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MEDICAID MEMO

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Update on Outpatient Reimbursement Rates and Billing for Rehabilitation Agencies and CORFs – Effective July 1, 2009

The purpose of this memorandum is to inform providers that effective with dates of service on or after July 1, 2009, the Department of Medical Assistance Services (DMAS) will be adopting Current Procedural Terminology (CPT) codes for rehabilitation services furnished by private Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Effective for dates of service on or after July 1, 2009, rehabilitation agencies and CORFs will have to submit claims on the CMS-1500 using CPT codes, and the UB 04 claim with revenue codes will be discontinued for use by them. Reimbursement will be based on a statewide fee schedule. This billing and reimbursement method was chosen to be consistent with Medicare and commercial payers. Please carefully review the information below regarding claims submission and prior authorization, which will also be affected by this change.

DMAS will continue to reimburse Community Services Boards and state agencies their allowed cost for rehabilitation services. Community Services Boards and state agencies still must change their billing to the CMS-1500 using CPT codes and follow the prior authorization changes. They will be paid initially according to the above fee schedule on the remittance. However, DMAS will make quarterly interim payments to approximate reimbursement at cost and will settle final reimbursement based on a cost report.

Statewide Fee Schedule and Cost Reporting Changes

Item 306.XX of the 2009 Appropriation Act directs DMAS to implement a statewide prospective rate for services furnished by rehabilitation agencies, including CORFs, effective July 1, 2009. The budget also directs DMAS to set the rates in a manner to save $371,818 in FY10. DMAS will establish statewide rates for the nine services that are allowed by DMAS to be furnished by rehabilitation agencies, effective July 1, 2009. DMAS is adopting Current Procedural Terminology

(CPT) codes for rehabilitation services to implement the statewide prospective rate. This reimbursement method was chosen to be consistent with Medicare and commercial payers.

In the new statewide fee schedule, there will be 8 CPT procedure codes (and 1 HCPCS code – S9129) herein after referenced collectively as "CPT" codes. The current revenue codes, the new procedure codes, the procedure code descriptions and the new rates are listed in the table below.

Private rehabilitation agencies will no longer have to submit cost reports for periods after June 30, 2009. The last complete cost report will be for the fiscal year ending prior to June 30, 2009. This cost report is used to establish rates for the next rate period. Providers will receive special instructions for filing a partial cost report for periods from the last fiscal year for a complete cost report year through June 30, 2009. This partial cost report will only settle payments made for services through June 30, 2009 using rates established from the last complete cost report. Cost reporting requirements for CSBs and state agencies remain unchanged.

Claims Submission, Prior Authorization, ClaimCheck/CCI and Billing Information:

All Outpatient Rehabilitative Agencies and CORF providers are to submit claims beginning with dates of service on or after July 1, 2009 utilizing the CMS-1500 (08/05) universal claim form. The use of the CMS – 1450 (UB 04) claim form for purposes of outpatient rehab agencies and CORF providers will be discontinued effective with dates of service on or after July 1, 2009. DMAS will eliminate the allowance of revenue codes for rehabilitation agencies and CORFs, effective June 30, 2009.

In the table below, DMAS has cross walked the current revenue codes to the appropriate CPT codes. DMAS does not allow any other CPT codes to be utilized for rehab agencies and CORFs at this time. Also, this table defines the measurement for each unit based on the CPT code.

Please follow the descriptions for each procedure code in the CPT code book, which

differ in some respects from the uses of the current revenue codes. Note that S9129 has the same national description as 97150. However, S9129 is to be used for occupational therapy (OT), whereas 97150 is to be used for physical therapy (PT). Also note that two of the codes (97110 and 97530) are defined in 15 minute intervals. For example, if an hour of therapy is provided, the provider would bill for 4 units of 15 minute increments for these two codes.

When requesting a Prior Authorization (PA) for these 2 codes, the units of time being requested should be based on the 15 minute interval and not based on a visit. Example: PT therapist has determined that a recipient needs to have an hour a day, three times a week for a total of four weeks of physical therapy. The PA request for PT would be for a total of 48 units (4 units per day times, 3 times a week, times 4 weeks = 48 units).

Special Note: Providers should bill their claims in date of service sequence. The initial allowable five units that do not require a PA should be billed and paid prior to billing for services that require a PA.

Revenue Code prior to and on June 30, 2009	Procedure Code effective on and after July 1, 2009	Procedure Code Description	DMAS Fee Schedule Amount effective July 1, 2009
0421	97110	Therapeutic procedure (PT), each 15 min. **Note**: unit = 15 minutes	$25.34
0423	97150	Therapeutic procedure(s) (PT), group **Note**: unit = a group session	$16.06
0424	97001	Physical therapy evaluation **Note**: unit = an evaluation	$64.60

0431	97530	Therapeutic activities (OT), each 15 min **Note**: unit = 15 minutes	$26.77
0433	S9129	Therapeutic procedure(s) (OT), group **Note**: unit = a group session	$16.06
0434	97003	Occupational therapy evaluation **Note**: unit = an evaluation	$69.23
0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual **Note**: unit = one treatment session	$58.88
0443	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group (2 or more individuals) **Note**: unit = one treatment session	$27.48
0444	92506	Evaluation of speech, language, voice, communication, and/or auditory processing **Note**: unit = an evaluation	$137.04

ClaimCheck/CCI Edits

These rehabilitation services claims will be edited by the ClaimCheck/CCI software utilized by DMAS. ClaimCheck/CCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the provider's weekly remittance cycle. All ClaimCheck/CCI edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, **when appropriately used** as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck/CCI process. DMAS has provided a listing of the modifiers, examples of common CCI and ClaimCheck edits and ClaimCheck edit error

reason codes that can be found at our website www.DMAS.virginia.gov, under Provider Services, Claims and Billing.

The modifiers that currently bypass the ClaimCheck/CCI edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Additional Billing Information:

For additional or specific billing information required by DMAS to be submitted on the CMS-1500 (08/05) form and additional information on ClaimCheck/CCI edits, please refer to the Rehabilitation Provider Manual, Chapter V.

Prior Authorization through KePRO

KePRO will continue to process requests for rehabilitation services with Revenue Codes *with dates of service on or prior to June 30, 2009.* Each July 1, recipients have 5 visits that do not require PA for each service (OT, PT and SLP). If a provider knows that the recipient will need treatment beyond 5 visits, the provider must request PA through KePRO. These 5 visits without PA are renewable each July 1st. KePRO will process all requests with an end date not to extend beyond June 30 of each year, in order to allow for the utilization of the 5 visits that do not require PA. Effective with the publication of this memo, no PAs will be processed for dates of service that span July 1, 2009. The request will reflect a determination through June 30, 2009. The provider must submit a new request using CPT codes for dates of service July 1, 2009 forward. Note that the service limits for CPT codes 97110 and 97530 will be calculated to equate each 15 minute unit to one-quarter of a visit.

Providers must request prior authorization Revenue Codes for dates of service prior to July 1, 2009 and CPT codes for dates of service on or after July 1, 2009. If a request with CPT codes is submitted with dates of service prior to July 1, 2009, KePRO will administratively reject the request and the provider must resubmit the request with Revenue Codes. Likewise, if a request with Revenue Codes is submitted with dates of service on or after July 1, 2009, KePRO will administratively reject the request and the provider must resubmit using the appropriate CPT codes.

Existing PAs with Revenue Codes that Span Past July 1, 2009

Current prior authorizations with Revenue Codes that span past July 1, 2009 will remain effective. The MMIS will cross reference the CPT code billed to the Revenue Code authorized for the time period submitted on the claim. Note that for existing PAs for revenue codes 0421 and 0431 that span July 1, 2009, the MMIS will convert claims for the corresponding CPT codes 97110 and 97530 at the following conversion rate: one unit of CPT code 97110 or 97530 equals 0.25 of an authorized unit of revenue code 0421 or 0431. The conversion is necessary because the unit for these CPT codes is 15 minutes whereas the revenue code units that have been authorized are visits.

PA Requests to Modify PAs with Revenue Codes

If a request is made to modify an existing PA with a Revenue Code and the dates of service being requested for modification are on or after July 1, 2009, the provider must request an end date for the Revenue Code and a start date with the CPT code and requesting the appropriate number of units. KePRO will process the request by ending the Revenue Code based PA and creating a new line under the same PA number using the appropriate CPT code for the dates of service remaining. Providers cannot request changes to a PA that has authorized service units billed and paid.

PA Requests Submitted with Dates of Service on or after July 1, 2009

Requests received with dates of service on or after July 1, 2009 must be submitted with a CPT code and requesting the appropriate number of units. Requests submitted that do not have the CPT code for dates of service on or after July 1, 2009 will be administratively rejected. The provider will be required to resubmit the request using the correct CPT code. All prior authorization requests will end on or prior to June 30th of each year. On July 1 of each year, the 5 service visit limit per discipline is renewed in order to allow for the utilization of the 5 visits that do not require PA. If a provider knows that the recipient will need treatment beyond 5 visits, they must request PA through KePRO.

All requests should be made within 30 days of the current authorized end date.

Please refer to the table on page 3 of this memo to determine the appropriate codes to submit for PA and the dates to use these codes.

Additional Information Related to Prior Authorization

Prior authorization decisions will continue to be made utilizing *McKesson InterQual® Criteria, Outpatient Rehab and Chiropractic Level of Care.*

Should you have any questions regarding the PA process for Outpatient Rehab Services, please send your inquiries via e-mail to providerissues@kepro.org or PAUR06@dmas.virginia.gov and enter *Outpatient Rehab Inquiry* in the subject line of the request.

Managed Care Organizations

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices will be applied to paper requests, effective July 1, 2009.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. For more information on the services that are offered contact the vendors.

Passport Health
Communications, Inc.
www.passporthealth.com
sales@passporthealth.com

Telephone #: (888) 661-5657

SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com

Telephone #: (610) 219-2322

Emdeon
www.emdeon.com

Telephone #: (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.