INDIANA MEDICAID UPDATE

September 29,1998

TO: **All Indiana Medical Assistance Program 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. The following are some of the areas recently identified through the desk and on-site reviews performed by the SUR department, and through communication with the Office of Medicaid Policy and Planning staff.

Update on Dental Procedure Codes

Procedure Code **Z2950** Base filling for Restorations **(effective June 5, 1998)** is included in the fee for the restorations.

Procedure Code **Z5154** Acid Etch for Restorations **(Effective June 5, 1998)** is included in the fee amount for restorations and sealants.

The aforementioned services are no longer reimbursed separately, but will be considered included in the fee paid for the preventive and restorative procedures.

Billing of Private Rooms In a Nursing Home Setting

Recent Surveillance and Utilization Review activities have revealed that some providers are continuing to bill revenue code 110, private room, in violation of Indiana Medicaid regulations. As specified in **405 IAC 5-31-4 Section 4:**

(1) Room and board (room accommodations, all dietary services and laundry services). The per diem rate includes accommodations for semiprivate rooms. Medicaid reimbursement is available for *medically* necessary private rooms. Private rooms will be considered medically necessary *only* under one (1) or both of the following circumstances:

(A) The recipient's condition requires isolation for health reasons, such as *communicable disease*.

(B) The recipient exhibits *behavior* that is or may be *physically harmful to self or others in the* facility.

Family Responsibility for Payment of Non-Medicaid Covered Private Room In a Nursing Home Setting

If it is determined that a private room is not medically necessary, the private room is considered a non-Medicaid covered service. Therefore, if the patient or his/her family requests a private room, the patient's family may be held responsible for the private room rate. The facility may bill the family directly for the difference in room rates. It should be noted, however, that a facility may bill the family for this additional service only when the private room is at the request of the resident and his/her family, and with the family's full understanding that it will be financially responsible for the difference between the semi private and private room rates.

Please refer to Bulletin E94-28 regarding the circumstances under which Medicaid reimbursement is available for private rooms in long term care facilities.

The Surveillance and Utilization Review Unit will continue to recover dollars paid to providers by Medicaid who bill for private rooms when postpayment review reveals that the private room was not medically necessary.

Recipient Diagnoses In a Nursing Home Setting

Postpayment review has also identified that some providers are inappropriately listing inactive diagnoses such as sepsis and pneumonia on the UB92 claim form. While a recipient may have had these illnesses at one time, these are not chronic conditions and should not appear on the UB92 month after month. The diagnoses listed on the UB92 should be current and help explain the need for extended care. Remote or inactive diagnoses should not be listed.

REMINDER: Do Not Bill Medicaid Recipients for Medicaid Covered Services

The Surveillance and Utilization Review (SUR) unit receives many telephone calls from Medicaid recipients indicating they are being billed by their Indiana Medicaid provider for Medicaid covered services when the provider's claim has been denied.

Medicaid providers are prohibited from charging any Indiana Medicaid recipient, or the family of a recipient, for any amount not paid on a covered Medicaid service as determined by the Medicaid Program. Providers are reminded that they must accept the Medicaid determination of payment as payment in full. A provider may only bill a Medicaid recipient for services that are not covered by the Indiana Medicaid program. If the recipient was made aware and signed a statement of awareness that the service was not covered prior to having the service performed, the provider may bill the recipient.

Please refer to Bulletin E98-06, issued 2/19/98, for a complete list of the conditions under which a Medicaid provider may bill a Medicaid recipient.

Echographies with the Diagnosis of Normal Pregnancy

Recent review of multiple Medicaid obstetric and radiological 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 code from the V22 series as the primary diagnosis and an ICD-9 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

Documentation in the patient's medical record must substantiate the medical need for the echography.

Sterilization Consent Form Requirements for Recipients in Cases of Premature Delivery or Emergency Abdominal Surgery

In the case of premature delivery or emergency abdominal surgery, a sterilization may be performed in less than 30 days after the date of the recipient's signature on the consent form. However, the form must have been signed for more than 72 hours before the procedure is performed. The reason for the surgery must be only because of premature delivery or emergency abdominal surgery. The physician's statement on the consent form contains a section that addresses this circumstance. The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery.

Should you have any questions concerning the contents of this bulletin, please contact the EDS Provider Assistance Unit at 1-800-577-1278.