



NORTH DAKOTA MEDICAID

PROVIDER BULLETIN

THE REIMBURSEMENT NEWS SOURCE

CONSISTENCY & ACCURACY IN BILLING

IN THIS ISSUE

CONSISTENCY & ACCURACY IN BILLING..... 1

PAYMENT ERROR RATE MEASUREMENT AUDITS ..2

COORDINATED SERVICES PROGRAM.....3

FOR MEDICAID PROVIDER INCENTIVE PAYMENT PROGRAM (PIPP)4

OUT-OF-STATE SERVICES4

MANAGED CARE: WALK-IN POLICY/DEFINITION5

CLAIMS – BILLING BITS ...6

CHECK-WRITE EXCEPTION DATES8

NEW FACES IN MEDICAL SERVICES8

The **North Dakota** Department of Human Services has conducted an ongoing review to examine medical claims for consistency and accuracy in billing processes. The goal has always been to be fair and equitable in this endeavor. The State of North Dakota Department of Human Services continues to utilize globally accepted guidelines including CPT regulations as documented by the AMA, Correct Coding Initiatives (CCI) and Post-Operative Period Guidelines as outlined by the Center for Medicare and Medicaid Services (CMS). In addition, Section 6507 of the Patient Protection and Affordable Care Act (PPACA) requires the use of National Correct Coding Initiative methodologies for claims filed to Medicaid agencies on or after October 1, 2010.

In our ongoing efforts to improve accuracy in claims processing and payment, and to ensure compliance ND Medicaid will be implementing a new claims editing program. The projected implementation date is late September 2010. This program will ensure a more thorough and comprehensive review of all professional claims billed on a CMS 1500 or as an 837P transaction by promoting compliance with globally accepted guidelines. Several areas of review are based on the following globally accepted coding principles:

1. **Global Surgical Principles:** CMS has defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. These procedure codes are evaluated based on major and minor service categories with different defined global day allocations for each.
2. **Add-On Principles:** Both CPT and CMS define codes that require the presence of a primary procedure code for appropriate coding. These rules follow the direction set forth in the CPT manual that describes Add-on codes as “procedures/services that are always performed, by the same physician” and “are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes.”

– Continued on Page 2

MEDICAL SERVICES DIVISION

~

MAGGIE D. ANDERSON,
DIRECTOR

~

Issue 67 • July 2010

3. **Multiple Surgeon Principles:** CMS rules based on the need for an assistant surgeon, co-surgeons, and team surgeons for all surgical procedures. CMS is the only governing body that continues to evaluate the need for this type of service.
4. **CCI- National Correct Coding Initiative:** As defined by CMS:
 - a. **Comprehensive:** These procedure codes have been identified as inappropriate unbundling of comprehensive procedure codes into its component parts (codes).
 - b. **Mutually Exclusive:** These procedure codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.
5. **Duplicates:** Procedure codes for radiology, Date Range Duplicates, Lifetime Duplicates and E/M Service Range identified as inappropriate duplicate services are billed.
6. **Evaluation and Management Crosswalk Principles:** Multiple submissions of E/M codes within the same category and/or two different categories, by the same provider on the same date of service.
7. **Incidental Procedures:** The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status of B (bundled) or P (bundled/excluded) in the CMS National Physician Fee Schedule Relative Value File.
8. **Medical Necessity Based on Appropriate ICD-9 Codes:** These are Regional and National Medical Necessity guidelines from CMS and their Medicare contractors. Services reported must have the appropriate ICD-9 codes submitted on the claim that demonstrate medical necessity.

The North Dakota Department of Human Services looks forward to the implementation of the claims editing program to improve correct adjudication of professional claims. ND DHS will keep providers apprised of the upcoming changes. Providers will be notified via informational letter in advance of the implementation of this program.



PAYMENT ERROR RATE MEASUREMENT (PERM) AUDITS

ND Medicaid is in the final stages of the Payment Error Rate Measurement (PERM) cycle for FY09. The PERM cycle is every three years and it was established to determine the accuracy of paid Medicaid claims and Medicaid eligibility. The auditing is conducted by vendors hired by CMS and the results are published nationally.

Requests for documentation were sent to 500 providers and 499 responded. Providers that were assessed errors, based on the review of the documentation provided, will receive written notification and

be afforded appeal rights. The ND Medicaid program appreciates the cooperation of the medical records department, etc. who spent a lot of time responding to the requests. In future newsletters, ND Medicaid will provide a PERM summary that will highlight the errors found so all can learn from the errors cited in this PERM cycle. If you have any questions you may contact Dawn Mock, ND Medicaid Program Integrity Administrator at 701-328-1895 or dmock@nd.gov

COORDINATED SERVICES PROGRAM

Program Requirements

- Recipients that are referred to the Coordinated Services Program (CSP) must choose a primary care provider by selecting one (1) family practice, general practice, nurse practitioner or internal medicine provider of their choice.
- CSP recipients are restricted to one (1) pharmacy of their choice to manage their prescriptions.
- Based on the usage of dental services, the recipient may also be restricted to one dentist of their choice.
- The recipient's selection of service providers is subject to approval by ND Medicaid.
-

Services Obtained From A Non-Designated Provider

Medicaid will not pay for: services obtained from a non-designated provider; services obtained without a referral from the recipient's CSP provider; or visits to the emergency room that are determined "non-emergent".

Treatment By A Specialist

- Only the recipient's CSP provider can authorize a referral to a specialist.
- Referrals must be for medically necessary services, and be received in the ND Medicaid office prior to the date of service.
- Once authorized, the specialist may order medically necessary tests and treatment.
- If services from a specialist are needed, the CSP provider must initiate the referral.

Physician Absences

If a CSP provider is busy or out for the day, the CSP provider can refer for a one day visit to a covering provider. The clinic can decide if the client needs to be seen or can wait for their CSP provider.

If a CSP provider is going to be absent from practice for an extended period of time, the CSP provider should refer the client to another provider (to serve as CSP) so the client can access necessary urgent/emergent care. The recipient should wait for the return of his/her CSP provider for services that are considered routine care.

Referral Forms

- Only the CSP provider can refer, except in the case of absences as stated above.
- Referral forms are available by calling the Department's Surveillance and Utilization Review Section at 701-328-4010, 701-328-2334 or 701-328-4024.
- The referral form must be mailed or faxed to the Department of Human Services, Attn: CSP Referrals at **701-328-1544**. The CSP Primary Care Provider may also notify the Department by telephone, if the referral is urgent.
- **No retro referrals will be accepted.**
- If there is no referral on file, the charges will be denied and the patient will be responsible for the bill
- Referrals are not needed for lab, x-ray and/or radiology if the CSP provider and/or referred provider is ordering these services.
- Chiropractic Services require a referral from the CSP provider.
- Services Rendered by Optometry and Ophthalmology providers do not require referrals.
- All services that are provided in the emergency room are reviewed for medical necessity. An example of non covered services in the emergency would be prescription refills. All routine services should be addressed with their CSP. All emergency room, walk-in, and urgent clinic claims must have notes attached for review.

MEDICAID PROVIDER INCENTIVE PAYMENT PROGRAM (PIPP)

In 2009, Congress passed the Recovery Act, which contains a section called the HITECH Act.

These acts require providers to implement Electronic Health Records (EHR) and move toward meaningful use. These acts also provide dollars to pay out Medicare and Medicaid incentives to assist providers in meeting these requirements. In order for states to pay out Medicaid incentives, they must complete and submit plans to the Centers for Medicare and Medicaid (CMS) outlining how they will pay out incentives, assist providers with meeting requirements and explore ways themselves to move their processes to electronic formats.

The ND Department of Human Services, Information Technology Services Division, has hired a State Medicaid Health Information Technology Coordinator to complete this plan and assist the state to prepare and implement the Provider Incentive Payment Program (PIPP). CMS has approved the first planning document required and strategic and implementation plans are due in August. The earliest incentive payments may be paid out is January 2011.

The State Health Information Exchange (HIE) and Regional Assistance Extension Centers (REACH) also are charged with assisting eligible providers to be ready electronically to qualify for incentives. A detailed fact sheet on Medicaid PIPP, including eligibility criteria, is available on the CMS website at <http://www.cms.gov/EHRIncentivePrograms/>

At the end of July, detailed information on the PIPP will be sent out to all eligible professionals, along with the address for a new state PIPP web page for eligible professionals to access. If providers have questions about the PIPP, please contact Nancy R. Willis, 701-328-1715 or nwillis@nd.gov.

OUT-OF-STATE SERVICES

North Dakota Medicaid has developed a form to capture the information required to process all out-of-state service requests. The information requested is required to make an informed decision pertaining to the medical necessity of the out-of-state service. By consolidating the information, a determination can be made more quickly to better serve recipients. We hope this will also help to clarify the information that is required, making the provider's part of the process easier.

This form can be found on the Medical Services website at: www.nd.gov/eforms/Doc/sfn00769.pdf and can be filled out electronically before printing. **The form is required.** Any request submitted without all of the required information will not be processed and will be returned as incomplete.

PRIOR AUTHORIZATION REQUIREMENTS

Out-of-state services at sites more than fifty miles from the North Dakota border must be prior authorized. Services received outside of the United States are not covered.

The recipient's Primary Care Provider must submit a written request to North Dakota Medicaid for authorization for out-of-state services before scheduling an appointment.

Requests must include:

- Recipient's name, Medicaid ID number, and date of birth
- Diagnosis
- Medical information supporting the need for out-of-state services
- Written second opinion from an appropriate in-state board certified specialist, following a current (within 3 months) examination, which substantiates the medical need for out-of-state care

– Continued on Page 5

Out-of-State Services continued –

- Physician and facility where the recipient is being referred
- Assurance that the service is not available in North Dakota

The Medicaid office determines if the referral meets state requirements and approves or denies the request in writing. A copy of the determination is sent to the primary provider, out-of-state provider(s), recipient, and County Social Service Office.

Emergency out-of-state services are allowable at the in-state provider's discretion but are subject to Medicaid review and denial of claims. The transferring facility must notify ND Medicaid within 48 hours of a transfer for emergency services out-of-state. Documentation must include: destination and date of transfer, mode of transportation, and discharge summary. The need for the use of air ambulance must always be substantiated.

Claims from out-of-state providers will not be paid without prior authorization in writing from the State office.

Recipients with private insurance are subject to prior authorization requirements as established by the primary insurance carrier in addition to ND Medicaid's prior authorization requirements.

The recipient's County Social Service Office is responsible for assisting the recipient with arrangements for travel, lodging and meals.

MANAGED CARE : WALK-IN POLICY / DEFINITION

Primary Care Case Management (PCCM) update to Walk-in Policy and Definition of "same clinic" regarding Designating Covering Providers (DCP).

The following policy/changes have been updated in the General Information for Providers Manual:

Primary care provided by a colleague/associate of the designated Primary Care Provider-PCP (during a PCP's absence or inability to see a recipient) does not require a referral from the PCP if the following applies:

The DCP must be associated with the same clinic as the PCP. Same clinic is defined as a clinic that is associated with the PCP's facility by having the same Medicaid Provider Identification number as the PCP's clinic when submitting a claim.

The DCP must also be that of a type and specialty that may serve as a PCP (i.e. family practice, internal medicine).

Walk-in Clinics

(urgent care/after-hours/convenience clinics):

Walk-in clinics are exempt from PCP referrals only when BOTH of the following conditions are met:

1. The Walk-in clinic must be associated with the PCP's clinic by having the same Medicaid Provider Identification number as the PCP's clinic when submitting a claim.

For example: A Provider acting as a PCP located at ABC Family Practice North Clinic (Provider # 99999) would be an associate /colleague of the Attending PCP assigned to the recipient at ABC Family Practice South Clinic (Medicaid Billing Provider # 99999). The clinic must be associated by having the same Medicaid Provider Identification number as the PCP's when submitting a claim.

2. The medical center/walk-in clinic has an electronic health record system in which the walk-in clinic provider is able to access the recipient's medical records immediately upon assessing the Medical recipient.

When both of these apply during the date of service the recipient is seen, a referral is not required. All other providers are allowed 15 working days from the date of the service to obtain a referral.

Please refer to the [General Information for Providers Manual](#), *Managed Care* Chapter.

CLAIMS POLICY – BILLING BITS

Check out the latest updates by clicking on the button on the Medicaid Provider Information web page. www.nd.gov/dhs/services/medicalserv/medicaid/provider.html

Immunization Administration for Vaccines/Toxoids

The immunization administration (90465-90474) of vaccines/toxoids are allowed/reimbursed at the current ND Medicaid fee schedule: www.nd.gov/dhs/services/medicalserv/medicaid/docs/fee-schedules/ma-basic-fee-sched7-01-09.pdf

The immunization administration code (90465-90474) must be billed with a vaccine/toxoid code (90476-90749). The provider must follow CPT® coding guidelines with regard to reporting initial immunization administration and each additional administration. Do not report more than one initial immunization administration per date of service (i.e. per CPT®, “Do not report 90471 in conjunction with 90473”).

ND Medicaid requires that providers report an immunization administration code for each vaccine/toxoid administered and reported. Currently the immunization administration codes MAY NOT be billed with multiple units.

EXAMPLE:



Patient – female age 12	Patient – female age 12
90649-SL \$0.00	90649-SL \$0.00
90471 \$__.	90471 \$__.
90713-SL \$0.00	90713-SL \$0.00
90472 \$__.	90715-SL \$0.00
90715-SL \$0.00	90472 \$__ (UNITS 2)
90472 \$__.	



Vaccines, Toxoids

Codes 90476-90749 identify the vaccine/toxoid product only. To report the administration of a vaccine/toxoid the vaccine/toxoid product code MUST be submitted **with the appropriate immunization administration code(s) (90465-90474)**.

The vaccine/toxoid product (90476-90749) supplied through the **NDDoH Vaccine for Children (VFC)** program for children 0-18 years is reported with the vaccine/toxoid CPT® code appended with modifier **SL**. ND Medicaid will not allow/reimburse for vaccines/toxoids or the immunization administration when the product is available through the NDDoH VFC Program. An exception will be made to allow/reimburse vaccine/toxoid **ONLY** when there is a **national** shortage of a particular vaccine/toxoid and ND Medicaid has been notified of the national shortage by the NDDoH Immunization Program Manager.

The NDDoH also makes available certain vaccines/toxoids for special populations (19 years and older) through the “Other State-Supplied Vaccines/**317 Vaccine**” program. When these products are available ND Medicaid expects providers to use the “Other State-Supplied/317” vaccines/toxoids when NDDoH specified criteria are met. The vaccine/toxoid product supplied through the NDDoH 317 Vaccine program is reported with the vaccine/toxoid CPT® code appended with modifier **SL**. ND Medicaid will **not** allow/reimburse for vaccines/toxoids or the immunization administration when the product is available through the NDDoH “Other State-Supplied/317” program for special populations (19 years and older) who meet NDDoH criteria.

Continued on Page 7

Claims Policy – Billing Bits continued –

See NDDoH Vaccine Coverage Table as of January 1, 2010:

<http://www.ndhealth.gov/Immunize/documents/Providers/Forms/Vaccine%20Coverage%201-2010.pdf>

The vaccines/toxoids supplied to adults (19 years and older) which are not available through NDDoH 317 Vaccine program OR supplies to adults who do not meet the 317 Vaccine Program criteria **may** be allowed/reimbursed at the current ND Medicaid fee schedule along with the appropriate immunization administration.

NOTE: When ND Medicaid is the secondary payer, the provider must submit the claim with vaccine/toxoid and immunization administration CPT® codes according to ND Medicaid guidelines; therefore it is acceptable for providers to change/add the appropriate immunization administration CPT® code on the claim.

Also see: **General Information for Provider Manual - Immunizations**

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf>



Medicaid Coding Guidelines

Gardasil (HPV vaccine): www.nd.gov/dhs/services/medicalserv/medicaid/docs/cpt/gardasil-hpv-vaccine.pdf

Please see the updated coding guideline for Positron Emission Tomography (PET) scans at the following link: www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html. This guideline is effective as of 4/1/2010. Please contact provider relations with any questions at 1-800-755-2604.

Requirements for Electronic Claims with Primary/Secondary Payer Amounts

All providers must provide previous payer adjudication information on the claims submitted to ND Medicaid. All claim adjustment reason codes and corresponding dollar amounts from the previous payer remittance advice must be reported for proper adjudication by Medicaid. The type of claim billed determines where this information should be reported.

Providers whose payment is calculated based on Diagnosis Related Groups (DRG) or at encounter rates must include the claim adjustment reason codes and corresponding dollar amounts at the claim level.

All other providers must include the claim adjustment reason codes and corresponding dollar amounts at the detail line level.

** All electronic claims must comply with the 12X 837 4010A1 Implementation Guide requirements, and include standard claims adjustment reason codes to describe adjustments that a previous payer made during adjudication. It is the provider's responsibility to report the appropriate Claim Level Adjustments (CAS) codes, along with other loops, segments, and data elements that apply prior to claim file transmission.**

ND Medicaid allows/reimburses only rebatable Rho D immune globulin.

When Rho D immune globulin is administered (intramuscular injection) during the pregnancy of an Rh negative mother who is currently a ND Medicaid recipient it must be a rebatable product. To be reimbursed for Rho D immune globulin the enrolled ND Medicaid providers must purchase the Rho D immune globulin from a company that participates in the drug rebate program. Currently ND Medicaid is aware of two companies that participate in the drug rebate program and are suppliers of Rho D immune globulin. They are WinRho (Baxter Bioscience) and Rhophylac (CSL Behring LLC). As with all drugs the provider must submit the claim electronically with the appropriate HCPCS (J code) and the NDC identified on the product packaging.

Providers submitting claims with HCPCS codes and an NDC other than that which is on the package label is submitting a False Claim and is subject to investigation.

ND DEPT OF HUMAN SERVICES
 DIVISION OF MEDICAL SERVICES
 600 E BOULEVARD AVE DEPT 325
 BISMARCK ND 58505-0250
 ADDRESS SERVICE REQUESTED

PRESORTED
 STANDARD
 U.S. Postage PAID
 Bismarck, ND
 Permit No. 50

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 remainder of 2010:

No Check-Write	Rescheduled Date
September 5, 2010	September 6, 2010
November 1, 2010	November 2, 2010



NEW FACES & PLACES IN MEDICAL SERVICES

-  .. **Barb Jennings** – Healthy Steps
 Eligibility Worker
-  .. **Patricia Hinsz** – Healthy Steps
 Eligibility Worker
-  .. **Janet Helbling** – Eligibility Program
 Administrator
-  .. **Kari C.** – Claims Auditor
-  .. **Janell Rath** – Administrative Assistant
-  .. **Cindy Sheldon** – Deputy Medical Services
 Director

