

PROVIDER MANUAL FOR **CHIROPRACTIC SERVICES**



Published By:

**Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505**

June 2013



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KEY CONTACTS

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Central Time).

Mailing Address:

Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Provider Enrollment

(800) 755-2604
(701) 328-4033

Send written inquiries to the address above, Attn: Provider Enrollment.

Or e-mail inquiries to:
dhsenrollment@nd.gov

Provider Relations

For questions about recipient eligibility, payments, denials or general claims questions:

(800) 755-2604
(701) 328-4043

Send written inquiries to the address above, Attn: Provider Relations.

Claims

Send paper claims to the address above, Attn: Claims Processing

Service Limits Prior Authorization

For prior authorization, you may fill & print the form located at <http://www.nd.gov/eforms/Doc/sfn00481.pdf>. It may be mailed to the address above, or faxed to: (701) 328-1544.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for Provider Enrollment:

(800) 755-2604
(701) 328-4033

HIPAA/EDI Electronic Data Interchange

For questions regarding electronic claims submissions:

(701) 328-2325

Provider Information Website

<http://www.nd.gov/dhs/>

- Updates for Providers
- Provider manuals
- Fee schedules
- Forms
- Provider enrollment
- Newsletters
- Links to other websites



VERIFICATION OF ELIGIBILITY

ND VERIFY

VERIFY is a recipient eligibility verification system provided by the ND Medicaid program for providers. This system allows the provider to enter the patient identification number using a touchtone telephone and receive a verbal response from the computer indicating the name and date of birth of the patient; the patient's eligibility for a given date of service; Coordinated Services Program information; existence of any third party liability (TPL); and if so, the name of the TPL carrier and the TPL policy number; amount of recipient liability, if any; co-pay; date of last eye exam, frames and lenses, and also the name of the primary care provider (PCP). All responses reflect the latest information available on the data base at the time of the call.

MEDIFAX

Eligibility may be checked at the following Web site: <http://www.medifax.com>.

CSHS AND VR

Children's Special Health Services (CSHS) and Vocational Rehabilitation (VR) eligibility information is not available on the VERIFY or MEDIFAX systems. Eligibility for VR recipients must be determined by contacting the regional VR office. Eligibility for CSHS recipients must be determined by contacting the state CSHS office.

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program available to eligible North Dakota women. Women who are in active treatment for cancer and are ND Medicaid eligible through Women's Way coverage are entitled to full ND Medicaid benefits. Women's Way eligibility information is not available on the VERIFY or MEDIFAX systems. Women's Way recipient identification numbers begin with WW000000. Questions on Women's Way eligibility can be directed to Provider Relations at 701-328-4030.



CHIROPRACTIC CARE

Chiropractic care is a service provided by a doctor of chiropractic, licensed under North Dakota law and enrolled as a ND Medicaid Provider.

ND MEDICAID COVERED SERVICES

Coverage extends only to treatment by means of:

- Manual manipulation of the spine for treatment of subluxations (incomplete or partial dislocation) demonstrated by x-rays or exam; *and*
- Determined to be medically necessary.

NON-COVERED SERVICES

An excluded service from ND Medicaid coverage is any service other than manual manipulation for treatment of subluxation of the spine. ND Medicaid does not cover the following services performed by a chiropractor:

- Examinations and consultations
- Laboratory services
- Vitamins or nutritional counseling
- Acupressure or Acupuncture
- Treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation
- Medical supplies or equipment supplied or prescribed by a chiropractor
- X-rays, other than those needed to support a diagnosis of subluxation
- Exercise counseling, activities of daily living counseling
- Physiotherapy modalities, including but not limited to ultrasound, diathermy, electrical muscle stimulation, interferential current, Russian stimulation, and application of cold/hot packs

PAYMENT LIMITATIONS AND BILLING PROCEDURES

- Payment for manual manipulations of the spine is limited to one manipulation per day and may not exceed 12 manipulations per calendar year. Effective for dates of service on or after January 1, 2005, NDMA will allow reimbursement to

chiropractors for E/M office and Other Outpatient Services – **New Patient (99201-99203)**. These E/M services may be billed in addition to the chiropractic manipulative treatment (98940-98942) **ONLY** when the patient has not received any professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice, within the past three years.

- Payment for x-rays may not exceed two (2) per year and are limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine.
- Chiropractic services are billed on the CMS-1500, or electronically using the 837-P HIPAA transaction.

MEDICAL NECESSITY FOR TREATMENT

Chiropractic services are considered medically necessary when ***all*** of the following criteria are met:

- The member has a neuromusculoskeletal condition and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition; ***and***
- The medical necessity for treatment is clearly documented; ***and***
- The patient must have a subluxation of the spine as demonstrated by X-ray or physical exam; ***and***
- Improvement is documented within the initial two weeks of chiropractic care.

NOT MEDICALLY NECESSARY SERVICES

- If no improvement is documented within the initial two weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
- If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.
- Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered *not* medically necessary.
- Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered *not* medically necessary.
- Chiropractic care in persons, whose condition is neither regressing nor improving, is considered *not* medically necessary.
- Manipulation of infants is considered experimental and investigational for non-neuromusculoskeletal indications.
- Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the

member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

- Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, Breech or other malpresentations, scoliosis, dysmenorrhea, otitis media, asthma and epilepsy; *this is not an all-inclusive list*) because its effectiveness for these indications is unproven and the paucity of evidence. Not medically necessary services considered experimental and investigational chiropractic procedures are as follows:

1. Active Release Technique
2. Active therapeutic movement (ATM2)
3. Applied Spinal Biomechanical Engineering
4. Atlas Orthogonal Technique
5. BioEnergetic Synchronization Technique
6. Biogeometric Integration
7. Blair Technique
8. Chiropractic Biophysics Technique
9. Coccygeal Meningeal Stress Fixation Technique
10. Cranial Manipulation
11. Directional Non-force Technique
12. Koren Specific Technique
13. Manipulation for infant colic and Manipulation for Internal (non-neuromusculoskeletal) Disorders (Applied Kinesiology)
14. Manipulation Under Anesthesia
15. Moire Contourographic Analysis
16. Network Technique
17. Neural Organizational Technique
18. Neuro Emotional Technique
19. Sacro-Occipital Technique
20. Spinal Adjusting Devices (ProAdjuster, PulStarFRAS)
21. Upledger Technique and Craniosacral Therapy
22. Webster Technique (for breech babies)
23. Whitcomb Technique
24. Computerized radiographic mensuration analysis for assessing spinal mal-alignment
25. Neurocalometer/Nervoscope
26. Para-spinal Electromyography (EMG)/Surface Scanning EMG
27. Spinoscopy
28. Thermography

SUBLUXATION

Definition

Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact. A subluxation may be demonstrated by an x-ray or by a physical examination.

Location of Subluxation

The precise level of subluxation must be specified in the medical record to substantiate the medical necessity for the manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name
Neck	Occiput		Occ, C0
	Cervical	7	C1 thru C7
	Atlas		C1
	Axis		C2
Back	Dorsal or	12	D1 thru D12
	Thoracic		T1 thru T12
	Costovertebral		R1 thru R12
	Costotransverse		R1 thru R12
Low Back	Lumbar	5	L1 thru L5
Pelvis	Ilii, R and L		I, Si
Sacral	Sacrum, Coccyx		S, SC

There are two ways in which the level of subluxation may be specified:

- The exact bones may be listed, for example: C5, 6 etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas), lumbo-sacral (L5 and Sacrum) and sacro-iliac (sacrum and ilium).

The following are examples of acceptable terms for the nature of the abnormalities:

- Off-centered
- Misalignment
- Malpositioning
- Spacing-abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation

- Listhesis- antero, postero, retro, lateral, spondylo
- Motion- limited, lost, restricted, flexion, extension, hyper mobility, hypo mobility, aberrant

Other terms may be used, if they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements.

MAINTENANCE THERAPY

- Chiropractic maintenance therapy is **not** considered to be medically reasonable or necessary under the ND Medicaid program, and is therefore not payable.
- Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promotes health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.
- When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

CHIROPRACTICE LIMITATIONS

- Chiropractic manipulative services for ND recipients are limited to a maximum of *12 chiropractic manipulations per calendar year* and manual manipulation to the spine is limited to one manipulation per day. *Prior authorization is required for visits exceeding this limit.* Authorization in excess of the above limits may be granted by the Medicaid Utilization Review staff when medically necessary.
- The chiropractic manipulative services rendered must have a direct therapeutic relation to the patient's condition and the services must provide reasonable expectation of recovery or improvement of function.
- The need for a service should be based upon the reasonableness and necessity of each individual patient encounter, and not based on a specific "covered" number. In other words, each treatment billed to ND Medicaid is subject to the same requirement to be reasonable and necessary under general program rules.
- ND Medicaid may apply stricter guidelines to numbers of treatments that we believe may indicate that the services are no longer reasonable and necessary; however, our application of any frequency guidelines is an internal matter, and is not subject to disclosure.

DIAGNOSTIC IMAGING SERVICES & LIMITATIONS

- Diagnostic imaging services for ND recipients are limited to a maximum of two chiropractic x-rays per calendar year and are limited to radiological examinations of the full spine; cervical, thoracic, lumbar, and lumbosacral areas of the spine.
- An x-ray is not required to demonstrate subluxation. An x-ray may, however, be used for this purpose if the chiropractor so chooses. If the chiropractor chooses to use an x-ray to demonstrate subluxation, then the documenting x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. An x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment.
- Diagnostic imaging must be related to the purpose of the diagnostic visit to confirm the existence of a neuromusculoskeletal condition requiring treatment. The imaging services must be performed and developed in the chiropractor's office, and read by the treating chiropractor.

DEMONSTRATED BY PHYSICAL EXAM

To demonstrate a subluxation based on physical examination, **two of the four** criteria mentioned below are required, **one** of which **must be** asymmetry/misalignment **or** range of motion abnormality:

- Pain/tenderness evaluated in terms of location, quality, and intensity;
- Asymmetry/misalignment identified on a sectional or segmental level;
- Range of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
- Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

The history recorded in the patient record should include the following:

- Symptoms causing patient to seek treatment;
- Family history, if relevant;
- Past health history (general health, prior illness, injuries, hospitalizations, medications, surgical history);
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and

Prior interventions, treatments, medications and secondary complaints.



CODING GUIDELINES

Two diagnostic codes must be listed on the prior authorization and claim to support medical necessity:

- The level of subluxation must be specified on the claim and must be listed as the **primary diagnosis**.
- The associated neuromusculoskeletal condition necessitating the treatment must also be listed as the **secondary diagnosis**.

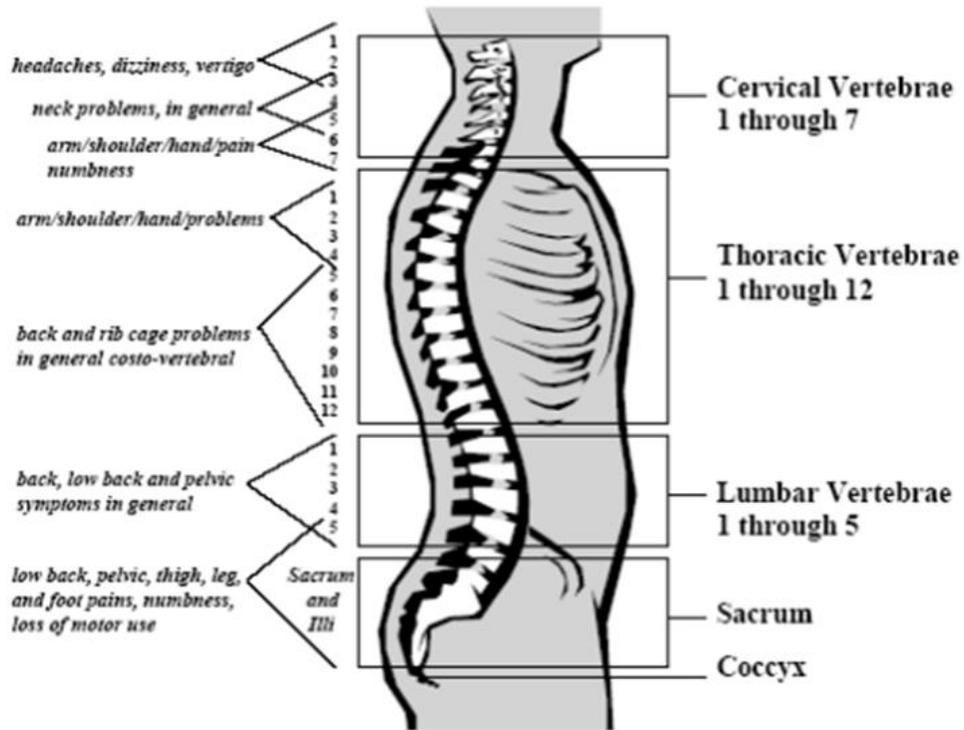
SYMPTOMS ASSOCIATED WITH SUBLUXATION

A secondary diagnosis consisting of symptoms necessitating the patient to seek treatment must be indicated. These symptoms must have a direct relationship to the level of subluxation stated in the primary diagnosis. As stated under documentation requirements, these symptoms should refer to the spine (spondylo or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal), joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general, other symptoms must relate to the spine as such. A statement on a claim that there is "pain" is insufficient. The location of the pain must be described and whether that particular vertebra is listed as capable of producing pain in that area. Spinal Axis, aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. There may be secondary or complicating conditions such as spinal ankylosis, curvature, or other chronic deformities that determine the reasonableness and necessity of the number of visits ND Medicaid will cover for chiropractic care.

Some other disease and pathological disorders do not provide the therapeutic grounds for chiropractic manipulative treatment. Examples of these are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia and emphysema.

Consistency in the pattern and frequency or in the use of diagnosis codes will be monitored. Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered. Coverage will be denied if there is not a reasonable expectation that the continuation of treatment would result in improvement of the patient's condition. While another joint problem anywhere in the

spine is obviously able to produce symptoms at that immediate place, other areas of the body and the vertebrae related to them follow the general scheme shown in the chart below. Please note that while these areas of the spine and the related body structures, as well as the symptoms listed, are generalized, they can serve as a useful guide.





SUBLUXATION

The following documentation requirements apply whether the subluxation is demonstrated by an x-ray or physical examination:

- The need for the specific treatment must be clearly documented in the patient record;
- The date of occurrence, nature of the onset, or other pertinent factors that will support the necessity of chiropractic treatments must be documented in the patient's record;
- Failure to completely document the necessity of the chiropractic manual spinal manipulation(s) may result in denial of prior authorizations and/or claim(s);
- Documentation must be legible and made available to ND Medicaid upon request;
- ND Medicaid limits reimbursement to no more than one treatment per day;
- The patient's record must document a specific level of subluxation (which may be demonstrated by an x-ray or by physical examination). The claim will document the area of subluxation by codes coded to the highest level of specificity. The practitioner's documentation should record the precise level of subluxation.

DOCUMENTATION REQUIREMENTS: INITIAL VISIT

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History as stated above.
2. Description of the present illness including:
 - Mechanism of trauma;
 - Quality and character of symptoms/problem;
 - Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - Aggravating or relieving factors;
 - Prior interventions, treatments, medications, secondary complaints; and
 - Symptoms causing patient to seek treatment. These symptoms must bear a direct relationship to the level of subluxation. These symptoms should refer to the spine (spondylo or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia),

inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
 - Recommended level of care (duration and frequency of visits);
 - Specific treatment goals; and
 - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

DOCUMENTATION REQUIREMENTS: SUBSEQUENT VISITS

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History
 - Review of chief complaint;
 - Changes since last visit;
 - System review, if relevant.
2. Physical exam
 - Exam of the area of spine involved in diagnosis;
 - Assessment of change in patient condition since the last visit;
 - Evaluation of treatment effectiveness.

Documentation of treatment given on day of visit.



UTILIZATION REVIEW

Utilization review activities required by the Department of Human Services are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary, and of optimum quality and quantity. Members and providers are subject to utilization review. Utilization control procedures safeguard against the following situations:

- Unnecessary care and services
- Inappropriate services or poor quality of service monitored in accordance with NDMA guidelines
- Inappropriate payments Utilization control measures safeguard against unnecessary or inappropriate use of Medicaid services and the prevention of excess payments.

Utilization review activities ensure the efficient and cost-effective administration of North Dakota Medicaid by monitoring the following items:

- Billing and coding practices
- Diagnosis-related group (DRG) validations
- Documentation
- Medical necessity
- Misuse and overuse
- Other administrative findings
- Quality of care
- Reasonableness of prior authorization (PA)



PROGRAM INTEGRITY

The Department's Surveillance/Utilization Review Section (SURS) is a federally mandated program that performs retrospective review of paid claims (**NDAC**) 75-02-05-04. SURS is required to safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments. If the Department pays a claim and later discovers that the service was incorrectly billed or the claim was erroneously paid, the Department is required by federal regulation to recover any overpayment.

The purpose underlying administrative remedies and sanctions in the Medicaid program is to ensure the proper and efficient utilization of Medicaid funds by those individuals providing medical and other health services and goods to recipients of medical assistance NDAC 75-02-05-01.



COORDINATION OF BENEFITS

WHEN CLIENTS HAVE OTHER COVERAGE

Medicaid clients often have optical services coverage through Medicare, Workforce Safety and Insurance, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions.

WHEN A CLIENT HAS MEDICARE

Medicare Part A Claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services.

Medicare Part B Crossover Claims

Medicare Part B covers physician care, eye exams, and other services. The Department of Human Services has an agreement with Medicare Part B carriers for North Dakota (Blue Cross Blue Shield of ND). In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not cross over).
- Submit their Medicare and Medicaid provider numbers to ND Medicaid Provider Enrollment.

Once the above conditions are met for clients who have coverage through Medicare Part B and ND Medicaid, providers need **NOT** submit Medicare Part B claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When Medicare Pays or Denies a Service

- When Medicare pays an eye exam claim for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit these claims to Medicaid.

Providers that are not set up for automatic crossover should submit a claim to Medicaid with the EOMB after Medicare pays, and Medicaid will consider the claim for payment.

If Medicare denies an eye exam claim, providers are to submit the claim with EOMB to Medicaid.

- For clients who have QMB only coverage, the provider bills Medicare first for eyeglass claims, and if Medicare pays the claim, Medicaid will process the claim for coinsurance and deductible. If Medicare denies the claim, Medicaid will also deny the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. The claim must also include the Medicaid provider number and Medicaid client ID number.



BILLING PROCEDURES

CLAIM FORMS

Services provided by ophthalmologists, optometrists, and opticians must be billed either electronically on a professional claim (HIPAA 837-P), or on a CMS-1500 paper claim form. CMS-1500 forms are available from various publishing companies; they are not available from the ND Medicaid program.

TIMELY FILING LIMITS

Providers must submit clean claims to Medicaid within the latest of:

Twelve months from whichever is later:

- The date of service
- The date retroactive eligibility or disability is determined
- **Medicare Crossover Claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by ND Medicaid, Clearinghouse, or Billing Agency.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly.
- If a claim submitted to Medicaid does not appear on the remittance advice within 60 days, contact Medicaid Provider Relations for claim status.

- If another insurer has been billed and 90 days have passed with no response, you should bill Medicaid for the proper denial ensuring timely filing is in accordance with ND Medicaid guidelines.

USUAL AND CUSTOMARY CHARGE

Providers must bill Medicaid their usual and customary charge for each service; that is, the same charge that is assessed to other payers for the service.

BILLING FOR RETROACTIVELY ELIGIBLE CLIENTS

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the eligibility determination letter to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

If the provider is informed the recipient has retroactive eligibility and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s).

MULTIPLE VISITS ON SAME DATE

When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit for review.

SUBMITTING ELECTRONIC CLAIMS

The ND Department of Human Services accepts electronic medical claims that are in the HIPAA compliant format.

- Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment.

To test HIPAA transactions, contact Medical Services at (701) 328-2325.

CLAIM INQUIRIES

The ND Medicaid Web site, <http://www.nd.gov/dhs/services/medicalserv/medicaid/>, contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more. The information may be downloaded and shared with others in your office. If you cannot find answers to your questions on the website, or if you have questions on a specific claim, contact Medicaid Provider Relations.

COMMON CLAIMS ERRORS

Common Claims Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions after this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field; verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field; check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 9-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see Prior Authorization in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim, 837-P).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.



RECIPIENT LIABILITY

WHAT IS RECIPEINT LIABILITY?

Recipient liability is the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is a monthly amount that is the recipient's responsibility to pay towards their medical claims.

Eligibility workers at the local county social service agency determine Medicaid eligibility for applicants, based on established federal and state guidelines. Eligibility determinations involve various criteria, which include family size, income, assets and expenses. These factors and any other program specific standards are calculated and compared against the family's income standard, as determined by program policy. When an individual's income exceeds the assistance program income standard, that person can still become eligible for Medicaid with a recipient liability. The individual must incur medical expenses that equal or exceed the recipient liability amount during the month.

Providers should submit all claims for recipients with a recipient liability in the usual manner. As claims are received and processed, they are applied to the recipient liability amount. The provider will be notified on their remittance advice once the claim has been processed. The recipient is also notified of the requirement to make payment to the provider. The recipient is obligated to pay the provider directly for any amount applied to the recipient liability.

TAKING RECIPIENT LIABILITY AT THE TIME OF SERVICE

With the exception of Pharmacy Point of sale, providers are not to collect Recipient Liability (RL) at the time of service. Rather, providers are to file the claim, and then collect the RL only if directed by the information on the Remittance Advice.



REMITTANCE ADVICES AND ADJUSTMENTS

REMITTANCE ADVICE

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services provided. The RA provides details of all transactions that have occurred during the previous week. Each line of the RA represents all or part of a claim, and explains exactly what has happened to the claims (paid, denied) and the reason the claim was denied.

KEY FIELDS IN THE REMITTANCE ADVICE (RA)

FIELD	DESCRIPTION
1. Date	The date the RA was issued
2. Provider number	The 9-digit number assigned to the provider after enrollment
3. Check or ACH number	System assigned # to check or Automated Clearinghouse (ACH) transaction
4. Page number	The page number of the RA
5. RA #	State assigned Remittance advice (RA) number
6. Provider name and address	Provider's business name and address as recorded with the Department
7. Internal control number (ICN)	Each claim is assigned a unique 13-digit number (ICN). Use this number when you have any questions concerning a claim.
8. Recipient ID	The client's Medicaid ID number
9. Name	The client's name
10. Case #	The 10-digit number assigned by the local county social service agency.
11. Patient control #	The number assigned by the provider.
12. Performing Physician	The number assigned to the performing physician.
13. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same will appear in both columns.
14. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC# billed will appear in this column. If a modifier was used, it will also appear in this column.

15. Unit of service	The number of services provided under this procedure code.
16. Billed charges	The amount a provider billed for this service.
17. Recipient liability or other insurance	Amount deducted due to recipient liability or other insurance payment.
18. Payment	Medicaid's allowed amount. The Medicaid payment may not be allowed amount if there is Other Insurance or RL.
19. Message/Explanation of Benefits (EOB)	A code that explains how or why the specific service was denied or paid. These codes and their meanings are listed at the end of the Remittance Advice.
20. Third Party Liability (TPL)	If applicable, name of third party payer will be listed.
21. Co-pay/deductible information	Indicated amount deducted that is recipient responsibility.
22. Total charge/payment amount	Total of claims on remittance advice, and total of charges billed by provider.
23. Explanation of message codes used above	Summary of codes that were used to pay or deny a service.

PAYMENT AND THE REMITTANCE ADVICE

Providers may receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. The Department encourages EFT as providers receive payment sooner than via normal mail delivery.

With EFT, the Department deposits the funds directly to the provider's bank account. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers.

To participate in EFT, providers must complete a SFN 661. The form may be obtained at: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/online-forms.html>. One form must be completed for each provider number.

Once electronic funds transfer is established, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact Provider Enrollment. (Sample of Remittance Advice (RA) has been provided on the next page.)

(1)09/17/04

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE

(2)Provider Number 012345

REMITTANCE ADVICE

(4)Page 1

(3)Check Number (or ACH) 00000001

(5)R/A Number 14

(6) Main Street Clinic
Anytown, USA

Control No.	ID Number	Recipient Name	Case Number	Pat. Control Num	Prog. ID	
P.Phys	Service Dates	RX. No. Service	Code/Mod	QTY Billed	RL/OI Payment	MSG

(7)	(8)	(9)	(10)	(11)		
1	1004162304510	000-11-1234	Mouse Mickey	02-00015-007	415503840	
(12)	(13)	(14)	(15)	(16)	(17)	(18)
2	000052565	052604-052604	99214	1.0	132.00	.00
(20)	TPL Carrier Code: 0382 Name: Workers Compensation					(19)
						22

(7)	(8)	(9)	(10)	(11)		
1	1004162304500	000-00-5555	Duck Daisy	23-00023-203	041550106	
(12)	(13)	(14)	(15)	(16)	(17)	(18)
2	000036529	052404-052404	99243	1.0	177.00	.00
(21)	Collect this co-pay amount from the recipient					(19)
						96.17

(21) Collect this co-pay amount from the recipient 2.00

(22)TOTAL CHARGE/Payment Amounts 2 309.00 96.17

(23) Explanation of message codes used above

22 Payment adjusted because this care may be covered by another payer per coordination of benefits

N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount

REBILLING AND ADJUSTMENTS

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits.

When to Re-bill Medicaid

- **Claim Denied.** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the corrected claim on a CMS-1500 form (not the adjustment form).
- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Submit the denied service on a new CMS-1500 form. (Do not use an adjustment form.)
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to Re-bill

- Check any EOB code listed and make your corrections on a new claim with the correct information.
- When making corrections on a claim, remember the claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim.

ADJUSTMENTS

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or the provider may submit a [Provider Request for an Adjustment](#) (SFN 639) form to Medicaid Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the

adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction.

When to Request an Adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid, but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to Request an Adjustment

To request an adjustment, use the Provider Request for an Adjustment form. The requirements for adjusting a claim are as follows:

- ND Medicaid must receive individual claim adjustment requests within 12 months from the payment date.
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section of the adjustment form.

Completing an Adjustment Request Form

- Below are instructions on how to fill out the Provider Request for an Adjustment (SFN 639) form. You may also download the form from the website at <http://www.nd.gov/eforms/Doc/sfn00639.pdf>. Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
- Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):

Field	Description
(1) Reason for Request	Check appropriate box
(2) Recipient Block: a. I.D. Number (9 digits) b. State Use Only c. Patient's Name d. Case Number (10 digits)	Medicaid ID number Leave blank The recipient's name is here. 10 digit number assigned by the county
(3) Provider's Name	Provider's name and address (and mailing address if different)
(4) Claim's Internal Control Number: (13 digits)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
(5)	Leave blank
(6) Provider Number	The provider's Medicaid ID number
(7) Remittance Advice Date (MM/DD/YY)	Date claim was paid found on Remittance Advice Field #1 (see the sample RA in the Remittance Advice Chapter)
(8) Date of Service:	The date the service was provided
(9) Units	Units/days of service.
(10) Place of Service	Where the service was provided
(11) Procedure/Ancillary/ Accommodation Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
(12) Mod	Modifier.
(14) Amount Billed	The amount billed by the provider.
(15) Amount Paid	The amount reimbursed by the department for that service.
(16) Total	The amount reimbursed by the department for the entire claim.
(17) Explanation/Remarks	The reason for adjusting the claim. Explain in detail.
(19) Provider's Signature	Signature, date, and telephone number of person initiating the adjustment.