

PROVIDER BULLETIN

THE REIMBURSEMENT NEWS SOURCE

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**NORTH DAKOTA
DEPARTMENT OF
HUMAN SERVICES**
~
**CAROL K. OLSON,
EXECUTIVE DIRECTOR**

Issue 69 - May 2012

CODING UPDATE

Effective July 1, 2012 North Dakota Medicaid will only be recognizing current ICD-9 diagnosis and surgical procedure codes. All claims with date of service(s) on or after July 1, 2012 must be submitted with current ICD-9 diagnosis and surgical procedure codes. Claims with invalid ICD-9 diagnosis or surgical procedure codes on the date(s) of service will be denied.

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.

2012 CHECK-WRITE EXCEPTION DATES

Typically, check-write occurs every Monday evening; however, the following exceptions will occur from May 2012 through December 2012.

No Check-Write	Rescheduled Date	No Check-Write	Rescheduled Date
May 28, 2012	May 29, 2012	October 3, 2012	October 4, 2012
July 4, 2012	July 5, 2012	October 31, 2012	November 1, 2012
August 1, 2012	August 2, 2012	Dec. 26, 2012	Dec. 27, 2012
Sept. 5, 2012	Sept. 6, 2012		

PROGRAM INTEGRITY

Provider Audits

The Surveillance Utilization Review Section (SURS) conducts quarterly audits in order to determine areas where potential overpayments may exist. These audits have resulted in recoveries, policy creation and policy clarification. SURS is in the process of finalizing the 4th Quarter 2011 audit which was comparing outpatient services billed while the recipient was inpatient. The 1st Quarter 2012 Provider audit will focus on the proper billing of Osteopathic manipulation codes (98925 – 98929). SURS also conducts Compliance Audits in order to determine if providers that were cited in a quarterly audit have taken the necessary steps in order to avoid additional errors specific to that particular audit topic.

Reporting of Suspected Fraud and Abuse:

To report suspected Medicaid Fraud, please call, 1-800-755-2604, select Option 4 or email: medicaidfraud@nd.gov

In addition, you may submit a Surveillance and Utilization Review Section (SURS) Referral (SFN 20) to report suspected fraud, waste, or abuse of the North Dakota Medicaid or Healthy Steps Programs. Since April 1, 2011, ND Medicaid has received 43 reports of suspected fraud, waste and abuse. This form is located at:

<http://www.nd.gov/eforms/Doc/sfn00020.pdf>

Completed forms can be mailed to:

North Dakota Department of Human Services
Attn: Galen Hanson
600 E. Boulevard Ave., Dept. 325
Bismarck, ND 58505-0250

Recovery Audit Contractor

The Medicaid Recovery Audit Contractor (RAC), Cognosante, is slated to begin implementing their first phase of audits this spring. The first phase includes reviewing professional claims. If you have questions you may contact the Medicaid RAC Toll-free # - (855) 637-2212 or (855) NDRAC12

ND RAC Fax # - (701) 281-4300

Email Address - northdakotarac@cognosante.com

Website - www.ndrac.com

Payment Error Rate Measurement

The Payment Error Rate Measurement (PERM) review is a federal requirement and North Dakota is on a rotation cycle to be reviewed once every three (3) years. North Dakota is currently in the PERM review period for Medicaid and Children's Health Insurance Program (CHIP) claims payment and eligibility determination. Providers will receive medical records requests from the Review Contractor (A + Government Solutions). Providers will have 75 days to submit the requested documentation which is a change from 60 days from the last PERM cycle. If no documentation or sufficient documentation is not submitted, the claim(s) will be considered an error and subject to recoupment.

Provider Enrollment

Provider Enrollment staff are updating provider files to ensure that current and accurate information is on file with ND Medicaid. When you are contacted to update information, please provide the requested documentation in a timely manner.

Medical Services staff is currently researching a "streamlined enrollment" process that will expedite enrolling ordering and referring providers. We expect this process to be available by July 1, 2012.

PROGRAM INTEGRITY (continued)

Program Integrity Staff Certification

Dawn Mock and Galen Hanson of the Program Integrity Unit have earned certification in fraud investigation.

The Association of Certified Fraud Examiners (ACFE) awarded Mock the Certified Fraud Examiner (CFE) credential for her demonstrated knowledge in fraudulent financial transaction, fraud prevention and deterrence, legal elements of fraud, and fraud investigation. She has met a stringent set of criteria and passed a written exam administered by ACFE.

Mock can examine data and records to detect and trace fraudulent transactions, interview individuals to obtain information and confessions, write investigation reports, and testify at trials. She also understands the law as it relates to fraud and fraud investigations, and can identify the underlying factors that motivate individuals to commit fraud.

She is the Program Integrity Administrator for the ND Medicaid Program.

Hanson has been recognized by the United Council on Welfare Fraud as a Certified Welfare Fraud Investigator (CWFI). As part of his certification, he met certain qualifications and passed a written exam focusing on ethics, sources of information, evidence, affidavits and statements, report writing and testimony, interviewing and interrogation, and quality standards for investigations.

Hanson also serves on the United Council on Welfare Fraud Board representing Region 8, which oversees the mission of the organization and integrity of public assistance programs including Medicaid, the Supplemental Nutrition Assistance Program, Childcare Assistance, and Temporary Assistance for Needy Families.

He is the Surveillance Utilization Review Section Administrator for the ND Medicaid program.

Suspension of payments in cases of fraud

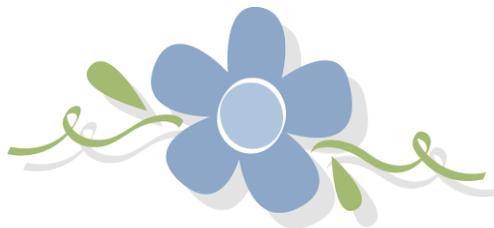
New guidance was issued from the Centers for Medicare and Medicaid Services that provides specific guidelines to State Medicaid Agencies for suspending payments to providers when a credible allegation of fraud exists. The federal citations are listed below:

42 Code of Federal Regulation (CFR) Subsection 455.2 indicates that a credible allegation of fraud may be an allegation which has been verified by the State, from any source, including but not limited to the following:

- (1) Fraud hotline complaints.
- (2) Claims data mining.
- (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously.

§ 455.23 Suspension of payments in cases of fraud.

- (a) *Basis for suspension:* (1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.



SUBSEQUENT OBSERVATION CARE 99224, 99225, 99226

Effective for dates of service **December 1, 2011** and older; North Dakota Medicaid will allow/reimburse subsequent observation care services when submitted with CPT® codes 99224, 99225, or 99226.

Payment for a subsequent observation care code is for all the care rendered by the attending/admitting physician on the day(s) other than the initial or discharge date. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate office and other outpatient service codes. **In the rare circumstance when a patient receives observation services for more than two calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.**



NEW FACES IN MEDICAID

Karla Backman, LSW, started with Medical Services as HCBS Program Administrator on February 2, 2012. Her main responsibilities are enrollment of qualified service providers, program review, which includes analysis of provider records and billing history, and administration of related policy. Karla has worked in a variety of human service agencies throughout her career, most recently with Vulnerable Protective Services at West Central Human Service Center.

NEW FACES IN MEDICAID

Joyce Johnson joined the Medicaid Eligibility Policy Division as a Medicaid Eligibility Policy Administrator on February 6, 2012. Joyce came to the Department from Morton County Social Services. Joyce has over 32 years of experience in which she was involved with Medicaid and other economic assistance programs, with about 21 years in eligibility and 6 months working with foster care eligibility in the Children and Family Services Division. Please join us in welcoming Joyce to Medical Services!

Erica Newgard will be supporting several programming areas including Partial Hospitalization, Out-of-State services, In-State Prior Authorizations, Fraud and Abuse, Dental Denials, and Vision Denials, and serves as a backup receptionist.

Sarah Schaaf is also new to the Administrative Support team with the Home and Community Based Services (HCBS) programs. She provides assistance to qualified service providers, county case managers, and the long-term care continuum program areas.

Meagan Heckaman joined the Medical Services Division on March 1, 2012. She is the Utilization Review Administrator. Meagan will be in charge of managing medical utilization review functions for all Medicaid services. Meagan is a Registered Nurse and brings with her experience in a variety of health care settings, including working with patients, providers, and the medical community. Meagan also holds a Master of Science degree in Nursing Administration.

Provider Enrollment has two new temporary staff, **Julie Havig** and **Amanda Brown**. They are working to update all provider files and will be working on provider re-enrollment for the new Medicaid claims processing system.

HEALTH MANAGEMENT

North Dakota Medicaid has made recent changes to the health management program. Providers, clinics and health teams (including FQHC's, RHC's and Indian Health Services), now have the option of providing additional care coordination services in the form of a health management program for recipients with certain chronic diseases (asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease).

Providers, clinics and health teams may qualify for an additional per member per month payment for providing services as outlined in the North Dakota Medicaid's health management program design.

The health management program will be comprised of an integrated package that may include but is not limited to: dedicated care coordinator, high risk screening and assessment, triage, referral system which includes tracking referrals and results, recall system for appointments, pharmacy review, inpatient and discharge transitions, education, and emergency department diversion.

US Care Management will provide nurse care managers throughout the state for those recipients who choose to continue with them. Recipients can also choose to enroll with US Care Management to receive their services.

More information on this program can be located on the Managed Care link of the Medical Services website at:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/managedcare.html>



PHARMACY UPDATES

The DUR Board has chosen to only cover 5/325 and 10/325 acetaminophen combination tablets of oxycodone and hydrocodone (e.g. Percocet® and Vicodin® products). In-between dosage combinations such as 2.5/325 and 7.5/325 will not be covered. For liquid hydrocodone/acetaminophen products, only the 7.5/325 per 15 mL product will be covered. These changes in coverage were effective 9/27/2011. The DUR Board's decision to change the coverage was directly related to the FDA's decision to phase out all acetaminophen/opioid combinations where the acetaminophen is greater than 325 mg per dosage unit.

The Medicaid State Plan is being amended to account for the discontinuation of the publication of the Average Wholesale Price (AWP) by First Data Bank (FDB) and the effect on the calculation of Estimated Acquisition Cost (EAC) for pharmacy pricing. The EAC will now be set at Wholesale Acquisition Cost (WAC) + 8%. If no WAC exists, then EAC will be set at Direct Price (DP) + 8%. If neither WAC nor DP exist, then EAC will be set at Suggested Wholesale Price (SWP) -10%. As SWP and DP are defined by FDB as being equivalent to the existing pricing baselines of AWP and WAC, respectively, there will be no financial impact.

The Medicaid State Plan is also being amended to include the existing pricing structure for compounded pharmacy claims. Compounds are priced in the same fashion as all other medications with the exception of the dispensing fee, which is \$10 per prescription to account for the increased time needed for preparing compounds.

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.

FAMILY PLANNING SERVICES

Family planning services consist of health services or family planning supplies for the voluntary planning of conception and pregnancy for individuals of childbearing age.

Physicians, clinics, outpatient hospital departments, pharmacies, nurse midwives, nurse practitioners, and family planning agencies may provide some or all of the available family planning services and family planning supplies. Family planning agencies may provide only those services within the scope of practice of the personnel working within the agency.

Cost Sharing (co-pays) may not be applied to North Dakota Medicaid recipients for Family Planning Services.

For more information on Family Planning services see the *Family Planning Chapter* in the *General Information for Providers Manual* located at:

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

NORTH DAKOTA MEDICAID PROVIDER ENROLLMENT CHANGES REGARDING PHYSICIANS ENROLLED IN RESIDENCY PROGRAMS

Effective March 1, 2012, all physicians in a residency program who have been granted a permanent license to practice medicine in North Dakota by the North Dakota Board of Medical Examiners, or have been granted a temporary special license for foreign medical school graduates as outlined in the Medical Practice Act of North Dakota (Chapter 43-17-18.4) must enroll with North Dakota Medicaid in order to bill for services rendered to North Dakota Medicaid clients. These residents shall not bill using a supervising physician's North Dakota Medicaid provider number or National Provider Identifier. Residents that have not been granted such licenses, but are part of the North Dakota residency program, may continue to bill according to supervisory physician billing guidelines.

Upon enrollment, residents in certain specialties will become available for selection as Primary Care Providers for Medicaid recipients. More information on provider enrollment and the Primary Care Case Management program can be found on the web at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf>



POLICIES RECENTLY ADDED TO THE MEDICAID GENERAL PROVIDER MANUAL FOR DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS & SUPPLIES (DMEOPS)

- Bath/Shower Chair: E0240
- Tub Stool/Bench: E0245
- External Insulin Infusion Pump: E0784

Policies are located at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/external-insulin-infusion-pump-final.pdf>; or

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/dme-manual.pdf>

COMMON NATIONAL PROVIDER IDENTIFIER ERRORS

Following is a list of the most commonly occurring National Provider Identifiers denial codes and their explanations:

- N253 – Missing/incomplete/invalid **attending** provider primary identifier
- N257 - Missing/incomplete/invalid **billing** provider primary identifier
- N286 - Missing/incomplete/invalid **referring** provider primary identifier
- N290 - Missing/incomplete/invalid **rendering** provider primary identifier

Reminder: All NPI numbers must be registered on the DHS/ Medicaid website prior to billing the electronic claim using the NPI. Go to www.nd.gov/dhs/providers/ and then click on the link “Register your NPI with ND Medicaid”. Only ND Medicaid enrolled providers may register an NPI with ND Medicaid. If the NPI number is linked to more than one Medicaid provider number, please be sure to use the appropriate qualifier on your claims submission: for 5010 claims use the **G2** qualifier, and for 4010 claims use the **LU** qualifier.

QUALIFIED MEDICARE BENEFICIARIES INFORMATION

QMBs (Qualified Medicare Beneficiaries) are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency. Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs. At the State’s discretion, Medicaid may also pay Part C Medicare Advantage premiums for those who join a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits. Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits. North Dakota processes cost-sharing for QMBs by using the Medicaid State Plan rate for the same service.

MONEY FOLLOWS THE PERSON PROGRAM

The Money Follows the Person Program helps older adults and people with developmental disabilities transition from nursing homes or institutions to community living that meets their needs and wants.

What services are provided?

A transition coordinator works with a person who wants to move back to community living by creating a written plan that identifies the person's needs and wants and arranges for services and supports to meet those needs.

A person moving from a nursing home will have 365 days of services and supports from a transition coordinator employed by a Center for Independent Living agency and ongoing services from a qualified service provider to assist with such needs as bathing, dressing, shopping, and cooking.

A person with a developmental disability moving from an institution will receive services and supports from a community developmental disabilities agency and ongoing follow-up from a developmental disabilities program manager.

How does a person qualify to take part in the Money Follows the Person Program?

A person must qualify for Medicaid, have lived in an institutional setting for at least three months, and have a desire to move back into community living.

How does the program help with costs of moving back into community living?

The Money Follows the Person Program pays up to \$3,000 for one-time transition costs, which may include, but are not limited to:

- Health and safety technology
- Security and utility deposits
- Home modifications
- Adaptive equipment
- Home/apartment furnishings
- Assistive technology devices

For more information, contact Jake Reuter - Money Follows the Person Program administrator at:

N.D. Department of Human Services, Medical Services Division
(701) 328-2321 | (800) 755-2604 | ND Relay TTY (800) 366-6888
dhsmed@nd.gov



ELECTRONIC SIGNATURES

Documentation submitted to ND Medicaid must be signed by the practitioner performing the service. All medical record entries must be legible and complete, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy.

Electronic signatures in medical records will be accepted in the following format:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: Dr. _____' with provider's name
- Digitized Signature" Handwritten and scanned into the computer
- 'This is an electronically verified report by Dr. _____'
- 'Authenticated by Dr. _____'
- 'Authorized by: Dr. _____'
- 'Digital Signature: Dr. _____'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Unacceptable Signatures are:

- Dictated, but not read
- Signed, but not read
- Auto-authentication
- Rubber Stamp Signatures (*Source: 7/29/08: MLN Matters SE0829 CMS States: "Stamped signatures are NOT acceptable on any medical record."*)

If there is no signature appended to medical record documentation, claims will be denied for no signature.



NORTH DAKOTA MEDICAID ALLOWS/REIMBURSES DEBRIDEMENT CPT® CODES 97597 AND 97598 EFFECTIVE JANUARY 1, 2011

North Dakota (ND) Medicaid has determined that effective **January 1, 2011** CPT® codes 97597 and 97598 will be allowed/reimbursed when the service is performed and documented by physicians (MD/DO); or nurse practitioners (NP), or physician's assistants (PA) or clinical nurse specialist (CNS), when it is within their scope of practice. Providers performing and billing for debridement as described by the CPT codes must submit the claim(s) under their ND Medicaid provider number. Physician assistants and clinical nurse specialists who perform and bill for these services, using these CPT codes (if within their scope of practice) **must append the appropriate modifier to the debridement CPT codes.**

Example: A PA performing debridement would submit **97597-U1**
 A CNS performing debridement would submit **97597-U2**

97597 Debridement (eg. high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg. fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; **first 20 sq cm or less**

+ 97598 Debridement (eg. high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg. fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; **each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure).**

If you have any questions, please contact North Dakota Medicaid at 1.800.755.2604 and ask to speak with a medical coder.

OUT OF STATE SERVICES — TRIAL POLICY

The Department of Human Services (Department) has been gathering input regarding how out of state services are reviewed for children eligible for North Dakota Medicaid.

Based on the input received, for out of state services requests received **March 1, 2012** or later, the Department will be implementing a new trial policy, which clarifies the definition of "unavailable". Providers requesting out of state care for children can use the provisions of the new policy when they have specific cases and situations that require a broader application of "unavailable". Requests made under the provisions of the policy must include a completed Out of State Services Certification form. The Department will be conducting post audits on a monthly basis and may find it necessary to modify the policy as we gain actual experience with application of the policy. The new policy and the Out of State Services Certification form can be found on the Department's web site at: <http://www.nd.gov/eforms/sfn00606.pdf>

HOW DO WE SUBMIT A REQUEST FOR OUT-OF-STATE SERVICES?

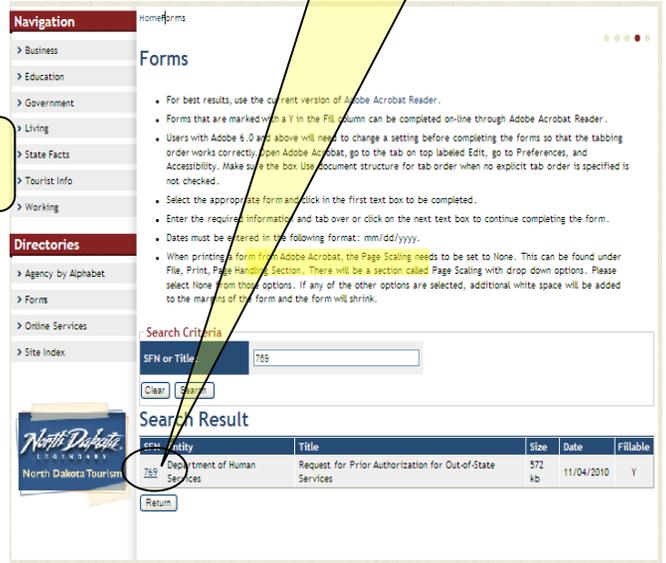
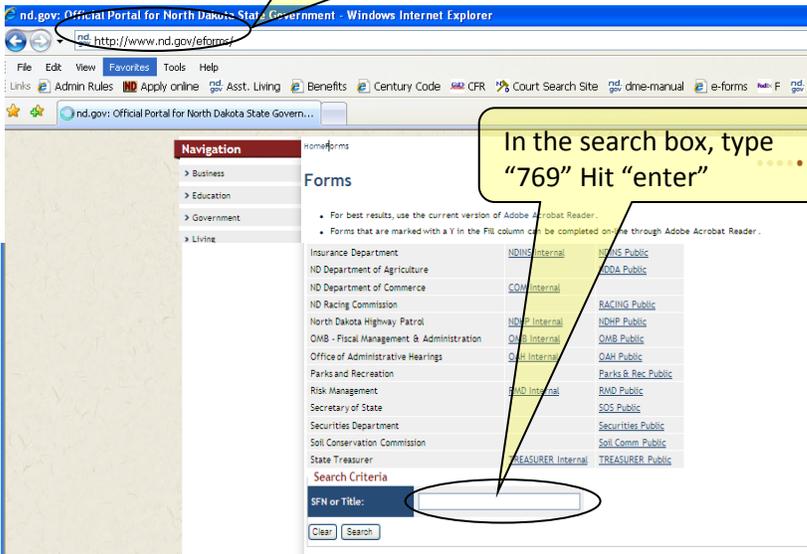
Please copy and route to ALL practitioners!

All requests must be made by submitting the SFN 769 Out-of-State Referral Form. This can be found by using the following instructions.

In your internet browser, type www.nd.gov/eforms Hit "enter"

Click on the link that will appear below the search box

In the search box, type "769" Hit "enter"



Fax your request to the number at the top of the first page of the 769 Form

Instructions are on page 2 of Form 769.

Don't forget to submit medical documentation to support the need for out of state services!

REQUEST FOR PRIOR AUTHORIZATION FOR OUT-OF-STATE SERVICES
 DEPARTMENT OF HUMAN SERVICES
 MEDICAL SERVICES DIVISION
 SFN 769 (Rev. 10-2010)

SEND TO:
 MEDICAL SERVICES DIVISION
 ND DEPARTMENT OF HUMAN SERVICES
 600 E BOULEVARD AVE, DEPT 325
 BISMARCK, ND 58506-0250
 FAX (701) 328-0376

Medically Urgent

TO BE COMPLETED BY A NORTH DAKOTA REFERRING PHYSICIAN ONLY!

NOTE: AN INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not authorization for payment or approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of services being enrolled in ND Medicaid. The provider of services must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from approval, unless otherwise noted by Medicaid. **MEDICAID ELIGIBILITY VERIFY LINE 1-800-428-4140**

RECIPIENT Last Name	First	Middle Initial	Date of Birth	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Medicaid ID #	Medicaid Eligibility Verified <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Insurance/Medicare			
Attendant Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Reason for Attendant				
Date(s) of Service	Quantity	Procedure Code-CPT/HCPC	Procedures/Services (describe)		
1.					
2.					
Diagnosis (ICD-9)					
Reason for Out-Of-State Medical Treatment (SEND ADDITIONAL INFORMATION WITH REQUEST-see page 2 for the minimum information that must be sent)					
In-State Provider #1 - Required			Facility Contact Person		
Referring Physician (In-State Board Certified Specialist)			Telephone Number	Fax Number	
Address		City	State	Zip Code	

SFN 769 (10-2010)
 Page 2 of 2

NORTH DAKOTA MEDICAL SERVICES USE ONLY:

Determination:	Travel Method:	Attendant:	Lodging:	Meals:
Approved <input type="checkbox"/>	Car <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pending <input type="checkbox"/>	Ambulance <input type="checkbox"/> Stretcher Van <input type="checkbox"/> W/C van <input type="checkbox"/>			
Denied <input type="checkbox"/>	Air <input type="checkbox"/> Cost <input type="checkbox"/>			
Comments:				
ND DSH Medical Consultant Signature				Date

- OUT-OF-STATE SERVICES PRIOR AUTHORIZATION REQUIREMENTS**
- Out-of-state services at sites more than fifty miles from the North Dakota border must be prior authorized. (Exception: Canadian services are not covered.)
 - Services received outside of the United States are not covered.
 - The recipient's ND Primary Care Physician 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,
 - a 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,
 - the physician and facility being referred to, and
 - 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 physician, out-of-state provider(s), recipient and County Social Service Office.
 - Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to Medicaid review and denial of claims. The transferring facility must notify ND Medicaid within 48 hours of the transfer. Documentation must include: destination and date of transfer, mode of transportation and discharge summary. Use of air ambulance must always be substantiated.
 - Claims from out-of-state providers will not be paid without written prior authorization.
 - Recipients with private insurance are subject to prior authorization requirements as established by the primary insurance carrier.
 - The recipient's County Social Service Office is responsible for assisting the recipient with arrangements for travel, lodging and meals.

**North Dakota Department of Human Services
Medical Services Division
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 Worker (LICSW)	N/A		
LPN/Registered Nurse (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		
Pharmacist (Vaccination administration only)	N/A		
Physical Therapist (PT)	Licensed/Certified Physical Therapy Assistant		General
Physician (MD/DO) Note: Physician (MD/DO) includes those physicians in a residency program who have a permanent license to practice medicine in North Dakota issued by the North Board of Medical Examiners, or have been granted a temporary special license for foreign medical school graduates (see Medical Practice Act of North Dakota - Chapter 43-17-18.4).	Clinical Nurse Specialist (CNS)	U2, or AS*	General
	CRNA	QX, or QZ	General
	LICSW, LCSW	AJ	Direct
	Nurse (RN, LPN)		Direct
	Registered Nurse (RN)	TD	General - ONLY for administration of influenza virus and/or pneumococcal vaccines
	Nurse Midwife	SB	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 ND Medicaid provider number.

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.**

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 ND Medicaid provider number of the supervising physician.

General Supervision

General supervision means that the North Dakota Medicaid 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.

A North Dakota Medicaid 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 ND Medicaid would apply this definition to LCSWs working under the direct supervision of a physician.

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

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

See chart on reverse side for supervision requirements.

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