



NORTH DAKOTA MEDICAID

PROVIDER BULLETIN

THE REIMBURSEMENT NEWS SOURCE

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DIRECTOR

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Issue 64 • October 2008

TAMPER RESISTANT PRESCRIPTION PADS

Beginning April 1, 2008, all prescriptions (on paper) for outpatient drugs prescribed to a Medicaid beneficiary were required to have at least one tamper-resistant feature, as outlined by Centers for Medicare & Medicaid Services (CMS). Beginning October 1, 2008, these same prescriptions (on paper) must have all three baseline characteristics of tamper-resistant pads.

The baseline characteristics must:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription by the prescriber; or
3. Prevent the use of counterfeit prescription forms.

There has been a large amount of information distributed on this issue from a variety of sources. Please go to our website, <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html> where we have all information available regarding this subject. ☺☺☺

FEE SCHEDULE UPDATE

In accordance with the legislative appropriation to update provider rates with a 5.0% inflationary increase the second year of the 07-09 biennium, we have increased provider rates effective for 7/1/2008 dates of service and after. Codes which are priced off a fee schedule will be adjusted with the 5% inflationary increase accordingly.

Codes which are priced using the Relative Value Unit (RVU) methodology have had the conversion factor adjusted. The adjustment in the conversion factor takes into account the implementation of the 2008 RVUs for dates of service on, or after, July 1, 2008. Based on previous 12 month's claims volume, the new RVU adjustments, along with the 5.0% inflationary increase, result in the conversion factor being adjusted to \$39.13. The previous conversion factor was \$36.68. Based on the changes to the RVU, some fees will increase while others may stay the same or decrease. ☺☺☺

DISABLED CHILDREN'S BUY-IN COVERAGE

The North Dakota Department of Human Services' Medicaid program administers a buy-in program to provide medical assistance to qualifying children with disabilities. Families with incomes up to 200 percent of the Federal Poverty Level can "buy in" to Medicaid coverage for a child with a disability. The Children with Disabilities Medicaid Coverage was available beginning April 1, 2008.

The program provides comprehensive coverage through Medicaid, including dental and mental health coverage, in return for a premium. Parents can apply at their local county social service office.

To qualify—

- A child must be under age 19, however coverage may extend through the month in which an eligible child turns 19;
- The child must be considered disabled (According to the Social Security Administration's definition of disability);
- The family's total net countable income cannot exceed 200 percent of the Federal Poverty Level.
- If either of the child's parents has medical coverage available for the child through an employer AND the employer pays at least half of the premium, the child must be enrolled in the private coverage.

- A family can have any private coverage and qualify for the buy-in. In approving the coverage, North Dakota legislators recognized that children with disabilities often have health care needs that exceed private coverage limits.
- Families of qualifying children pay a monthly premium equal to five percent of the family's gross countable income.
- If the child is covered by other health insurance, the premium for Children with Disabilities Medicaid Coverage will be reduced by the premium amount paid by the family for the other insurance.
- There is no asset limit for this coverage. In other words, children are not disqualified if families own a home, more than one car, or other assets.

Children covered under North Dakota's Children with Disabilities Medicaid Coverage are entitled to the same covered services as other Medicaid participants, and they are also subject to the same Medicaid benefit caps and limits. These children are not required to name a Primary Care Physician. A fact sheet entitled "Children with Disabilities – Medicaid Buy-in Coverage" is available at

<http://www.nd.gov/dhs/info/pubs/medical.html>.

CHILDREN WITH MEDICALLY FRAGILE NEEDS

On April 1, 2008, Centers for Medicare & Medicaid Services (CMS) approved a 1915 (c) waiver for children, who are medically fragile and living in the home of a legally responsible care giver, to receive additional assistance to avoid institutional placement. This waiver will cover 15 children at one time, with a waiting list, if needed. This is a parent directed waiver with a maximum of \$18,966 for available waived services, per family, per year.

The waived services available are:

- Case management
- In - home support
- Institutional respite
- Dietary supplement
- Individual and family counseling
- Equipment and supplies

- Environmental modifications
- Transportation

Criteria to qualify are:

- Child qualifies for Medicaid,
- Age 3 until 18th birthday,
- Child is living in their legally appointed caregiver's home,
- Child must qualify for skilled nursing home level of care, and
- Child must receive a minimum score of 40 on the Level of Need review.

The applications can be found at <http://www.nd.gov/eforms/> form #394. For further information you can contact the Program Manager, Katherine Barchenger at 701-328-3701.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The Balanced Budget Act of 1997 established the PACE model of care for both Medicare and Medicaid programs. The Act enables States to provide PACE services to Medicaid beneficiaries as a State option. In North Dakota, this option became available on September 1, 2008. Northland PACE is the provider of PACE services, serving the Bismarck and Dickinson area.

PACE providers receive a set amount of money on a monthly basis, for each eligible Medicare and Medicaid enrollee, to provide patient-centered and coordinated care to frail elderly individuals living in the community

PACE programs provide a comprehensive service delivery system, which includes all needed preventive, primary, acute, and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. PACE Providers assume full financial risk for participants' care without limits on amount, duration, or scope of services. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services, if necessary).

In order to qualify for the PACE program a participant must:

- Be a Medicare and/or Medicaid enrollee,
- Age 55 or older,
- Eligible for nursing home level of care, and
- Live in a PACE service area.

For more information about PACE and how to enroll potential participants into the program, contact Northland PACE: Bismarck 701-751-3051; Dickinson 701-456-7387; or Toll Free 1-888-883-8959. ☞

CLAIMS

CHANGE TO DENTAL CODES

Effective July 1, 2008, North Dakota Medicaid will be providing reimbursement to dentists for the following codes for children through age 20:

Endodontic Therapy

- D3330 Molar (excluding final restoration)
- D3347 Re-treatment of previous root canal therapy –bicuspid
- D3348 Re-treatment of previous root canal therapy – molar

Both codes D3347 and D3348 will need to have prior authorization before the service can be performed.



MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REPLACEMENT PROJECT UPDATE

The Medicaid Management Information System (MMIS) Replacement Project; that was started back in the 2003 – 2005 biennium with the creation of a Request for Proposal (RFP), has completed the requirements phase and has entered into the detailed design portion of the construction phase.

In September 2007, the department completed the requirements phase with the official approval of the Requirements Analysis Document (RAD). This document contained the high level business requirements for the new system. The RAD for the State of North Dakota Department of Human Services was in excess of 2,300 pages. The business requirements vary from system process workflows to high level descriptions of web pages and reports.

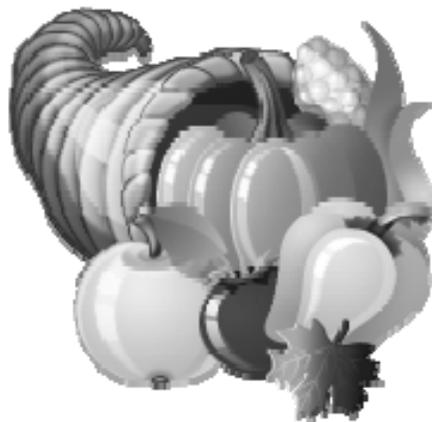
As part of the eventual provider go-live process, every provider wishing to continue to bill services to North Dakota Medicaid will be required to re-enroll. The entire re-enrollment process has not yet been fully developed; however due to the inconsistencies of the data contained in the current MMIS, pre-population of data for the re-enrollment process will not be an option. However, the new system's online web re-enrollment will be a user-friendly interface containing descriptions of required data along with online help. The department has tailored the re-enrollment process so different information will be required

based on the provider type/specialty of the organization. This will help to keep the re-enrollment effort for providers to a minimum.

The new system will accommodate providers having multiple service locations, multiple provider types, multiple provider specialties, multiple certifications, and/or multiple licenses to match to the entered provider type and provider specialties. The new application will also allow for the input of an NPI number, as well as multiple taxonomy codes to match back to the provider type and specialties. Since the application can be lengthy, one of the Department's requirements was to allow for an online application to be saved in an incomplete status so a provider can return at a later time to finish the application. The Department also recognized that some of the information can change over time so there will be a self-service provider portal where the provider can update most of their information without the need to contact the state.

The Department is currently in the process of developing a re-enrollment project plan that will define the training that will be provided to the providers before the re-enrollment process begins.

The Department will also be launching a website, specifically for keeping providers informed of re-enrollment and go-live requirements.



MEDICAL RECORD DOCUMENTATION

As a condition of participation, ND Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the North Dakota Medicaid program. Records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements. HIPAA does not prohibit the release of records to ND Medicaid. Record documentation is used by ND Medicaid to determine medical necessity and to verify that services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

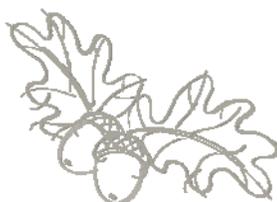
1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care, including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record. ◀◀

EVALUATION AND MANAGEMENT (E/M) DOCUMENTATION

ND Medicaid adheres to the Center for Medicare and Medicaid Services (CMS) Evaluations and Management (E/M) documentation guidelines. Currently, ND Medicaid allows the use of and **conducts reviews using** CMS' guidelines for either 1995 or 1997; whichever is more advantageous to the physician/enrolled provider.

For complete CMS Documentation Guidelines for E&M Services see the following website:

http://www.cms.hhs.gov/MLNEDWebGuide/25_EMDOC.asp. ◀◀



Please route to:

- Billing clerks
- Insurance Processors
- Schedulers
- Other Appropriate
Medical Personnel

Please make copies as
needed.

CHECK-WRITE EXCEPTION DATES

Typically, check-write occurs every Monday evening; however, there will be the following exceptions for 2008-2009:

No Check-Write	Rescheduled Date
December 1, 2008	December 2, 2008
January 19, 2009	January 20, 2009
February 16, 2009	February 17, 2009
May 25, 2009	May 26, 2009
June 1, 2009	June 2, 2009

NEW FACES & PLACES IN MEDICAL SERVICES

- ☺ Kristi Hruby – Administrative Assistant
- ☺ Jeff R. – Medical Claims Processing Specialist
- ☺ Michelle – Medical Claims Processing Specialist
- ☺ Nikki L. – Claims Processing Auditor
- ☺ Deb Baier – Administrator, Long-Term Care
& Psych Under 21
- ☺ Mary Jo Prochnow – Administrative Assistant
- ☺ Pam Heinrich – Administrator, Utilization
Review



**North Dakota Department of Human Services
Medical Services
Definitions of Direct and General Supervision**

Direct Supervision

Office Setting: Direct supervision in an office setting means that the physician (MD, DO) must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service. However, the physician does not need to be physically present in the same room as his/her/clinic employee.

Physician Directed Clinic: In clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians, as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by the employee are covered even though they are performed in another department of the clinic. The service would be billed under the PIN of the supervising physician.

General Supervision

General supervision means that the enrolled Provider need not be physically present at the facility where the service is rendered but must be immediately available by phone or by other means of communication. However, the service must be performed under his/her overall supervision and control and the following criteria must be met.

1. The service is an integral part of the enrolled Provider's services to the patient. This means the enrolled provider must initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient's care.
2. The services are reasonable and necessary, and not otherwise excluded from Medicaid coverage.

An enrolled Provider cannot hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under state law, or whose professional qualifications exceed those of the "supervising" provider.

Addendum: This is not part of the definition; however this is an example of how we would apply this definition to LICSW/LCSWs working under the direct supervision of a physician.

Services rendered by the LICSW/LCSW under the direct supervision of the physician must bill for his/her services under the supervising physician's PIN and append the procedure (CPT) code with modifier -AJ (clinical social worker)

This document supersedes all previous information distributed by the Department related to Provider Enrollment and Supervision.

See chart on reverse side for supervision requirements.

**North Dakota Department of Human Services
Medical Services (NDMA)
Provider Enrollment**

Enrolled Providers	Auxiliary Personnel	Modifiers	Supervision
Audiologist	N/A		
Certified Registered Nurse Anesthetist (CRNA)	N/A	QX, or QZ	
Chiropractor	N/A		
Dentist	N/A		
Licensed (Clinical) Psychologist	N/A		
Licensed Registered Dietician (LRD)	N/A		
Licensed Independent Clinical Social Workers (LICSW)	N/A		
LPNs/Registered Nurses (Private Duty Nursing only)	N/A		
Nurse Practitioner	N/A	AS*	
Nurse Midwife	N/A		
Occupational Therapist (OT)	Licensed/Certified Occupational Therapy Assistant		General
Optometrist	N/A		
Pharmacists (Vaccination Admin only)	N/A		
Physical Therapist (PT)	Licensed/Certified Physical Therapy Assistant		General
Physician (MD/DO)	Clinical Nurse Specialist (CNS)	U2, or AS*	General
	CRNA	QX, or QZ	General
	LICSW, LCSW	AJ	Direct
	Nurse (RN, LPN)		Direct
	Nurse Midwife	SB	General
	Nurse Practitioner (NP)	SA, or AS*	General
	Physician Assistant (PA)	U1, or AS*	General
	Certified Diabetic Educator		General
Podiatrist	N/A		
Speech Pathologist	N/A		

*AS - Physician assistant, nurse practitioner, or clinical nurse specialist services for **assistant at surgery**

Note: N/A indicates that no auxiliary personnel may render and/or bill for services under the enrolled provider's PIN.

Auxiliary personnel rendering services under the direct or general supervision of an enrolled provider may only render services that are defined in the enrolled provider's scope of practice. **See Direct and General Supervision definition.**