Indiana Title XIX

# MEDICAID BULLETIN

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**To:** **All Indiana Medicaid Providers**

**Subject:** **Billing Recipients, Filling Prescriptions for Restricted Recipients (Lock-in), and Echographies**

## Overview

Medicaid Surveillance and Utilization Review (SUR) department periodically prepares educational bulletins regarding issues uncovered during previous SUR reviews. This bulletin includes both new and reminder issues. Although discussion may center around issues which have previously been brought to the attention of the provider community, these issues are included again since noncompliance in these areas remains. Our intention is to supply information to providers to assist them in correcting inappropriate claims submissions or to remind them of program compliance issues.

## Surveillance and Utilization Review

1. **Billing Recipients – Acceptance of Medicaid Reimbursement by Practitioners and Providers**

   Indiana Medicaid practitioners and providers are prohibited from charging a Medicaid recipient or the family of the recipient, for any amount billed but not paid on a covered Medicaid service. Acceptance of payment in full is a condition of participation in the Indiana Medicaid program.

*405 IAC 1-1-3 (I)* states:

"A Medicaid provider shall not collect from a Medicaid recipient or from the family of the Medicaid recipient any portion of his charge for a Medicaid covered service which is not reimbursed by the Indiana Medicaid Program, except for co-payment and any recipient liability payment as authorized by law.

The intent of this provision is to ensure that no recipient or family of a recipient is billed in excess of the amount paid by the Medicaid Program. As a condition of the provider's participation in the Indiana Medical Assistance Programs, the provider must accept the Medicaid determination of payment as payment in full. If the provider disagrees with the Medicaid determination of payment, his/her right of recourse is limited to an administrative review and appeal as provided in *405 IAC 1-1-3.* Violation of this section constitutes grounds for the termination of the provider agreement, and de-certification of the provider, at the option of the Indiana Family Social Service Administration (IFFSA)."

A Medicaid provider may bill a Medicaid recipient only when the following conditions have been met:

- The service rendered must be a service determined **not covered** by the Indiana Medical Assistance Programs or **the recipient has exceeded the program limitations for a particular service**. Examples include services rendered not being Medicaid program benefits or the services not approved by Prior Authorization.
- The Medicaid recipient must understand, before receiving the service, that the service is not covered under the Indiana Medical Assistance Programs, and that the recipient will be responsible for service charges.
- The practitioner/provider must maintain documentation that the recipient voluntarily chose to receive the service, knowing that the Indiana Medical Assistance Programs would not reimburse for the service. A generic consent form is not acceptable unless it identifies the specific procedure that is to be performed and is signed by the recipient prior to rendering the services. If written statements are utilized, the statements may not contain language such as, "If a Medicaid service is not covered…"

  If the recipient has a Primary Medical Professional and wishes to receive services from another practitioner/provider, the practitioner/provider must inform the recipient that the service can be received free of charge from the PMP.

**2. Billing No More than Usual and Customary Charges**

Recently a dental provider reported that he inadvertently loaded Medicaid maximum fees, rather than his usual and customary charges, into his computer system for billing claims to Medicaid. In some instances, Medicaid was charged an amount greater than the provider's usual and customary fee. To rectify this situation, several claims had to be adjusted. Item #14 in the Medicaid provider

Agreement obligates providers to accept payment as determined by IFSSA or its fiscal agent in accordance with federal and state statues and regulations as payment in full for all Medicaid-covered services. In addition, page 4-4-1 of the Provider Manual prohibits providers from charging more for services provided to Medicaid patients than is charged for similar services provided to or other private-pay patients. Providers must bill their usual and customary fee to Indiana Medicaid. Any questions should be directed to Customer Assistance at 1-800-577-1278 or (317) 655-3240 for callers in Marion County.

**3. Filling Prescriptions for Restricted Recipients (Lock-in)**

It is the practitioner/provider's responsibility to check the status of all Indiana Medical Assistance Program recipients prior to rendering services.

Recipient Restricted status data are available from the following sources:

- Automated Voice Response (AVR) System
- National Electronic Claim Submissions (NECS) dial-up
- OMNI Swipe Card Devices (OMNI)

If no restrictions are listed, the recipient is not restricted to any specific pharmacy. If AVR, NECS, or OMNI lists restrictions, the recipient is restricted to receiving specific types of services from only the specific practitioner/provider(s) indicated. Medicaid will reimburse prescriptions for a restricted recipient only if it is written by the specified lock-in practitioner/provider or the recipient has a written referral from the lock-in practitioner/provider to be seen by the practitioner/provider that has written the prescription. Prescriptions that have been written by any physician other than those listed on the restriction information by AVR, NECS or OMNI must be hand-billed to the normal claims filing address.

The Medicaid Program will not reimburse pharmacy services for a restricted recipient to any pharmacy other than the pharmacy to whom the recipient is restricted, unless a referral is on file, or the service is an emergency.

If the recipient would need to have an emergency prescription filled then the pharmacy may request that the recipient provide documentation that he or she was treated in an emergency situation (emergency room record, discharge instructions, physician bill with emergency diagnosis, for example). The pharmacy may provide a copy of the recipient's documentation with the properly submitted paper claim to ensure payment. Information regarding referrals may be obtained from the recipient's physician or by contacting Health

Care Excel, to speak to the reviewer handling claims for recipients with a restricted card. Pharmacists may reach the restricted card reviewer by calling (317) 347-4527 or 1-800-457-4515.

> *Note: Claims for services rendered by a pharmacy not assigned or referred to a restricted card recipient, will appropriately be denied by the claims processing system.*

**4. Echographies for Pregnancy-Related Diagnoses**

Echographies with the Diagnosis of Normal Pregnancy

(Reminder from Bulletin dated September 29, 1998)

Recent review of multiple Medicaid obstetric and radiological practitioners/providers revealed that echographies are being submitted with a diagnosis of normal pregnancy. A diagnosis of normal pregnancy does not explain the reason for the echography. Echographies performed on recipients who have a normal pregnancy for the purpose of detecting fetal malformations or intrauterine growth retardation should have an ICD-9-CM code from the V22 series (Supervision of pregnancy codes) as the Principal diagnosis and an ICD-9-CM diagnosis code from the V28 series, antenatal screening, listed as the secondary diagnosis.

These secondary codes are as follows:
- V28.3 Screening for malformation using ultrasonics
- V28.4 Screening for fetal growth retardation using ultrasonics

> *Note: Documentation in the patient's medical record must substantiate the medical need for the echography.*

***405 IAC 5-27-6 Sonography***

**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-12-21-2; IC 12-15-21-3**

**Affected: IC 12-13-7-3; IC 12-15**

Sec. 6 (a) Medicaid reimbursement is available for sonography performed during pregnancy when warranted by one (1) or more of the following conditions:

1. Early diagnosis of ectopic or molar pregnancy;

2. Placental localization associated with abnormal bleeding;

3. Fetal postmaturity syndrome;
4. Suspected multiple births;
5. Suspected congenital anomaly;
6. Polyhydramnios or oligohydramnios;
7. Fetal age determination if necessitated by:
   - Discrepancy in size versus fetal age; or
   - Lack of fetal growth or suspected fetal death;
8. Guide for amniocenteses;
9. Reimbursement is available for sonography for fetal age determination prior to therapeutic abortions when the age of the fetus cannot be determined by the patient's history and physical examination and the information is essential for the selection of the abortion method.