INDIANA MEDICAID UPDATE

February 19, 1998

TO: **Indiana Medical Assistance Providers**

SUBJECT: **Medicaid Utilization Review Update**

The Indiana Medicaid Surveillance and Utilization Review (SUR) department periodically identifies areas of non-compliance and/or misunderstanding in relation to the Medicaid program billing, Medicaid program benefits and reimbursement. This information is being reported to the Medicaid provider community since you are well positioned to help stop Medicaid program abuse and reverse trends in relation to mis/overutilization of services and inappropriate billing practices. Following are some of the areas recently identified through the desk and on-site reviews performed by the SUR department:

DRG Reimbursement Methodology

The principal diagnosis (as described by the ICD-9-CM code as being the condition established after study to be chiefly responsible for occasioning the admission of the patient for inpatient care), principal procedure and any secondary diagnoses and procedures must be supported by the medical record. Secondary diagnoses (as defined in the Uniform Hospital Discharge Data Set) are all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay.
405 IAC 1-10.5-2(h)(w)

Examples of incorrect diagnosis and procedure code assignments for hospital claims, found during the desk and on-site review of hospital claims, include:

- Assignment of admitting diagnosis and/or the symptom noted at the time of the patient's admission, instead of the condition responsible for the admission.
- Secondary diagnoses which are not substantiated by the medical record, i.e. a previous diagnosis noted in the history and physical which are no longer active, subsequent to, and/or affecting the treatment received during the inpatient stay.

Ancillary and Therapy Billing for Long Term Care Facility Residents

No provider is allowed to bill the Indiana Medicaid Program for medical or nonmedical supplies and equipment, and therapies provided to residents in Long Term Care facilities. Food supplements, nutritional supplements, and infant formulas are also excluded from separate billing and reimbursement. Any inappropriate billing and/or reimbursement will be recovered by the EDS Surveillance and Utilization Review Unit.

405 IAC 1-14.1-22 and 405 IAC 1-14.1-23 (prior to July 1, 1997), 405 IAC 1-4-25, 405 IAC 1-4-26, 405 IAC 1-14.2-19, 405 IAC 14.2-20, 405 IAC 1-6-21

The billing of supplies, equipment and therapies for nursing facility residents has been found in the review of pharmacy, DME and therapy providers. All medical and nonmedical supplies, routine medical equipment and therapies are included in the nursing facility per diem rate. This billing exclusion applies to all Medicaid providers who are billing for patients in the nursing facility.

Billing of Refill Prescriptions

SUR desk reviews of claims for pharmacy providers have revealed that many claims fail to specify if the charge is for a new or refill prescription. While the provider is reimbursed no more or less for new versus refill prescription, the failure to indicate this information hampers our ability to track Medicaid recipient utilization. Therefore, providers should complete field number 11 on the pharmacy drug claim form, and field number 10 on the pharmacy compound drug claim for, denoting the applicable refill indicator. Either use 00 if the prescription is a new order, or indicate the refill number; for example, use 01 for the first refill, 02 for the second, etc. Remember to utilize two (2) digits; 00-99.

Billing Waiver Services Under The Appropriate Provider Number

It has come to the attention of the EDS Surveillance and Utilization Review (SUR) unit that some Home Health and Waiver Service Providers have been using incorrect billing practices when billing for Waiver services. Waiver service providers must bill these services to their separate and distinct provider number which was issued by Provider Enrollment. Home Health Agencies who also provide Waiver services must bill these services to the Waiver Provider Number which is separate and distinct from the Home Health Agency Provider Number. Please check to be sure that you are billing Waiver services to an appropriate Waiver Services Provider Number. Waiver services must be billed on a HCFA 1500 claim form. Home health services must be billed on a UB92 claim form. Home health agencies must be enrolled with a separate number to bill Care Coordination Services for Pregnant Women services. These services must be billed on the HCFA 1500 claim form using the care coordination provider number.

Billing Procedure Code A0070

Procedure code A0070 (Ambulance service, oxygen, administration and supplies, life sustaining situation) should not be billed with procedure code A0220 (Ambulance service, advanced life support [ALS] base rate, all inclusive services, emergency transportation, one way). Procedure code A0220 is an ***all inclusive*** code for the trip run, supplies and oxygen utilization for an advance life support situation. The appropriate procedure code (A0221) indicating the mileage for the trip should be the only other procedure code billed with procedure code A0220.

Procedure code A0070 can be billed with procedure code A0010 (Ambulance service, basic life support [BLS] base rate, emergency transport, one way). The medical record documentation of the Emergency Medical Technicians and Paramedics must be able to substantiate the medical necessity of the oxygen utilization.

Billing a Medicaid Recipient

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 copayment and any patient liability payment as authorized by law."

Providers are reminded that they must accept the Medicaid determination of payment as payment in full. If the provider disagrees with the Medicaid determination of reimbursement, the provider's right shall be limited to an administrative review and appeal as provided in 405 IAC 1-1-3. However, prior to filing an administrative review and appeal, the provider must take one of the following actions:

1. Resubmit a corrected claim if the original submission was denied for incorrect billing;
2. Submit an adjustment request, as appropriate; or
3. Submit a written request to EDS Provider Inquiry, stating why the provider disagrees with the denial or amount of reimbursement.

Violation of this section shall constitute grounds for the termination of the provider agreement and the decertification of the provider, at the option of the IFSSA.

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

- The service rendered must be a service determined to be not covered by the Indiana Medicaid program or the recipient has exceeded the program limitations for a particular service.
- The Medicaid recipient must understand Medicaid does not cover a service and accept financial responsibility prior to receiving a service which is not covered by the Indiana Medicaid program. This requirement may be waived for exceptional circumstances such as emergency services or an incompetent recipient.
- The provider must maintain documentation that the recipient voluntarily chose to receive the service, knowing that it was not covered by the program.
- The covered or noncovered status of embellishments or enhancements to basic services may only be considered separately from the basic service if a separate procedure, revenue or National Drug Code (NDC) exists. Only if separate codes exist may a noncovered embellishment be billed to the recipient and the basic charge be billed to Medicaid. Otherwise, the service in its entirety is considered covered or noncovered. For example, since no such procedure exists for embellishments to a standard pair of eyeglass frames, it is not allowable for Medicaid to be billed for the basic frames and for the recipient to be billed for additional charges. The provider must accept the payment from Medicaid as payment in full for the frames, whether they are basic or fancy frames.
- A provider may bill the recipient in situations where the provider has taken appropriate action to ascertain and identify a responsible payer for a service, and the recipient has failed to advise the provider of his or her Medicaid eligibility prior to the expiration of the one year claims filing

limitation. Documentation must be maintained to establish that the recipient was billed and/or the information was requested within the one (1) year filing limit.

- If the recipient is in the managed care program Hoosier Healthwise, the provider must contact the recipient's primary medical provider (PMP) to obtain authorization to provide services. If the authorization is refused by the PMP, the recipient must be told that services can be provided free of charge if the recipient seeks the services from the PMP. If the recipient still desires to see the provider, the service is non-covered and the recipient may be billed. If a signed waiver is used, the waiver cannot contain language "If the service is not covered by Medicaid", since this would appear to circumvent the need to verify eligibility or seek PMP authorization.

Assignment of Provider Claims

Pursuant to the Medicaid Provider Agreement and the Federal regulations, Indiana Medicaid providers are reminded that they may only submit claims for services rendered by the provider or employees of the providers. A Medicaid provider may not submit a claim for services rendered by a contractor unless the Medicaid provider is a healthcare facility (i.e. hospital, ICF/MR, or nursing facility) or a government agency.
42 CFR 447.10

Health care fraud and abuse hurts all of us and we rely on the provider community to be active participants in detecting and deterring Medicaid program fraud and abuse. Should you be aware of any potential abusive or fraudulent activity, please contact the Medicaid fraud and abuse toll-free hotline at 1-800-457-4515.

If you have any questions regarding the information contained in this bulletin, please contact the EDS Provider Assistance Unit at 1-800-577-1278, or for local providers and out-of-state providers not in a contiguous state, at (317) 655-3240.

Memorandum

DATE: September 5, 2002

TO: **All Indiana Medicaid Providers**

FROM: EDS Provider Relations

RE: Attachment to Indiana Medicaid Update Bulletin, E98-05 Re: Diabetes Self Management Reimbursement

Attached you will find a copy of SENATE ENROLLED ACT No. 184.

Please attach to your copy of the Indiana Medicaid Update Bulletin, E98-05, dated 2/11/98, regarding Diabetes Self Management Reimbursement. This attachment was erroneously omitted from the previous mailing.

We apologize for any inconvenience this omission may have caused.

Thank You

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First Regular Session 110th General Assembly (1997)

PRINTING CODE. Ammendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new costitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word NEW will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict Reconciliation: Text in the statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1996 General Assembly.

SENATE ENROLLED ACT No. 184

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-14.5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1998]:

Chapter 14.5. Coverage for Services Related to Diabetes

Sec. 1. As used in this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract; provided to an insured.

(b) The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplment to liability insurance.

(3) Worker's Compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance policy issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

Sec. 2. As used in this chapter, "insured" refers to an individual with:

(1) insulin-using diabetes;

(2) non-insulin using diabetes; or

(3) elevated blood glucose levels induced by pregnancy or another medical condition;

who is covered by a health insurance plan issued by an insurer.

Sec. 3. As used in this chapter, "insurer" means any person who provides health insurance and issued health insurance plans in Indiana. The term includes the following

(1) A licensed insurance company.

(2) A prepaid hospital or medical service plan.

(3) A health maintenance organization.

(4) A state employee health benefit plan.

(5) The state Medicaid plan.

(6) Any person providing a plan of health insurance subject to state insurance law.

Sec. 4. A health insurance plan issued by an insurer must provide coverage to the insured for the medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29, subject to the general provisions of the health insurance plan.

Sec. 5. (a) An insured may not be required to pay an annual deductible or copayment that is greater than an annual deductible or copayment established for similar benefits under the health insurance plan. If the plan does not cover a similar benefit, the copayment or deductible may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.

(b) An insured may be subject to coinsurance that is not greater than coinsurance established for similar benefits under the health insurance plan. If the plan does not cover a similar

benefit, the coinsurance may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.

Sec. 6. (a) A health insurance plan issued by an insurer must provide coverage for diabetes self-management training that is:

(1) medically necessary;

(2) ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29; and

(3) provided by a health care professional who:

(A) is liscensed, registered, or certified under IC 25; and

(B) has specialized training in the management of diabetes.

(b) Coverage for diabetes self-management training may be limited to the following:

(1) One (1) or more visits after receiving a diagnosis of diabetes.

(2) One (1) or more visits after receiving a diagnosis by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29 that:

(A) represents a significant change in the insured's symptoms or condition; and

(B) makes changes in the insured's self-management medically necessary.

(3) One (1) or more visits for reeducation or refresher training.

(c) Coverage for diabetes self-management training is subject to the requirements of the health insurance plan regarding the use of participating providers.

Sec. 7. The department may adopt rules under IC 4-22-2 to carry out this chapter.

SECTION 2. [EFFECTIVE JANUARY 1, 1998] IC 27-8-14.5, as added by this act, applies to all health insurance plans (as defined in IC 27-8-14.5-1, as added by this act) issued or renewed after December 31, 1997.

SEA 184