



# NORTH DAKOTA MEDICAID

# PROVIDER BULLETIN

## THE REIMBURSEMENT NEWS SOURCE

### IN THIS ISSUE

LEGISLATIVE UPDATE ..... 1  
CONTINUED ..... 10-11

MEDICAID PROGRAM  
INTEGRITY EFFORTS.....2

MEDICAID PROGRAM  
INTEGRITY – EXCLUDED  
PARTIES ..... 3-4

COORDINATED SERVICES  
PROGRAM.....4

FORENSIC MEDICAL  
EXAMINATION COSTS .....5

GENERAL PRINCIPLES  
OF DENTAL RECORD  
DOCUMENTATION .....5

UNDER 21 PRTF AND  
ACUTE PROGRAMS..... 6-7

CLAIMS POLICY –  
BILLING BITS .....7

SUBMISSION OF PAPER  
CLAIMS .....8

DURABLE MEDICAL  
EQUIPMENT BILLING .....9

NEW FORM FOR OUT-OF-  
STATE SERVICES .....9

VACCINE REFERRALS... 11

CHECK-WRITE EXCEPTION  
DATES ..... 12

NEW FACES IN MEDICAL  
SERVICES ..... 12

MEDICAL SERVICES DIVISION

~

MAGGIE D. ANDERSON,  
DIRECTOR

~

Issue 65 • July 2009

## 2009 LEGISLATIVE UPDATE

### HOUSE BILL 1012

#### Appropriations Bill for the Department of Human Services.

- Includes an inflationary increase of 6% for providers each year of the biennium. (For those being rebased; Hospitals, Physicians, Chiropractors, Ambulance, – the inflation is for year two only. Dentists will also receive the 6% inflationary increase in year two only.)
- Includes funding to increase reimbursement Hospitals at 100% of rebasing report, Physicians at 75% of rebasing report, Chiropractors at 75% of rebasing report, Ambulance Providers at the Medicare rate of reimbursement, and the Dental fee schedule will be increased to pay (at a minimum) an average of 75% of average billed charges.
- Increases and funds the Children’s Health Insurance Program at 160% of the federal poverty level (net). It is estimated this increase will serve an additional 439 children.
- Includes and funds a change in the limit on adult eye exams and glasses to one eye exam and one pair of glasses every two years (previously every three years).
- Increases the amount allowed for funeral set aside from \$5,000 to \$6,000.
- Includes funding for a Hospice Waiver for Children. (This is expected to be implemented in July 2010).
- Includes funding to increase the medically needy income levels to 83% of poverty – this will allow clients who have a recipient liability to keep more of their monthly income before any recipient liability must be paid.
- Includes funding to increase the reimbursement for vaccine administration.

Legislative Update – **Continued** on page 10

# MEDICAID PROGRAM INTEGRITY EFFORTS

The Centers for Medicare & Medicaid Services (CMS) has taken the next steps in the agency's comprehensive efforts to identify improper Medicare payments and fight fraud, waste, and abuse in the Medicare program by awarding contracts to four permanent Recovery Audit Contractors (RACs) designed to guard the Medicare Trust Fund.

The North Dakota Medicaid program has been proactively addressing Medicaid fraud, waste, and abuse through various measures as well. The Audit Medicaid Integrity Contractor (MIC) is the Medicaid equivalent to Medicare's RAC. Health Management Systems (HMS) was awarded an audit contract by CMS, under the new CMS Medicaid Integrity Program (MIP). They will audit claims for payment of items or services furnished, or administrative services rendered under the state plan and identify overpayments to individuals or entities receiving federal Medicaid funds. They will provide desk, field, comprehensive, and cost report audits of providers in ND. The anticipated start date is unknown.

In addition, the Medical Services Division addresses each of the areas highlighted as RAC functions:

- To review for potential payment/duplicate payment errors, MMIS has edits in place to capture areas specific to payment errors.
- The fiscal division reviews financial transactions for accuracy.
- Medical necessity determination falls under our Utilization Review Department.
- Coding falls under our Utilization Review Department. We also have two "coders" on site that are subject matter experts.

ND Medicaid must participate in the Payment Error Rate Measurement (PERM) audits, directed by CMS, which take place every three years and are coordinated with an outside vendor. We are currently in second PERM Review cycle.

In an effort to put the needed emphasis and focus on Program Integrity, a Medicaid Program Integrity Administrator position has been added. This position will assist with PERM functions and audits, coordinate program integrity and program improvement activities, and serve as a compliance resource.

## **JOINT OPERATING AGREEMENT (JOA) BETWEEN THE AUDIT MEDICAID INTEGRITY CONTRACTOR (MIC) AND THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES DIVISION, THE STATE MEDICAID AGENCY (SMA)**

### **Purpose of JOA**

In accordance with the Deficit Reduction Act (DRA) of 2005, the Centers of Medicaid & Medicare Services, Medicaid Integrity Group (CMS-MIG) is obligated to engage MICs to audit claims for payment for items or services under a State plan, and identify overpayments to individuals or entities receiving Federal funds. The JOA is the agreement between the MIC, Health Management Systems (HMS) and the SMA and is designed to promote cooperation and collaboration between the parties, and to establish guidelines, duties, and shared expectations of how each will conduct business with each other. The JOA provides the framework for sharing information in order to complete CMS-MIG mandated audits successfully and in a timely way, to decrease unnecessary duplication of effort by clarifying roles and responsibilities between the parties, and to improve the integrity of the Medicaid program as a whole.

### **Role of Audit Medicaid Integrity Contractors**

The obligation of HMS pursuant to its contract with CMS-MIG is to conduct audits that examine payments made to individuals or organizations providing services or items under Title XIX of the Social Security Act, as amended. As appropriate, the audits may result in the identification of potential overpayments. The types of audits to be conducted include audits of Medicaid providers, including individual practitioner, institutions, and other providers, cost report audits, and audits of managed care organizations as directed by CMS-MIG. In the course of these audits, medical documentation and other supporting information will be reviewed for paid Medicaid claims of services or items furnished under the state plan in accordance with Title XIX of the Social Security Act, as amended. ♦

---

---

# MEDICAID PROGRAM INTEGRITY – EXCLUDED PARTIES

---

---

## Background

The Health & Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and CHIP) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i) (2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or an authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

Following are some examples of the types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable\*:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

– **Continued** on page 4

## Excluded Parties continued –

- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

\* This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs.

### Policy Clarification

All current providers and providers applying to participate in the Medicaid program should take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded.
- Agree to comply with this obligation as a condition of enrollment.
- Search the HHS-OIG website by the names of any individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Immediately report to them any exclusion information discovered.

### Where Providers Can Look for Excluded Parties

The HHS-OIG maintains a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The List of Excluded Individuals/Entities (LEIE) website is located at <http://www.oig.hhs.gov/fraud/exclusions.asp> and is available in two formats. ♦

## COORDINATED SERVICES PROGRAM (CSP)

### Can a CSP recipient change providers?

A CSP recipient may request a change in provider(s) by notifying their county eligibility worker of their request in writing. The request must contain the reason(s) for the requested change(s) along with applicable supporting documentation. The county worker submits the request to the Department of Human Services' SUR unit for review. The recipient is notified of the decision in writing with a copy to the county eligibility worker.

### What if the CSP recipient obtains services 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. Emergency services that are determined non-emergent.

The CSP recipient is responsible for these incurred costs.

### What if the recipient needs to see a specialist?

Only the recipient's CSP provider can authorize a referral to a specialist. Referrals must be medically necessary. Medicaid will not approve retroactive referrals. Once authorized, the specialist may order medically necessary tests and treatment. If additional specialists are needed, the CSP provider must initiate the referral.

If a CSP provider is going to be absent from practice, they should refer the recipient to another provider for necessary, urgent, or emergent care. The recipient should wait for the return of his/her CSP provider for services that are considered routine care.

If a recipient is required to name a dentist, and if it is necessary to be referred to an oral surgeon, a referral from the CSP dentist is needed. If the recipient is not required to name a dentist and needs to be referred to an oral surgeon, there must be a referral from the CSP provider. ♦

# FORENSIC MEDICAL EXAMINATION COSTS

During the 2009 Session, SB 2216 was enacted as follows; which amended the language (as noted with underline) that was enacted in 2007 Senate Bill 2103.

1. An acute forensic medical examination is an examination performed on an alleged victim of criminal sexual conduct for the purpose of gathering evidence of an alleged crime and is performed within ninety-six hours after the alleged crime unless good cause is shown for the delay in performing the examination. When an acute forensic medical examination is performed, the cost incurred by a health care facility or health care facility or health care professional for performing the acute forensic medical examination or any preliminary medical screening examination may not be charged, either directly or through a third-party payer, to the alleged victim.
2. A child forensic medical examination is an examination performed on an alleged child victim of criminal sexual conduct for the purpose of gathering evidence of an alleged crime. When a child forensic medical examination is performed, the costs incurred by a health care facility or health care professional

for performing the child forensic medical examination or any preliminary medical screening examination may not be charged, either directly or through a third-party payer, to the alleged child victim or the child's parent, guardian, or custodian.

3. Upon submission of appropriate documentation, the attorney general, within the limits of legislative appropriations, shall reimburse the health care facility or a health care professional for the reasonable costs incurred in performing ~~an~~ the medical screening and acute forensic medical examination.
4. Evidence obtained during ~~an acute forensic~~ a medical examination under this section may not be used against an alleged victim for the prosecution of the alleged victim for a separate offense.

Forensic medical examinations (code 99201-99215-32) and any preliminary medical screening examinations must be billed to the Attorney General's office. The reimbursement form, instructions, and information about the process are available from the Office of Attorney General website; at [www.ag.nd.gov](http://www.ag.nd.gov) select *News/Publications/Forms*. ♦

# GENERAL PRINCIPLES OF DENTAL RECORD DOCUMENTATION

1. The record should be complete and legible.
2. The dental record should include:
  - a. Patient name and demographic information
  - b. Medical and dental history, including medication prescription history
  - c. Progress and treatment notes
  - d. Diagnostic records and radiographs
  - e. Treatment plan
  - f. Patient complaints and resolutions
3. The information in the dental record should be handwritten in ink or computer printed. It must be dated and signed by the person rendering the service.
4. Health risk factors related to the dental procedure should be identified.  
<http://www.nd.gov/dhs/services/medicalserv/medicaid/>
5. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
6. The information contained in the dental record should contain a limited amount of abbreviations.
7. The identifying practitioner should be clearly noted in the dental record.
8. The CPT, CDT, and ICD-9-CM codes reported on the CMS-1500 Claim Form, ADA Dental Claim Form, or UB-04 Claim Form must be supported by the documentation in the dental record.
9. Any services rendered in the outpatient hospital or ambulatory surgical center must be supported by an operative report showing medical necessity of the services performed. ♦

# UNDER 21 PRTF & ACUTE PROGRAM REQUIREMENTS

## Certification and Continued Stay Review Requirements for Under 21 Psychiatric Residential Treatment Facility (PRTF) and Acute Programs

The *Under 21* program is a mechanism for ensuring appropriate use of inpatient psychiatric services for individuals under age 21. Determinations are made by DDM Ascend and must integrate two key areas of focus: *appropriate utilization* and *quality of care*. These factors are evaluated in order to arrive at a decision regarding suitability of treatment for a particular child, and inpatient services should only be considered after less restrictive treatment settings have been considered or attempted. The Code of Federal Regulations, Title 42 CFR 441 Subpart D and Subpart G of 483, describes essential federal boundaries that the State’s Utilization Review/CON agency must follow to enact oversight requirements and to perform Utilization Review (UR) for hospital and non-hospital based inpatient care, including determination of:

- *Whether ambulatory resources available in the community could meet the treatment needs of the recipient;*
- *Whether proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and*
- *Whether services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.*

These standards are further defined through state criteria which mandate evaluation of the individual’s psychopathology, historical psychiatric indicators, diagnostics, and impairments resultant from current symptoms and the quality of the proposed and current plan of care for the child.

The plan of care must be delivered vis-à-vis an individualized program of care with psychotherapeutic interventions provided within a total therapeutic program. As such, the State Medicaid Agency, hence DDM Ascend, upholds an imperative in ensuring that the child is served in the **least restrictive and least resource intensive level of care** necessary to meet the child’s needs, that the **level of restriction in care is reduced at the earliest possible time, and that the services are individualized to address the unique needs of the child.**

Inpatient and PRTF providers of services to children under age 21 are required to submit screening protocols to DDM Ascend at admission and by or before the final authorized date of services. Because of federal and state requirements, it is mandatory that providers meet the following standards in submitting screening information:

<i>Area</i>	<i>Issue</i>
<i>Completeness of screening forms</i>	<ul style="list-style-type: none"> <li>– Complete screening forms in their entirety, preferably online. DDM Ascend will provide individualized training for any provider staff needing assistance.</li> <li>– <b>All</b> required demographic and clinical information must be provided on the screening forms.</li> </ul>
<i>Clear description of symptoms, behaviors, needs</i>	<ul style="list-style-type: none"> <li>– Provide extensive detail about the <b><u>intensity, severity, and frequency of behaviors and symptoms</u></b> of the child and avoid use of euphemisms or jargon to describe behavior (e.g., rather than using descriptions such as ‘dyscontrol’, describe the behaviors, when they occur, precipitators, intensity, etc.).</li> <li>– Continued stay reviews must <b><u>demonstrate how services are effectively meeting the child’s needs, as well as the basis for why the child continues to require ongoing care</u></b> at the level of intensity requested. This must occur through clear demonstration of the child’s response to services and a clear description of ongoing symptoms and behaviors and their intensity, frequency, and severity.</li> </ul>

– Continued on page 7

## Certification and Continued Stay Review Requirements – Continued

<i>Area</i>	<i>Issue</i>
<i>Treatment Plans which are dynamic and active</i>	<ul style="list-style-type: none"> <li>- Detail <b><u>dynamic</u></b> and <b><u>active treatment plans</u></b> that are modified ongoing to reflect the changing needs of the child and are <b><u>individualized to address the specific symptoms and behaviors</u></b> that warrant the intensity of requested care.</li> <li>- Establish goals and expectations that are reasonable and attainable.</li> </ul>
<i>Demonstration of Active Treatment</i>	<ul style="list-style-type: none"> <li>- <b><u>Psychiatric Visits:</u></b> Care must be provided <b><u>under the direction of a physician.</u></b> <b><u>Frequent psychiatric appointments and evaluations</u></b> must be delivered and must be clearly reflected in ongoing descriptions of treatment and in progress notes. Likewise, the basis for medication changes must be clearly described.</li> <li>- <b><u>Individual Therapy:</u></b> Must be provided routinely to the child and must demonstrate active services and the associated basis for why the child continues to require care.</li> <li>- <b><u>Family Therapy/Guardian:</u></b> Involvement by the family/guardian is an important part of care, whenever possible, and <b><u>is critical when children anticipate reintegrating with the family</u></b> at the conclusion of services. Failure to involve family ongoing and early in the treatment process is a great concern in the review process in affirming the presence of an active and appropriate treatment plan for the assessed child.</li> </ul>

Failure to demonstrate **both** the basis for the child’s needs **and** a commensurate level of **active treatment** will result in a denial of services. Failure to submit screening forms in their entirety, including all required demographic information may result in technical denial for the child’s stay. Technical denials cannot be appealed through the fair hearing process.

DDM Ascend unveiled its online screening protocols in 2007. Online screening, when screening forms are submitted with complete and descriptive information, enables the provider to receive more rapid Utilization Review decisions and enables the State to track and trend critical information about services, resources, and the profile of children served through these programs. The Medical Services Division strongly encourages providers to submit screening information online. DDM Ascend will provide training for provider staff if needed in the areas of online screening submission, education about criteria, or education on the Under 21 screening requirements. Contact Amy Gantt, North Dakota Operations Manager at DDM Ascend, for additional information (877.431.1388, ext. 3326). ♦

## CLAIMS POLICY – BILLING BITS

### SFN 511: Medical Procedure/Device Prior Authorization Request

When requesting ND Medicaid coverage of procedures or devices, SFN 511 must be completed and submitted. SFN 511 can be found at: <http://www.nd.gov/eforms/Doc/sfn00511.pdf>

### SFN 905: Provider Technology/Procedure Assessment Form

Providers are reminded to utilize SFN 905 when requesting ND Medicaid to consider coverage of new technology or new procedures. SFN 905 can be found at: <http://www.nd.gov/eforms/Doc/sfn00905.pdf>

### Medicaid Payment Is Payment-In-Full

Providers must accept Medicaid payment as payment in full for any covered service, except applicable co-payment or recipient liability that should be charged to the client. 42 CFR§ 447.15♦

# GUIDELINES FOR SUBMISSION OF PAPER CLAIMS

*Please follow these guidelines when submitting paper claims. This will help ensure that your claims can be scanned and processed in a timely manner. If claims and attachments are not submitted according to these guidelines, they will be returned to the provider.*

1. Use only black (preferable) or blue ink. Do not use red ink.
2. All information must be legible, typed (Times New Roman font is preferred) or printed, and within the boxes. Please make sure information does not touch or cover the lines or writing on a claim.
3. Submit claims and attachments on 8½ X 11 white paper. If document is smaller or larger than this size, copy it to 8½ X 11 white paper.
4. Do not submit carbon or NCR copies.
5. Documents cannot have any dark smudges, blackouts, or dark print that runs together.
6. Do not place any stickers, labels or tape on documents.
7. Do not submit two-sided documents.
8. Do not use a highlighter.
9. Do not use liquid whiteout. Correction tape can be used.
10. Only one line of service is allowed per detail line on the claim form. Do not bill with two service lines compressed into one detail line.
11. Do not use special character i.e. dashes, slashes, or decimals.
12. Revenue Code cannot be greater than three positions. Do not enter a leading zero.
13. When submitting multiple-page claims, Total Charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim MUST be filled in following these guidelines:

**The following fields MUST match on all pages of a multiple page UB-04:**

Statement Covers Period (box 6)  
Provider ID (box 57)  
Diagnosis codes and principle procedure code

**The following fields MUST match on all pages of a multiple page CMS-1500:**

Recipients Medicaid ID Number (box 1a)  
Recipients Medicaid Name (box 2)  
Provider Name and Number (box 33)

Do not include contractual agreement or write off amounts from primary insurance(s) i.e. box 29 on the CMS 1500 and box 54 on the UB04. The boxes should indicate the actual dollar amount paid by the primary insurance(s). The totals will need to balance i.e. boxes 28, 29, 30 on the CMS 1500 and boxes 23, 54, 55 on the UB04. For example, billed amount \$40.00; primary insurance actual payment \$30.00; amount due would be \$10.00. The amount due may differ from the primary insurance EOB because of the claims submittal requirement. ♦

# DURABLE MEDICAL EQUIPMENT BILLING

An updated version of the Durable Medical Equipment (DME) Purchase and Rental Fee Schedule has been posted to the department's website (<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html>) along with a memo indicating what Health Care Professional Coding System (HCPCS) codes have been added and/or deleted from the file.

## MODIFIERS ADDED

- RA—Replacement of a DME item due to loss, irreparable damage, or when the item has been stolen.
- RB—Replacement of a part of DME furnished as part of a repair.

## DME REMINDER

Durable medical equipment providers should remember to check the current HCPCS book for code descriptions and what constitutes one unit. An example is code A4253—blood glucose test or reagent strips for home blood glucose monitor, per 50 strips. Fifty strips would equal one unit of service. Another example is code E0973—wheelchair accessory, adjustable height, detachable armrest, complete assembly, each. One arm rest equals one unit so if you dispense a right and a left armrest you should be requesting two units of service.

## CODING REGULATIONS

Providers need to ensure they are following correct coding requirements to avoid potential billing errors. Providers can determine the appropriateness of coding by having current HCPCS book to ensure the services provided meet the full definition of the codes that are billed on claims or submitted on prior authorizations to Medicaid. Medicaid staff cannot provide billing codes to providers.

## CORRECT INFORMATION

As of 6/15/2009, the DME Administrator will no longer update and change recipient information on already adjudicated prior authorizations. It is the responsibility of the DME supplier to provide current information on Medicaid Recipients. ♦

# NEW FORM FOR 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 as to the medical necessity of the out-of-state services. By having all of the information together, we will be able to make a determination more quickly and therefore, better serve the Medicaid recipients. The new form will also help clarify the information that is required, making your part of the process easier.

The form can be found on our website at: <http://www.nd.gov/eforms/Doc/sfn00769.pdf> and can be filled out on your computer before printing.

We will require these forms to be used by November 1, 2009. Any request submitted after that date without all of the required information will not be processed and returned as incomplete. There are instructions on page two of the form, however if you have additional questions, please call the Medicaid office at 1-800-755-2604, or 328-2321. ♦

## LEGISLATIVE UPDATE - CONTINUED

House Bill 1012 provides for a \$.86 salary and benefit enhancement for basic care and nursing facility employees. Facility administrators and Directors of Nursing are not included in this increase. The increase is effective July 1, 2009.

House Bill 1012 provides for a supplemental payment to eligible critical access hospitals (CAH). To be eligible under this section a CAH's percentage of revenue received from Medicaid must exceed 25% of its total annual revenue in its most recent audited financial statements and the CAH must be located in a city with a population that does not exceed 1,450 people.

### **SENATE BILL 2044**

#### **Basic & Long-term Care Bed Capacity**

Senate Bill 2044 continues the moratorium on the expansion of basic care and long-term care bed capacity through July 31, 2011. The current exceptions to the moratorium are still effective.

### **SENATE BILL 2158**

#### **Primary Care Case Management Program**

The 2009 Legislature approved Senate Bill 2158 which allows advanced registered nurse practitioners to serve as Primary Care Case Managers (PCCM) within the North Dakota Medicaid's Primary Care Case Management Program. This change will be effective later this calendar year.

The North Dakota Medicaid's Primary Care Case Management Program (formerly known as the Primary Care Provider "PCP" Program) was implemented in 1997. The intent of the program is to ensure adequate access to primary care, provide coordination and continuity of health care services, and decrease over-utilization of medical services. Other provider types that may serve as PCCM's are general practitioners, family physicians, internal medicine physicians, obstetrician/gynecologist, or pediatricians.

More information on the Primary Care Case Management program can be found in the *Managed Care Chapter* of the *General Information for Providers* located on the Department of Human Services website.

### **SENATE BILL 2167**

#### **Reuse, Recycling, or Resale of Durable Medical Equipment**

This bill indicates, "If a state agency uses state funds to provide free medical equipment to an individual, that state agency shall establish a policy addressing the possible reuse, recycling, or resale value of the medical equipment upon replacement of the medical equipment by that state agency or upon disuse of the medical equipment by the individual."

The Department has met with the Durable Medical Equipment suppliers on this change and in the future will be adding information to the Prior Authorization Form. Information will also be included in the Recipient Newsletters.

### **SENATE BILL 2216– See "Forensic Medical Examination Costs" Article on Page 5**

### **SENATE BILL 2318**

#### **Program of All-Inclusive Care of the Elderly - PACE**

The 2009 Legislation approved Senate Bill 2318 providing the North Dakota PACE program the opportunity to serve those individuals who are not covered by Medicare and/or Medicaid. Individuals who are able to privately pay for PACE services may now enroll in the program if they meet the PACE qualifications.

PACE is a program in which PACE providers receive a set amount of money on a monthly basis, for each eligible enrollee to provide patient-centered and coordinated care to frail elderly individuals living in the community. The PACE program became an option in 2008 for those residing in the Bismarck and Dickinson area.

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

- Age 55 or older
- Eligible for nursing home level of care, and
- Live in a PACE service area

For more information about PACE contact Northland PACE Senior Care Services: Bismarck 701-751-3050; Dickinson 701-456-7387; or Toll Free 1-888-883-8959. – Continued on page 11

## LEGISLATIVE UPDATE - CONTINUED

### **SENATE BILL 2333**

#### **Public Health Network Pilot Project/ Statewide Immunization Services**

Senate Bill 2333 provides \$275,000 from the general fund to the ND Department of Health for a regional public health network pilot project. The pilot will be regionalized through the Central Valley Health District in Jamestown, which will be the lead agency and will enter into a Joint Powers Agreements with local public health units in the surrounding area. The lead agency would provide necessary services for those communities and other public health services such as school health, nutrition, and immunizations, among others.

Also included in this bill is \$1,200,000 from Federal Stimulus funds with a general fund contingency of the same amount for statewide immunization services. The ND Department of Health has been asked to work with the Local Public Health Units throughout the state to determine needs as they relate to the statewide administration of immunizations. Once the ND Department of Health has gathered this information they will need to submit a grant to receive the Federal Stimulus funding.

### **HOUSE BILL 1303**

#### **Allowable Bad Debt Expense in Nursing Home Rates**

House Bill 1303 increases amount of the allowable bad debt expense that may be included in the nursing home rate to 180 days of resident care per year or a total of 360 days of resident care per individual. The allowable bad debts expenses would be included in the property costs category in the report year that the bad debt is determined to be uncollectible. The change is subject to approval by the Centers for Medicare and Medicaid Services.

### **HOUSE BILL 1307**

#### **Allowable Education Expense in the Nursing Home Rate**

House Bill 1307 increases the amount of allowable education expense that may be included in the nursing home rate to a total of \$15,000 per per-

son. A facility may claim the lesser of one-half of the individual's education expense or \$3,750. Allowable education expenses include materials, books or tuition and must be provided by an accredited academic or technical educational facility. An individual who receives education assistance through this program must commit to a minimum of 664 hours of employment after completion of the education program for each year that assistance was provided.

### **HOUSE BILL 1327**

#### **Remodel a Nursing Facility**

The bill provides for a grant of \$150,000 to remodel a nursing facility to meet the requirements of assisted living and basic care and \$50,000 for a pilot project on assisted living rent subsidies for at least four residents.

### **HOUSE BILL 1433**

#### **Supplemental Payment for Skilled Nursing Facilities.**

This bill authorizes the Department to seek approval from the Centers for Medicare and Medicaid Services (CMS) for a supplemental payment for certain skilled nursing facilities. In order to be eligible for the supplemental payment, the facility must be owned by the city or county and have a capacity of fewer than 31 licensed beds. ♦

## VACCINATION REFERRALS

Effective 6-8-09 North Dakota Medical Assistance (NDMA) no longer requires Primary Care Provider (PCP) referrals for vaccines/toxoids (90476-90749) and immunization administration for vaccines/toxoids (90465-90474). This affects those recipients participating in the Primary Care Case Management (PCCM) Program.

NOTE: Recipients in the Coordinated Services Program (CSP) are required to have a referral from their designated CSP provider for any services (including vaccines/toxoids and immunization administration of the vaccines/toxoids). ♦

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 2009:

No Check-Write	Rescheduled Date
August 31, 2009	September 1, 2009
September 7, 2009	September 8, 2009
November 30, 2009	December 1, 2009

## NEW FACES & PLACES IN MEDICAL SERVICES

- ☺ **LeeAnn Thiel** –Medicaid Payment & Reimbursement Services Administrator
- ☺ **Dawn Mock** – Medicaid Program Integrity Administrator
- ☺ **Alyssa N.** – Provider Relations
- ☺ **Brian Nybakken** –Medical Claims Administrator
- ☺ **Jason H.** – Medical Claims Auditor

