, Wisconsin Medicaid will adjust claims already paid for home health services provided on and after August 1, 1995, to reflect the new reimbursement limits.

Early in 1996, Wisconsin Medicaid will start to recoup payments that were greater than your usual and customary charge, or your rate on file, whichever is less. 100 percent recoupment will occur until the overpayments are satisfied.

When adjustments begin, you will receive a message on your Remittance and Status (R/S) report. The R/S message is your official notice for the recoupment.

Recoupment Due to New Home Health Services Reimbursement Limits *An Example*

Acme Home Health Agency billed Wisconsin Medicaid \$95.00 for a home health nursing initial visit made on August 4, 1995, and was paid the maximum allowable fee of \$78.50. Acme's rate on file is \$65.00. Wisconsin Medicaid recoups \$13.50 for this visit.

Some Previously Denied Home Health Ongoing Assessment Visits May Be Automatically Adjusted

The fiscal agent denied claims for home health ongoing assessment visits (procedure code W9925) if the visits were *followed* by nursing visits within 55 days. The denials should have been based on nursing visits *preceding* the ongoing assessment visits. For more information about the nursing visits, refer to page 2L2-010 in your home health handbook.

In early 1996, EDS will identify the claims that were incorrectly denied and make adjustments.

Home Health Software Required to Ensure Appropriate Medicare Billing

Wisconsin Medicaid gives all home health and personal care agencies software to help identify the proper payer.

You *must* use the software:

- ✓ for all Wisconsin Medicaid recipients, including recipients with Medicare *and* Medicaid (also known as dual-entitled recipients)
- ✓ for all Wisconsin Medicaid claims for services provided on and after July 1, 1995
- ✓ each time you admit a Wisconsin Medicaid recipient or client
- ✓ for all changes in the recipient's payer information
- ✓ for all changes in the recipient's condition that might affect the payer source

- ✓ for each case that is shared with another agency, even if you are not billing Wisconsin Medicaid

**About Personal Care and
Medicare Home Health Services . . .**

Wisconsin Medicaid does not pay for personal care services if Medicare will pay a home health agency to provide the care. For agencies that provide personal care, refer to *Wisconsin Medicaid Update 95-26* for more information.

The software, part of the total Wisconsin Medicaid Home Health Software package, has various prior authorization, billing, and accounts receivable forms, as well as production reports.

You can call the software contractor, United Wisconsin Proservices, Inc. at (414) 226-6541, for more information about the software. If you have questions regarding the software's Medicare portion, call Medicare Provider Education at (414) 226-6075.

The printed reports for each recipient must be kept on file on the agency's premises for auditing.



State of Wisconsin
Department of Health and Social Services

Attachment 1

**HOME HEALTH SERVICES PROVIDED BY HOME HEALTH AGENCIES
TERMS OF REIMBURSEMENT**

The Department will establish maximum allowable fees for all covered home health services provided to Wisconsin Medicaid recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including: an analysis of Medicare cost reports, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

The Department will establish rates on file for all covered home health services provided to Wisconsin Medicaid recipients eligible on the date of service. The rates on file will be the lesser of the maximum allowable fee, or the amount that the federal Medicare program reimburses the agency for a home health service, or would reimburse if the agency billed Medicare.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of the provider's usual and customary charge, or the rate on file established by the Department. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 44

Effective Date: August 1, 1995

PR08160B.KW/TOR