



LAB, RADIOLOGICAL AND DIAGNOSTIC SERVICES

This document is subject to change. Please check our web site for updates.

This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services performed by a provider of (independent) laboratory services, (independent) x-ray services, or portable x-ray services and are certified by Medicare and enrolled with North Dakota (ND) Medicaid.

INDEPENDENT LABORATORIES, MEDICARE CERTIFIED

The Centers for Medicare and Medicaid Services (CMS) CLIA directives that require Medicaid to identify the independent laboratory and check certification for procedures they are authorized to perform. Medically necessary services provided by certified independent laboratories are covered by ND Medicaid if those services fall within the range of Medicare certified specialties and subspecialties for that laboratory. Hospital laboratory services also must be certified by Medicare for ND Medicaid coverage. Services that are not certified will not be covered.

CODING GUIDELINES

ND Medicaid follows CMS National Coverage Determination (NCD) and specified Local Coverage Determination (LCD) guidelines for some laboratory, radiological and diagnostic procedures.

COMPONENTS OF AND BILLING FOR RADIOLOGIC SERVICES

Both professional and technical components may be billed to ND Medicaid. The professional component is applicable in any duration in which the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities. To bill for the professional component, use the applicable procedure code appended with modifier 26 in the appropriate modifier field of the CMS1500 claim form or the electronic equivalent. When more than one provider is involved with providing and billing the procedure the providers should

establish a written agreement as to which component each provider will be billing. Duplicate billing is considered fraudulent.

When a physician or physician clinic is billing for services performed, and the equipment used is owned by the physician or clinic, the service should not be separated into a technical and professional component. Bill the appropriate CPT code but do not modify the code.

The professional component represents the professional services of the physician. The professional component includes: examination of patient when indicated, performance or supervision of the procedure, interpretation, and written report of the examination.

The technical component includes the charges for personnel, materials, including usual contrast media and drugs, film or xerograph, space, equipment and other facilities but excludes the cost of radioisotopes. (Technical components may be billed by providers owning the equipment). To identify a charge for the technical component, enter the procedure code and append modifier TC in the appropriate modifier field.

LABORATORY SERVICES IN A PHYSICIAN'S OFFICE

Providers eligible for reimbursement of laboratory services in a physician's office are physicians or physician extenders under the direct supervision of the physician.

Physicians also may send laboratory specimens to independent or outpatient hospital laboratories. However, claim submission must be done by the independent or outpatient hospital laboratory.

CT SCAN / MRI

ND Medicaid will cover medically necessary MRI and CT scans. MRI and CT scans can be used for the diagnosis of many medical conditions. Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Medicaid does not cover CT or MRI scans that are not medically necessary.

BILLING GUIDELINES

Providers must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.