

NORTH DAKOTA MEDICAID



PROVIDER BULLETIN

THE REIMBURSEMENT NEWS SOURCE

In this Issue

Changes to Medicaid Enrollment Forms	1
2011 Check-write Exception Dates	1
Referral Requirements for the PCCM Program	2
Submitting Claims Adjustments	2
Identification of Fraud, Waste or Abuse	3
Children with Medically Fragile Needs	3
Pharmacy Claims	3
Coordinated Services Program Information	4
Insulin Pump Policy	4
Out of State Services	5
ND Medicaid Optometric Billing Tips	6 & 7
Additional Billing Reminders	7 & 8
Service Limits	8
Nurse Practitioners Must Obtain Own ND Medicaid Provider Number	9
NEW! Managed Care Email and Contact Information	9
DME Providers	9
How to Report Fraud, Waste and Abuse	9
New Faces in Medical Services	9

NORTH DAKOTA
DEPARTMENT OF
HUMAN SERVICES

~
CAROL K. OLSON,
EXECUTIVE DIRECTOR

Issue 68 - April 2011

CHANGES TO MEDICAID PROVIDER ENROLLMENT

Effective immediately, all providers enrolling with North Dakota Medicaid must complete the updated Medicaid Program Provider Agreement SFN 615 (rev. Jan 2011). Applications received with a provider agreement form with a creation date prior to 2010 cannot be processed and ND Medicaid will contact the provider for additional information.

Another new requirement is the addition of the Ownership/Controlling Interest and Conviction Information form SFN 1168. Facilities should refer to 42 CFR 455.104 to determine if this form is applicable. All other documents previously required remain applicable. The web information below provides instructions and will help you obtain the forms from the Department of Human Services website. ND Medicaid encourages providers to reference the website as it will contain the most recent information and current forms.

Available on the ND Department of Human Services website under On-Line Forms:

- **SFN 615 – Medicaid Program Provider Agreement:**
<http://www.nd.gov/eforms/Doc/sfn00615.pdf>
- **SFN 1168 – Ownership/Controlling Interest and Conviction Information:**
<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/ownership-controlling-interest-and-conviction-information-sfn1168.pdf>
- **Link to Provider Enrollment Information:**
<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html>

2011 CHECK-WRITE EXCEPTION DATES

Typically, check-write occurs every Monday evening; however, the following exceptions will occur from May 2011 thru June 2011.

<u>No Check-Write</u>	<u>Rescheduled Date</u>
May 2, 2011	May 3, 2011
May 30, 2011	June 1, 2011
June 27, 2011	June 28, 2011

REFERRAL PROCEDURE REMINDER FOR THE PRIMARY CARE CASE MANAGEMENT (PCCM) PROGRAM

Referral Procedure REMINDER – Hospital Services

The Primary Care Case Management (PCCM) program requires referrals to be obtained from the Medicaid recipient's Primary Care Provider (PCP) for all hospital inpatient services with the exception of those provided by: OB/GYN, psychiatrist, psychologist, and emergency hospital admission.

If the Primary Care Provider did not individually order the hospital admission, the medical facility must notify the Medicaid recipient's PCP of the admission and begin the referral process within 24 hours of admission and document any and all contact with the PCP.

If the PCP is not the overseeing provider for the inpatient stay (i.e. patient is followed by a hospitalist during the inpatient stay), the referral provided by the PCP for the inpatient stay should cover all Medicaid covered services related to the diagnosis of the inpatient stay for inpatient services/consults, unless otherwise noted by the Primary Care Provider. **It is important to note that the PCP referral DOES NOT "transfer" with the patient to another (inpatient) hospital/facility. The hospital to which the patient is transferred must obtain a separate referral from the PCP.**

BILLING ND Medicaid - How a Valid PCP Referral is Documented:

Professional Claim

- CMS 1500 (hardcopy) – Enter the PCP ND Medicaid provider/legacy number in Box 17a and the NPI in Box 17b
- Electronic (837P) - Enter the PCP's NPI *only* in the referring provider field

Institutional Claim

- UB04 (hardcopy) – Enter the PCP ND Medicaid provider/legacy number in Box 76 and the NPI in Box 76
- Electronic (837I) – Enter the PCP's NPI *only* in the referring provider field

Subsequent referrals resulting from the PCP's initial referral will also require the PCP's Medicaid provider number/NPI in the appropriate referring provider fields as noted above.

More information on referral requirements within the PCCM program can be located in the General Information for Providers Manual, Managed Care Chapter, which is located on the Medical Services website at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>

SUBMITTING CLAIMS ADJUSTMENTS

Providers submitting claims adjustments past one year from the date of service, need to attach copies of the ND Medicaid Remittance Advice along with all other applicable documents. If the purpose of the adjustment is to prove a claim is not past timely filing, please attach all Remittance Advices regarding the claim.

IDENTIFICATION OF FRAUD, WASTE AND ABUSE OF SERVICES

In an effort to keep providers informed of items that directly affect them, Medical Services would like to share the following examples of situations that may be misrepresentations by Medicaid standards.

Provider Misrepresentations:

- Fallacious alteration of a claim with intent to get it paid
- Incorrect coding (up-coding, unbundling, multiple codes)
- False data submitted to get a claim paid
- Administrative/financial action that may be misrepresentation
 - Falsifying credentials for payments
- Services that may be misrepresentations:
 - Billing for services/supplies not provided
 - Misrepresentation of services or supplies
 - No written documentation of services
 - Excessive services based on similar providers
 - Services not performed but billed
 - Forged or altered prescriptions

If you have any questions or concerns regarding Fraud, Waste or Abuse, please contact Dawn Mock, Medicaid Program Integrity Administrator, at 701-328-1895 or dmock@nd.gov.

To report fraud, contact Galen Hanson, Fraud and Abuse Administrator, at 701-328-4024 or email gehanson@nd.gov.



CHILDREN WITH MEDICALLY FRAGILE NEEDS

North Dakota Medicaid has a waiver available to families who wish to maintain their medically fragile child within the home. Services that are available under the waiver are transportation, dietary supplements, individual and family counseling, in-home support, equipment, supplies, environmental modifications, institutional respite, and case management.

To qualify for this waiver; a child must:

- Meet the income eligibility for Medicaid;
- Meet the Nursing Home Level of Care; and
- Score a 40 or more on the Level of Need (as determined by the child's primary care provider).

Applications can be found at: www.nd.gov/eforms/doc/sfn00394.pdf or by calling 701-328-3701.



PHARMACY CLAIMS BILLING

Please remember to appropriately bill outpatient medication claims (e.g. J-codes, pharmacy claims). For a medication requiring an National Drug Code (NDC), the NDC that is used must be submitted on an electronic claim.

ND Medicaid has a NDC drug lookup available to assist providers in determining if NDC's are covered for ordering/stocking purposes. Please do not use the site to "find an NDC that will pay," and submit the claim with an NDC that wasn't actually used. Any payment made to a provider for an inaccurately reported drug claim will be recouped by ND Medicaid.

Remember: All outpatient medication claims must be billed electronically.

COORDINATED SERVICES PROGRAM

The Coordinated Services Program is for recipients who need assistance in appropriate utilization of healthcare services.

Program Requirements

- Recipients that are referred to the Coordinated Services Program (CSP) must choose a primary care provider by selecting one family practice, general practice, nurse practitioner or internal medicine provider of their choice.
- CSP recipients are restricted to one pharmacy of their choice.
- 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: (1) services obtained from a non-designated provider; (2) services obtained without a referral from the recipient's CSP provider; or (3) 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 must be received in the ND Medicaid office prior to the date of service.

Once authorized, the specialist may order medically necessary tests and treatment.

Referral Forms

- Referral forms are available by calling the ND Medicaid Surveillance and Utilization Review Section at 701-328-2334.

- The referral form must be mailed or faxed to the Department of Human Services, Attn: CSP Referrals; **mail to Medical Services Division, 600 East Blvd Ave, Dept 325, Bismarck, ND 58505 or fax to 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 CSP referral on file, the claim will be denied and the patient will be responsible for the charges.
- All services that are provided in the emergency room are reviewed for medical necessity. All emergency room, walk-in, and urgent clinic claims must have notes attached for review.



INSULIN PUMP POLICY Policy Review & Comment Period

As of May 1, 2011 the draft version of the Insulin Pump Policy will be posted to the Department of Human Services Website via the Provider Update Link:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html> for a 30-day review period.



OUT-OF-STATE SERVICES REFERRAL REQUESTS

When does an out-of-state service need to be Prior Authorized? When out-of-state services will occur at sites more than fifty miles from the North Dakota (ND) border. Services received outside of the United States are not covered.

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

What must be included in the request? North Dakota Medicaid requires a Request for Prior Authorization for Out-of-State Services (form SFN 769) for all out-of-state referral requests. This form can be found on the North Dakota eforms website at: www.nd.gov/eforms/Doc/sfn00769.pdf and can be filled out online before printing. Any request submitted without all of the required information will not be processed and will be returned as incomplete. Required medical information includes medical information supporting the need for out-of-state services, such as: clinic notes, test results, or a written second opinion from an appropriate in-state board certified specialist following a current (within 3 months) examination.

How do Providers submit the request? Providers are to fax the request to the Medical Services dedicated out-of-state fax line at: 701-328-0376 or mail it to the address on the outside of the newsletter.

How long does this take? It generally takes two to three weeks for processing the out-of-state requests. However, in the case of a medical emergency, fax in the information listed above, marking "urgent" on the top of the form. In the case of an extreme emergency, call the ND Medicaid office to alert us and then fax the above information. Urgent/emergent cases are given priority processing. Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to Medicaid review and possible denial of claims. The transferring facility must notify ND Medicaid within 48 hours of the transfer. Documentation must also include: date of transfer, mode of transportation and discharge summary. Use of air ambulance must always be substantiated.

What is the process after approval from Medicaid? Once the ND Medicaid office determines if the referral meets state requirements and approves or denies the request, a copy of the determination is sent via fax to the primary (in-state) providers, all out-of-state providers, and to the County Social Service Office. A copy is also mailed to the recipient.

What if prior authorization is not obtained? Claims from out-of-state providers for non-emergency services will not be paid without written prior authorization.

What if the recipient has other insurance? Recipients with private insurance are subject to prior authorization requirements as established by their primary insurance carrier as well as the ND Medicaid Prior Authorization requirements stated above.

Is there any assistance available with travel, lodging, and meals? The recipient's County Social Service Office is responsible for assisting the recipient with arrangements for travel, lodging and meals.



ND MEDICAID OPTOMETRIC BILLING TIPS

ND Medicaid requires providers to bill usual & customary charges with claims coded to the highest degree of specificity including CPT codes, HCPCS codes, and ICD-9-CM codes.

- All claims submitted to ND Medicaid with other insurance applied must match the EOB. If an EOB is attached to the claim, please indicate in Box 29 of the CMS-1500 claim form only the amount paid from other insurance. Do not include any write-off amounts or contractual obligations. ND Medicaid determines payment from the patient responsibility (coinsurance and deductible).
- Please check the VERIFY eligibility system to find out the eligibility of ND Medicaid clients. This is not a requirement; however, this may prevent claim denials if the patient is not currently eligible for a routine eye exam, refraction, and glasses. To use VERIFY, please call **701-328-2891 or 1-800-428-4140**. Press option 5 for optometry or option 6 for all eligibility information, including recipient liability information, CSP information, Third Party Liability information, and co-payment information.
- Claims need only be submitted one time for payment. If partial payment is received, i.e. some charges paid and some charges denied, then the entire claim must be filed on an adjustment claim form (SFN 639) with all applicable documentation. This documentation includes EOB's and optometrist/ophthalmologist documentation supporting medical necessity.
- If a code change is needed or requested after the claim has been paid, a request must be made on an adjustment claim form with all applicable documentation including EOB's and physician documentation supporting medical necessity. The Provider Request for an Adjustment form SFN 639 can be found at <http://www.nd.gov/eforms/Doc/sfn00639.pdf>.

Frames and Lenses must be billed through Walman Optical

If there is a primary insurance, the EOB must be supplied to Walman Optical. Walman Optical bills ND Medicaid for the frames, lenses, and any additional features (tints, scratch coat) for the glasses. As a dispensing provider of these glasses, the dispensing code (92340, 92341, or 92342) appropriate to the type of glasses ordered may be billed to ND Medicaid. Non-covered add-on features for glasses, such as antireflective coating, may be billed to the patient if no prior authorization is in place.

In special circumstances, frames and lenses after cataract surgery may be covered by ND Medicaid. The diagnosis and documentation must support the services being rendered, and documentation must be available upon request. ND Medicaid will only allow services outside the Walman Optical contract when Medicare is primary and when Medicare has paid for lenses and/or frames after cataract surgery.

Optometric Billing Tips Continued on next page...



ND MEDICAID OPTOMETRIC BILLING TIPS (continued)

As a general rule, ND Medicaid allows one routine eye exam, refraction, and eye glasses per year for children age 20 and under and one exam, refraction and eye glasses every two years for adults 21 and older. The limits are for routine services only. Eye exams for medically necessary circumstances, i.e. conjunctivitis, cataracts, do not require prior authorization.

Diabetic eye exams are allowed once per year per patient. ND Medicaid only allows the exam to check the health of the eye, no additional refraction is allowed. The exams must be coded appropriately with diabetes as the primary diagnosis.

Please become familiar with the ND Medicaid Optometric Provider Manual. This manual can be found at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/optometric-manual.pdf>.

Vision services prior authorization form can be found at: <http://www.nd.gov/eforms/Doc/sfn00292.pdf>.



ND MEDICAID BILLING INFORMATION REMINDERS

Please watch for ND Medicaid provider updates. This link provides very valuable information and the most current Medicaid updates. <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html>.

**UPDATES
FOR PROVIDERS**

The Provider Request for an Adjustment Form 639 can be found at: <http://www.nd.gov/eforms/Doc/sfn00639.pdf>.

If you have any questions on these ND Medicaid billing information reminders, please contact: Sara Regner, CPC-H, via telephone: 701-328-4825 or fax 701-328-1544.

Claim Submission Time Frames

- **New Claims:** Providers have one year from the date of service to submit new claims.
- **Processed Claims:** Providers have one year from the last Remittance Advice date to resubmit or adjust claims.

Billing Information Reminders continued on next page...

ND MEDICAID BILLING INFORMATION REMINDERS (continued)

Third Party Liability Payment Billing Instructions - Providers must bill their usual and customary charge to North Dakota Medicaid.

- The **TOTAL CHARGES** would be the provider's usual and customary charges.
- The **AMOUNT PAID** would be the actual payment received from the primary payer.
- The **BALANCE DUE** would be the **TOTAL CHARGES** less the **AMOUNT PAID**.
- If the **AMOUNT PAID** is less than the ND Medicaid allowable amount, ND Medicaid will pay the difference up to the ND Medicaid allowable amount, or the patient responsibility, whichever is less.
- If the **AMOUNT PAID** amount is greater than the ND Medicaid allowable amount, ND Medicaid pays \$0.00. Providers must accept Medicaid payment as payment in full.

SERVICE LIMITS

The Department of Human Services established policies and procedures that ultimately consider what is reasonable in terms of medical or dental treatment, vision, pharmacy, home health, durable medical equipment, therapies and other services reimbursed by ND Medicaid. Medical necessity is Medicaid's determining factor when providers request exception to the established service limits.

Service limit prior authorizations are not intended to be used to request additional services prior to initial allowable amounts being evaluated for effectiveness, etc. Existing service limits were established using ND Medicaid utilization, other payer standards, and legislative and budget directives.

North Dakota Medicaid Service Limits:

- **Chiropractic manipulation visits** = 12 per year
- **Chiropractic x-rays** = 2 per year
- **Occupational therapy evaluation** = 1 per year
- **Occupational therapy visits** = 20 per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children).
- **Physical therapy evaluation** = 1 per year
- **Physical therapy visits** = 15 per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children).
- **Psychological evaluation** = 1 per year
- **Psychological testing** = 4 units (hours) per year
- **Psychological therapy visits** = 40 per year
- **Speech evaluation** = 1 per year
- **Speech therapy visits** = 30 visits per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children).
- **Vision testing and prescriptions for glasses** = under 21 years of age - one exam and one set of glasses per year; 21 and older-one exam and one set of glasses every two years

Authorization in excess of the above limits may be granted by the Medicaid utilization staff, when medically necessary. The Service Limits Prior Authorization SFN 481 is located on the DHS website at:

<http://www.nd.gov/eforms/Doc/sfn00481.pdf>.

NURSE PRACTITIONERS MUST OBTAIN OWN ND MEDICAID PROVIDER NUMBER

ND Medicaid will require that all Nurse Practitioners who provide services to Medicaid clients enroll with ND Medicaid to obtain an individual provider number. Effective July 1, 2011, ND Medicaid will no longer allow Nurse Practitioners to submit claims under their supervising physician's ND Medicaid provider number and appending modifier 'AS' to the CPT code.

Note exception: Nurse Practitioners enrolled with ND Medicaid assisting at surgery will continue to submit claims with their own ND Medicaid provider number and append the modifier 'AS' to the surgical procedure CPT code.

To enroll, Nurse Practitioners can go to the following link and submit the necessary forms.

<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-info.html>

For more information please contact:

Barb Koch, LPN, CPC,
Medical Coding Specialist
Telephone: 701-328-1044 or fax 701-328-1544

NEW! MANAGED CARE EMAIL and CONTACT INFORMATION

Provider inquiries about Primary Care Case Management (PCCM), ExperienceHealth ND (ND Medicaid's Disease Management program), or the Program for All-Inclusive Care of the Elderly (PACE) can be made to the following email box:
dhsmci@nd.gov.



DME PROVIDERS

Please be reminded that "span dates" are required when billing for monthly medical supplies.

Example: Mary has an order from her physician for 90 urinary catheters per month. On November 2, 2010, Mary picks up the entire monthly supply. The claim should have a range of dates "or span dates"; for example: a "from date" of 11/2/2010 and a "to date" as 12/1/2010.



HOW TO REPORT SUSPECTED FRAUD, WASTE OR ABUSE

To report suspected fraud, waste or abuse involving the ND Medicaid Program please call, 1-800-755-2604, select Option 2 and then Option 7 or email: medicaidfraud@nd.gov

NEW FACES IN MEDICAL SERVICES

Julie C. ~Administrative Assistant
Kim M. ~ Claims Processing
Karmen H. ~ Claims Processing
Pamela K. ~ Claims Processing
Eileen C. ~ Claims Processing

Irene K. ~ Program Administrator, Eligibility
Candace F. ~ Provider Enrollment
Cheri J. ~ Claims Processing
Lin K. ~ Claims Processing
Megan S. ~ Administrative Support

ND DEPT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
600 E BOULEVARD AVE DEPT 325
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Please route to:

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

Please make copies as
needed.