Background on Reimbursement Changes for Private Rehabilitation Agencies

DMAS is mandated by Item 306.XX of Chapter 781 of the 2009 Acts of the Assembly (the Appropriation Act) to "convert the current reimbursement methodology for rehabilitation agencies to a statewide prospective rate for individual and group services" effective July 1, 2009. DMAS decided to base the statewide rate on global CPT codes and to require providers to change billing from the UB-04 to the CMS-1500 to accommodate this. In general, we believe that most rehab agency providers bill other payers on the CMS-1500 and these other payers use CPT codes to reimburse providers.

DMAS decided, however, to only cover global CPT codes and not to cover all possible CPT codes. DMAS made this decision for several reasons. The codes that DMAS covers are broad enough to encompass all the rehabilitation therapy services furnished by rehab agencies. Furthermore, it is no different than the number of codes available to providers billing currently. There were nine revenue codes and they have been crosswalked to nine CPT/HCPCS codes. Using codes that describe the services broadly was also necessary to maintain our ability to control and prior authorize these services consistent with current regulations.

The rates for these CPT/HCPCS codes were developed to include the total costs reimbursed by DMAS using the current methodology (minus savings DMAS was directed to make as a result of the budget) so that the rates for the DMAS covered CPT/HCPCS codes include costs for electrical stimulation, ultrasound, gait training, etc., even if DMAS doesn't cover the codes for the specific modalities. The rate differences reflect the differences in Medicare relative value units for these codes. Because statewide rates are based on average costs, providers whose costs are higher than the average may see a reduction while providers whose costs are lower than the average may see a lower reduction or even an increase. The proposed rate methodology includes annual inflation increases, which are not common for all providers.

Some private rehabilitation agencies also serve Early Intervention recipients. DMAS recognizes that furnishing services for these individuals is more expensive, but these rates do not reflect that. DMAS is developing an early intervention initiative that will pay higher rates for therapy furnished in the natural environment for children. However, that initiative will not be implemented until at least October 1, 2009.

Even though billing instructions have changed to be more consistent with other payers, the fact that Medicaid billing instructions differ from other payers has not changed. Providers should bill Medicaid consistent with Medicaid billing instructions when Medicaid is the primary payer even if they do not customarily bill this way for other payers.

When Medicaid is the secondary payer, providers should follow the billing instructions of the primary payer. If Medicare is primary, the claim will crossover and Medicaid will follow its current rules for pricing. Medicaid pays the lower of either the difference between the Medicaid approved amount and the Medicare payment or the copay and deductible. If private insurance is primary, the provider bills the private insurance first. After receiving the private insurance payment, the provider follows Medicaid billing instructions when submitting the claim to Medicaid and includes the private insurance payment as TPL.

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