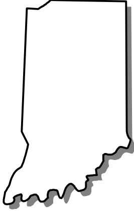

PROVIDER BULLETIN

BT200123 JUNE 15, 2001

To: **All Indiana Health Coverage Programs Waiver Case Managers, BDDS District Managers, BDDS D&E Teams, Nursing Facilities, Supervised Group Living Providers, and Large Private ICF/MR Providers**

Subject: **Initial Assessments and Annual Functional Assessments Currently Conducted by the D&E Teams for Individuals with Developmental Disabilities**

Overview

The purpose of this bulletin is to notify providers of the requirements for initial and annual assessments for individuals with developmental disabilities to be reimbursed through Medicaid or Division of Disability, Aging, and Rehabilitative Services (DDARS) state funding. Currently, providers bill Medicaid for certain diagnostics and evaluations (D&E) that are no longer necessary. These D&Es will no longer be reimbursed as a separate service**. This bulletin clarifies the types of billable assessments, valid procedure codes, and claims payment system for authorized assessments that are currently in effect (Table 1.1). This bulletin also lists procedure codes being deleted from Indiana*AIM* effective August 1, 2001 (Table 1.2).**

Definitions

PAS Review

No changes are being made to either the pre-admission screening (PAS) or resident review assessment.

Initial Assessments

Initial assessments should be based on existing collateral D&E information whenever possible. Only in cases where the available collateral information is not sufficient to

determine eligibility and to resolve other related issues will new diagnostic testing and evaluations be authorized.

Annual Functional Assessments – Supported Living Settings (including HCBS waiver-funded and state-funded settings)

Annual assessments should include a functional assessment to ensure that the individual's needs are being met by his or her service plan. In cases where significant changes occur in an individual's condition, new diagnostic testing and evaluations will be authorized by the Bureau of Developmental Disabilities Services (BDDS) or the Office of Medicaid Policy and Planning (OMPP). Individuals transitioning from intermediate care facility for the mentally retarded (ICF/MR) settings may have D&Es authorized by BDDS.

Annual Assessments – Supervised Group Living and Large Private ICF/MR Settings

Annual assessments in ICFs/MR are used solely for the facility to develop ongoing treatment plans and implement those plans. The facility determines which entity (D & E teams, corporate office, interdisciplinary teams, contracted entities, and so forth) performs the assessment. The only specific requirement of the Family and Social Services Administration (FSSA) and Indiana State Department of Health (ISDH) for the annual assessment is that the needs of the residents must be fully assessed at least annually and when significant changes in the residents' physical or mental condition occur.

State Developmental Centers

Annual assessments are required in state developmental centers to fully assess the needs of the individuals (annually or more frequently as needs change) and to ensure those needs are met.

Valid Assessments

Table 1.1 – Valid Assessments

Program	Initial or Annual	Required?	Procedure Codes to Bill	Billing System
Nursing Facility (OBRA and PASRR)	Initial	Yes	**9075** – PAS MR Evaluation **9076** – PAS Psychological Evaluation	Medicaid (Bill through OMPP)
	Annual	No*	**9077** – RR-MR evaluation **9082** – RR-Psychological Evaluation	*See note below. If needed, payer is Medicaid. (Bill through OMPP)
Waivers with Nursing Facility Level of Care (Aged and Disabled, Traumatic Brain Injury, Medically Fragile Children, if individual has developmental disabilities)	Initial	As requested by the OMPP, if individual has developmental disabilities	**Z5121**** – D & E **Z5122**** – Psychological Evaluation	Medicaid (Bill through EDS)
	Annual	As requested by the OMPP, if individual has developmental disabilities	**Z5121**** – D & E **Z5122**** – Psychological Evaluation	Medicaid (Bill through EDS)
Applying for or on Waivers with ICF/MR Level of Care	Initial	Yes	**Z5112** – D & E **Z5113** – Psychological Evaluation	Bill through EDS (BDDS pays state match to Medicaid)
	Annual	Yes	**Z5701** – D & E **Z5702** – Psychological Evaluation	Medicaid waiver funding (Bill through EDS)
Supported Living Non-Waivers (Not eligible for Medicaid)	Initial	Yes		BDDS (Note: If Medicaid eligible and applying for a waiver, use codes for ICF/MR level of care initials and bill through EDS)
	Annual	Yes		BDDS

(Continued)

Table 1.1 – Valid Assessments

Program	Initial or Annual	Required?	Procedure Codes to Bill	Billing System
Supervised Group Living (Group homes)	Initial (including re-admissions and moves)	Yes	**Z5121**** – D & E **Z5122**** – Psychological Evaluation	Medicaid (Bill through EDS)
	Annual	Yes	Built into per diem rate. Provider arranges for assessments.	Provider builds into cost reimbursement per diem rate.
Large Private ICFs/MR	Initial (including re-admissions and moves)	Yes	**Z5121**** – D & E **Z5122**** – Psychological Evaluation	Medicaid (Bill through EDS)
	Annual	Yes	Built into per diem rate. Provider arranges for assessments.	Provider builds into cost reimbursement per diem rate.
State Operated Developmental Facilities	Initial	Yes (if requested by the OMPP)	**Z5121**** – D & E **Z5122** **– Psychological Evaluation	Medicaid (Bill through EDS)
	Annual	Yes	Built into per diem rate. Provider arranges for assessments.	Provider builds into cost reimbursement per diem rate.
Transition from ICFs/MR (Only with application for other Medicaid-funded setting)	Initial	Yes	**Z5112** – D & E **Z5113** – Psychological Evaluation	Bill to EDS. (BDDS pays state match)
	Annual	Not applicable		

* *OBRA*

Reminder: There is no longer a federal requirement for mandatory annual resident review of developmentally disabled residents in nursing facilities. Instead, under federal law, a resident review is required promptly if there is a “significant change in the resident’s physical or mental condition.” Assessment will be authorized for individuals who have undergone a significant change in condition. Assessment will also be authorized for individuals residing in nursing facilities who are receiving specialized services. BDDS will continue to follow these individuals to ensure their needs are being met.

** Procedure Codes Z5121 and Z5122

Billing procedure codes Z5121 and Z5122 are effective for reimbursement of claims effective January 1, 2001.

ICFs/MR

Annual assessments are required for individuals residing in large private ICFs/MR and supervised group living settings. However, these assessments are included in the facility's per diem rate. If a facility does not already include this information in its cost report, it will need to do so in the future for rate setting purposes.

Invalid Assessment Codes

Table 1.2 provides additional D&E related assessment codes in Indiana*AIM* that are currently being billed for assessments. **These codes are no longer valid and will be deleted effective August 1, 2001.** Claims submitted for reimbursement using these codes will be denied as of that date.

Table 1.2 – D&E Codes Deleted August 1, 2001

Code	Description
W9072	Initial D and E
W9073	Annual D and E
W9074	Updated D and E
W9078	ICF/MR CRF/DD ARR

Note: The OMPP, in coordination with the ISDH, eliminated reimbursement for Rule 7 *assessments that had been conducted for residents with developmental disabilities in nursing facilities under* 410 IAC 16.2-7. *Notification of this termination was sent in a Medicaid bulletin jointly issued by the OMPP and ISDH February 24, 1992.*

However, some Rule 7 related assessment claims have continued to be submitted for reimbursement using one or more of the codes listed in Table 1.2 that are being deleted. Medicaid will not reimburse for Rule 7 assessments. This includes Rule 7 assessments that have previously been billed for residents of nursing facilities that converted to large private ICFs/MR.