ARC 0709C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Iowa Administrative Code.

These amendments change billing codes used by Iowa Medicaid Enterprise (IME) from atypical, state-created codes to nationally recognized codes. These amendments also provide standardization of service definitions amongst the home- and community-based services (HCBS) waivers. Finally, these amendments clarify the wording of some service definitions.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), no state Medicaid department can use atypical billing codes. (See 45 CFR 162.1000 and 162.1002.) Most of the codes used to bill waiver services to the IME are atypical and therefore need to be changed to standardized healthcare common procedure coding system (HCPCS) or current procedural terminology (CPT) codes. Those standardized codes have different unit descriptions from the unit descriptions currently contained in Chapter 78. For example, the atypical billing code unit definition is one hour; the new conversion code has a unit definition of 15 minutes.

The standardization and clarification of service definitions provides continuity amongst the waiver programs and clearer definition of the service for the member, provider, and state. The description of each waiver service is the same for all waiver programs, unless a waiver has a very specific exception.

Notice of Intended Action for these amendments was published in the Iowa Administrative Bulletin as **ARC 0589C** on February 6, 2013. That Notice was a companion to the Notice of Intended Action to amend Chapter 79 that was published as **ARC 0588C** on the same date (see Adopted and Filed **ARC 0710C** herein). Together, those Notices were the second set of changes to the unit time and rate definitions for home- and community-based services (HCBS) waiver and habilitation services. The first set was published in the Iowa Administrative Bulletin as **ARC 0567C** and **ARC 0568C** on January 23, 2013 (see Adopted and Filed **ARC 0707C** and **ARC 0708C** herein).

The Department received four responses from interested parties.

The first respondent was concerned that if the 15-minute billing rate is based on four hours of service time (16 15-minute increments), providers will be forced to bill for the entire service time of four hours, to equal the rates currently available for half days. The respondent summarized the comment by stating that the documentation requirements for day habilitation are at best cumbersome, and there is no current method for providers to bill for documentation time. The respondent believes that these amendments could potentially increase the cost of services of all providers.

The Department response is that documentation of service delivery is not, and has never been, a Medicaid billable activity. Documentation has always been considered as part of the overhead incurred by a provider that is not directly billable to or reimbursable by the Department. Providers that are billing Medicaid for the time to document services are at risk of recoupment of paid funds.

The Centers for Medicare and Medicaid Services (CMS) mandate regarding atypical billing codes was that each state Medicaid program is required to use only nationally standardized billing codes. For most of the codes used in HCBS services, the only nationally standardized code available for use is defined as 15 minutes. The nationally standardized codes list does not offer half-day units for day habilitation or prevocational services. The IME does not have the authority to alter the time frame definition of a standardized code. Therefore, in order to comply with the CMS mandate, the IME needed to eliminate these two time frames from those services.

Each provider is responsible to understand and implement the documentation standard rules as found in the Iowa Administrative Code, 441—79.3(249A). In addition, the IME outreach team has provided at least 8 documentation standards training sessions per year since 2008, and in many years the number of sessions rose to 16 per year. This training has been posted on the IME Web site each year. All Medicaid providers have been invited and encouraged to attend these sessions so they could better understand

the billing codes and the requirements for documentation. Rule 441—79.3(249A) has its foundation in federal and state requirements for each provider to substantiate the service provided such that the state can ensure that the service was provided in accordance with the service description and that the payment for that service is in accordance with federal requirements.

The second respondent expressed similar concerns as the first respondent. This respondent requested that the Department redefine the proposed definitions of the units of service for a full day to be 4.01 hours to 8 hours per day. The current rules define 4 to 8 hours as a full day. If a member determines that the member needs and wants full days of service, the provider will still have to plan for days the member does not receive full days because of a medical appointment or some other appointment or issue. In this case, a number of hourly units for prevocational services and 15-minute units for day habilitation services will have to be planned for to take into account data available on attendance. The problem then becomes if a member does not get 4.25 hours of service to bill a full day, then the provider has to bill the hourly or 15-minute units of service instead. The provider, in this case, will get shorted on reimbursement when compared to the current rules. The provider plans staffing based on the wants and needs of members. Providers cannot just send staff home if members do not come for services, leave early, or do not get a full day in when a full day was planned. Providers cannot afford a cut in service reimbursements. This change makes an already complicated system more complicated. It would seem that CMS is not requiring the units of service for a full day to be written as the Department has proposed in the new rules, and sometimes rules have unintended negative consequences.

The Department response is that the definitions of half-day, full-day, and extended-day services have been adopted for all waiver services that offer these time frames. The case stated in the comment about the provider planning to provide service but the member is not available for the service was the same before as it is under these amendments. Situations will always exist where the provider has made plans for the member, but the member is not available and, therefore, no staff is needed or billable. The intention of these amendments is to limit the amount of money paid by the IME when no service is provided.

IME staff devised the service time frames to more closely align IME payments with service provision. Currently, a provider could provide service for only one hour, but charge a rate to the IME based upon four hours of service. Under the adopted amendments, if the member receives only one hour of service, then the IME pays for one hour of service. In addition, the existing rules have overlapping times, but with the adoption of these amendments, there is no question as to whether four hours is billed as a half day or a full day.

The time frames were derived using the 15-minute rounding rules. The rounding rules state that for a 15-minute unit of service, 7 or fewer minutes are rounded down to a zero unit, and 8 to 14 minutes are rounded up to a full billing unit. Over time, providers should be rounding down as often as rounding up. Carrying the rounding rules over to the longer time frames lends a consistency to the reasoning behind the rounding of service time.

In regard to service planning, each provider and case manager will need to more closely plan for each member. Each member's plan may be comprised of any combination of the time frame options (15 minutes, half day, full day, or extended day). Also, at the end of the month, the provider may contact the case manager to alter the service plan to match actual service provision, if applicable. The purpose of the waiver is to provide services to meet the needs of the member in the most efficient manner.

The third respondent also requested that the Department redefine the proposed definitions of the units of service for a full day to be 4.01 to 8 hours per day for intellectual disability and brain injury waiver prevocational services and the intellectual disability day habilitation service.

The Department response is that the time frames for units of service were derived using the 15-minute rounding rules. The rounding rules state that for a 15-minute unit of service, 7 or fewer minutes are rounded down to a zero unit, and 8 to 14 minutes are rounded up to a full billing unit. Over time, providers should be rounding down as often as rounding up. Carrying the rounding rules over to the longer time frames lends a consistency to reasoning behind the rounding of service time.

The fourth respondent's concerns were nearly identical to those of the first respondent, and the Department's comments on those concerns are identical. This respondent raised one additional question about whether rules will be written to specify the maximum number of service units a month. Currently,

Informational Letter 1164 specifies no more than 31 units a month. Of course the units of allowable services per month will have to be reviewed and changed since half days of service are going away.

The Department's response to the additional query by the respondent is that the informational letter refers only to half-day and full-day units. These amendments indicate that a member can have 15-minute or hourly units (depending upon the service) and daily units. The limit to the number of full-day units billable per month will continue to be limited as described in the informational letter. The number of 15-minute or hourly units is already included in these amendments.

No changes were made to these amendments as a result of the comments received by the Department during the comment period. These amendments are identical to those published under Notice of Intended Action.

The Council on Human Services adopted these amendments on April 10, 2013.

These amendments do not provide for waivers in specified situations because CMS has not indicated that any state can be exempt from the guidelines relating to atypical billing codes. The Department does not see any reason why any provider type would be exempt from adherence to CMS guidelines. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective July 1, 2013.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these amendments [amendments to Ch 78] is being omitted. These amendments are identical to those published under Notice as **ARC 0589C**, IAB 2/6/13.

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[For replacement pages for IAC, see IAC Supplement 5/1/13.]