Background on Reimbursement Changes for Private Rehabilitation Agencies

DMAS is mandated by Item 288.SSSS of Chapter 2 of the 2024 Acts of the Assembly (the Appropriation Act) to “update the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale” effective July 1, 2024.

In 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 methodology prior to July 1, 2009 (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. The proposed rate methodology applies a budget neutrality factor to any rate calculation to ensure and maintain budget neutrality.

Department of Medical Assistance Services (DMAS)
June 2024