

GENERAL INFORMATION

FOR PROVIDERS

NORTH DAKOTA MEDICAID

AND OTHER MEDICAL ASSISTANCE

PROGRAMS



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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).

Provider Enrollment

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

Send written inquiries to:

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

or e-mail inquiries to:

dhsenrollment@nd.gov

Call Center

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

(701) 328-7098
(877) 328-7098

or e-mail inquiries to:

mmisinfo@nd.gov

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

(701) 328-4024
(800) 755-2604

Send written inquiries to:

Primary Care Case Management

dhsmci@nd.gov

Coordinated Services Program

Inquiries regarding coordinated services program members:

(800) 755-2604
(701) 646-4559

Medicaid Expansion through Sanford Health Plan

(855) 305-5060

Healthy Steps Health Benefit (BCBS of ND)

(800) 342-4718

Healthy Steps Dental Benefit (Delta Dental of MN)

(855) 648-1406

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 755-2604
(701) 328-2347

Send written inquiries to:

Third Party Liability Unit

ND Medicaid

Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Human Services
Dept 325
600 E Boulevard Ave
Bismarck ND 58505-0250

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

or e-mail inquiries to:

Or e-mail inquiries to:

dhsmed@nd.gov

medicaidtpl@nd.gov

Service Authorization Contacts

Behavioral Health	(701) 328-7068 (ph) (701) 328-1544 (fax)
Dental	(701) 328-4825 (ph) (701) 328-0350 (fax)
Durable Medical Equipment	(701) 328-2764 (ph) (701) 328-0370 (fax)
LTC UR/UC and Inpatient Psychiatric Services for Children Under 21	(701) 328-4864 (ph) (701) 328-1544 (fax)
Out of State Medical Care	(701) 328-7068 (ph) (701) 328-0376 (fax)
Pharmacy	(701) 328-4023
Service Limits	(701) 328-4825 (ph) (701) 328-0377 (fax)
Quality Health Associates	(701) 852-4231 (ph) (701) 857-9755 (fax)
Ascend (Long Term Care and Inpatient Psych Services for Children under 21)	(877) 431-1388

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- Member Inquiry
- Payment Inquiry
- Service Authorization Inquiry
- Claims Status

AVRS Access Telephone Numbers (available 24/7)

Toll Free: 877-328-7098

Local: 701-328-7098

Providers are granted access to the Automated Voice Response System (AVRS) by entering their ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One provider PIN number is assigned to each Medicaid ID number.

Touch Tone Phone Entry	Function
*	Repeat the options
9 (nine)	Return to main menu
0 (zero)	Transfer to Provider Call Center (M-F 8am – 5pm CT) –or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVR system at any point to speak with a provider call center customer service representative. The call center is available during regular business hours from 8am to 5pm central time, Monday through Friday, and observes the same holidays as the state of North Dakota. Providers may also elect to leave a voicemail message at any time when the call center is not available. Except during heavy call times, provider voice mail messages will be responded to in the order received on the following business day during regular business hours.

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AVRS Options	Secondary Selections
<p>Option 1: Member Inquiry</p>	<p>Callers may select any of the following options:</p> <ul style="list-style-type: none"> ▪ Eligibility/Recipient Liability ▪ Primary Care Provider (PCP) ▪ Coordinated Services Program (CSP) enrollment ▪ Third Party Liability (TPL) ▪ Vision ▪ Dental ▪ Service Authorizations
<p>Option 2: Payment</p>	<p>Remittance Advice payment information is available for the specific time frame entered.</p>
<p>Option 3: Claims Status</p>	<p>Claim information is available based upon the Member ID number entered, including:</p> <ul style="list-style-type: none"> ▪ TCN (Transaction Control Number) ▪ Billed Amount ▪ Claim Submit Date ▪ Date(s) of Service ▪ Claim Status (paid, denied, suspended) ▪ Paid Amount (if applicable)
<p>Option 4: Service Authorization Inquiry</p>	<p>Service Authorization information is available based upon the Member ID number entered, including:</p> <ul style="list-style-type: none"> ▪ Service Authorization (SA) Number ▪ Date(s) of Service ▪ Authorization Status

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT ELIGIBILITY

To be eligible for enrollment, a provider must:

- Provide services to at least one ND Medicaid eligible member.
- Meet the conditions in this chapter and conditions of provider agreement (SFN 615) regarding the specific type of provider, program, and/or service.
- Be a provider with a valid license, certification, accreditation or registration according to North Dakota state laws and regulations.

Providers that are on the List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM) or excluded by another State Medicaid Agency will be denied enrollment.

ENROLLING

Providers must complete an online application. The application is located at <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>. Retroactive application effective dates may be approved on a case by case basis if warranted.

Medicaid payment is made only to enrolled providers.

Each newly enrolled provider will receive a letter via the United States Postal Service that includes log-in information to access the MMIS provider web portal.

ENROLLMENT REVALIDATION

Providers are required to revalidate their enrollments at least once every five (5) years. ND Medicaid will determine revalidation dates and providers will receive revalidation notices in their web portal inbox. The revalidation date also appears in the online provider portal.

RESIDENCY PROGRAM

All physicians in a residency program who have been granted a license to practice medicine in North Dakota by the ND 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 ND (Chapter 43-17-18.4) must enroll with ND Medicaid in order to bill for services rendered to ND Medicaid members. These residents shall not bill using a supervising physician's NPI.

OUT OF STATE PROVIDERS

An "out of state provider" is a provider located more than 50 miles from a North Dakota border. All out of state services require prior authorization (except in the local trade area within 50 miles of the North Dakota border or services provided in response to an emergency). Out of state emergency services require a retroactive authorization in order to receive payment.

An out of state provider may apply for a retroactive enrollment date for the date of service provided to a ND Medicaid member. Timely filing applies for claims processing purposes. Providing a claim to provider enrollment for enrollment purposes does not equate to submitting a claim for timely filing purposes.

Providers must complete an online application. The application is located at <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>. In addition to the forms indicated in the online application, an Out of State Enrollment Clarification form (State Form Number 509) is required. The form is available at www.nd.gov/eforms.

Enrollment forms may be faxed to provider enrollment at 701-328-1544. Questions regarding the enrollment process may be directed to dhsenrollment@nd.gov.

CHANGES IN ENROLLMENT

Providers are responsible for ensuring that enrollment information remains current. Changes that are needed but cannot be updated through the provider web portal may be emailed to dhsenrollment@nd.gov. Changes that include sensitive information such as social security numbers, dates of birth, etc., may be sent via secure fax at 701-328-1544, attn. Provider Enrollment.

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To avoid any payment delays, notify Provider Enrollment of address or Automated Clearing House (ACH) changes in advance.

CHANGE IN OWNERSHIP

Providers are required to furnish changes in owners who have 5% or more ownership interest within 35 days. Refer to 42 Code of Federal Regulation (CFR) § 455.104 for more information. For tax reporting purposes, it is necessary to notify provider enrollment at least 30 days in advance of any changes that cause a change in tax identification number.

TERMINATING MEDICAID ENROLLMENT

Medicaid enrollment may be terminated at any time by submitting a notice either via email to dhsenrollment@nd.gov or via fax to 701-328-1544, attn: Provider Enrollment. Include name, national provider identifier (if applicable) and the termination date. Termination without cause must be provided in writing and requires 30 days' advance notice. ND Medicaid may also terminate enrollment under the following circumstances:

- Breaches of the provider agreement;
- Demonstrated inability to perform under the terms of the provider agreement;
- Failure to abide by applicable North Dakota and U.S. laws; or
- Failure to abide by the regulations and policies of the ND Department of Human Services or the ND Medicaid program.

North Dakota Administrative Code [75-02-05](#) provides additional information.

PROVIDER REQUIREMENTS

By signing the application to enroll as a provider for North Dakota Medicaid, providers agree to abide by the conditions of participation addressed on the provider agreement. The Medicaid Program Provider Agreement (SFN 615) is available at www.nd.gov/eforms. Additional requirements may apply based on the provider type or provider specialty. This section includes:

- No member should be abandoned in a way that would violate professional ethics.

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- Members may not be refused service because of race, color, national origin, age or disability.
- Members enrolled in Medicaid must be advised in advance if they are being accepted only on a private pay basis.
- When a provider arranges ancillary services for their Medicaid member through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the member as a Medicaid member and they may not bill the member directly.
- Most providers may begin Medicaid coverage for retroactively eligible members at the current date or from the date retroactive eligibility was effective.

ELECTRONIC CLAIMS SUBMISSION

Medicaid claims that are submitted electronically experience fewer errors and quicker payment. Electronic claims submitted for Medicaid services must be in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. More information on the format and data requirements is available at the following link:

www.nd.gov/dhs/info/mmis/guides.html.

Providers submitting claims for non-medical services are exempt from submitting HIPAA compliant claims. These services include home and community-based services, waiver services and travel/lodging services.

PROVIDER INFORMATION

COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND POLICIES

Providers must follow all applicable rules of ND Medicaid and all applicable state and federal laws, regulations and policies including but not limited to:

- United States Code governing the Medicaid program;
- Code of Federal Regulations (CFR);
- North Dakota Century Code;
- North Dakota Administrative Code;
- Federal Department of Health and Human Services policies governing the Medicaid program;
- Written department policies; and
- All state laws and rules governing provider licensure and certification, as well as with the standards and ethics of their business or profession.

CONFIDENTIALITY

All Medicaid member and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of health care information subject to applicable laws. HIPAA does not prohibit the release of records to ND Medicaid to carry out treatment, payment or healthcare operations under 45 CFR §164.506.

AVAILABILITY OF RECORDS

Providers are required to permit ND Medicaid personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the member because the purpose for the disclosure is permitted under the HIPAA Privacy rule. Health plans contracting with ND Medicaid must be permitted access to all information relating to services reimbursed by the health plan.

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Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records and other documents and records that must be maintained. (Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid.) Records may only be released to other individuals if they have a release signed by the beneficiary authorizing access to his records or if the disclosure is for a permitted purpose under all applicable confidentiality laws.

DOCUMENTATION

ND Medicaid providers are required to keep records necessary to completely or thoroughly document the extent of services rendered to members and billed to ND Medicaid. Records must be retained for a period of at least seven years from the date of service, unless a longer retention period is required by applicable federal or state law, regulation or agreements. Record documentation is used by ND Medicaid to determine medical necessity and to verify that services were billed correctly. Such records may include but are not limited to the following:

- Original prescriptions;
- Certification of medical necessity;
- Treatment plans;
- Medical records and service reports including (but not limited to):
 - Patient's name and date of birth;
 - Date and time of service;
 - Name and title of person performing the service, if other than the billing practitioner;
 - Chief complaint or reason for each visit;
 - Pertinent medical history;
 - Pertinent findings on examination;
 - Medication, equipment and/or supplies prescribed or provided;
 - Description and length of treatment;
 - Recommendations for additional treatments, procedures or consultations;

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- X-rays, tests and results;
- Dental photographs/teeth models;
- Plan of treatment and/or care and outcome;
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information;
- Claims, billings and records of Medicaid payments and amounts received from other payers for services provided to Medicaid members;
- Records and original invoices for items that are prescribed, ordered or furnished; and
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers and other financial information.

MEMBER SERVICES

Billable services provided to members shall be made a part of the medical record. Providers must treat Medicaid members and private-pay clients equally in terms of scope, quality, duration and method of delivery of services (unless specifically limited by regulations).

USUAL AND CUSTOMARY CHARGES

Providers are required to bill ND Medicaid their usual and customary charge for each service provided. "Usual and customary charge" refers to the amount the provider charges the general public in the majority of cases for a specific item or service.

Providers may not charge ND Medicaid a higher fee than that charged to non-Medicaid covered individuals, even if the ND Medicaid allowable fee is greater than the provider's usual and customary charge. If special discounts are available to non-Medicaid covered individuals, claims submitted to ND Medicaid must represent the same discounted charges as those available to the general public.

WHEN MEMBERS HAVE OTHER INSURANCE

If a Medicaid member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's health care, claims should not be submitted to Medicaid until the charges are processed by the primary payer. (Medicaid is the payer of last resort; some exceptions apply, e.g., vocational rehabilitation).

PAYMENT FOR SERVICES

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled with ND Medicaid.
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law.
- Member must be eligible for Medicaid.
- Service must be medically necessary. ND Medicaid may review medical necessity at any time before or after payment.
- Service must be covered by ND Medicaid and not be considered cosmetic, experimental or investigational.
- Medicaid and/or third-party payers must be billed according to rules and instructions as described in this manual, the most current Provider Bulletin and the ND Medicaid website.
- Billed charges must be usual and customary.
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at \$0.
- Claims must meet timely filing requirements. ND Medicaid Timely Filing Policy is located at www.nd.gov/dhs/services/medicalserv/medicaid/provider-policies.html
- Prior authorization requirements must be met where applicable.

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MEDICAID PAYMENT IS PAYMENT IN FULL

Providers must accept Medicaid payment as payment in full for any covered service, except applicable copayments or recipient liability that should be collected from the member.

WHEN CAN A MEDICAID MEMBER BE BILLED?

In most circumstances, providers may not bill members for services covered by Medicaid. Providers may bill Medicaid members directly under the following circumstances:

- For copayments. Providers may choose to collect member copayments at the time of service or bill the member later.
- For recipient liability (RL) amount documented on the remittance advice. Providers (with the exception of Point of Sale Pharmacy) may not collect RL at the time of service.
- For services not covered by ND Medicaid, as long as the member was given advance notice prior to rendering services.
- If a provider chooses not to enroll as a Medicaid provider, the member is responsible for all charges.

Providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid;
- When the provider bills Medicaid for a covered service and Medicaid denies the claim because of billing errors; or
- When the provider fails to secure the necessary authorizations.

When services are being provided free to other individuals, Medicaid may not be billed for those services either.

ELECTRONIC SIGNATURES

Documentation submitted to ND Medicaid must be signed by the ND Medicaid enrolled provider 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

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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; or
- 'Signature Derived from Controlled Access Password'.

Unacceptable Signatures are:

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

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

MEDICAID COVERED SERVICES

This table contains general information about services. For detailed information regarding service authorization, coverage and cost sharing information for specific services, refer to the specific service manual or chapter within this manual.

Covered services are subject to change based on changes in funding, legislative action, and changes in administrative rules.

Copayments may apply – refer to the Copayments chapter.

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Addiction services	No	Yes	No	No
Ambulance services	No	No	For emergency out of state transport: referring providers have 48 hours following the service to notify ND Medicaid of transport	No
Ambulatory surgical services	Yes	No	Some services require SA from QHA	No
Audiology	Yes	No	No	No
Behavioral health services	No	40 therapy visits per year; testing 10 hours per year	Yes, after limits are met	No
Certified nurse midwife services	No	No	No	No

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Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Chiropractic services	No	12 manipulations per year; x-rays 2 per year	Yes, after limits are met	No
Dental services	No	Some limits apply - see dental manual	Some services require SA – see dental manual.	Some age restrictions apply. See dental manual
Durable medical equipment, medical supplies, prosthetic providers, hearing aids	Yes	Some limits apply - see DME manual	Some services require SA - see DME manual	Some age restrictions apply. See DME manual
Family planning	No	No	Some services require SA	No
Federally qualified health centers (FQHC)	No	No	No	No
Home and community-based services (HCBS waiver)	No	No	Must be screened and meet level of care	No
Home health care services	Yes	50 visits per year	Yes, after limit is met	No
Hospitals (inpatient)	Yes, except psychiatric services	rehab limited to 30 days per year for adults; psychiatric admission limited to 21 days with maximum of 45 days per year	Some in-state services require SA. All out of state admissions require SA	No
Hospital swing bed services	No	No	Yes, must meet level of care	No
Immunizations	No	No	No	Yes, some age restrictions apply

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Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Inpatient psychiatric services	No	Yes	Yes, must meet certificate of need if under age 21	Yes, services provided in an IMD to ages 21-64 are noncovered
Intermediate care facilities for individuals with intellectual disabilities	No	No	Yes, must meet level of care	No
Laboratory	Yes, except for independent labs	No	Some services require a SA	No
Local Public Health Units	No	No	No	No
Nonemergency medical transportation	No	No	Yes, administered by county social services	No
Nurse practitioner services	Yes, unless care received in same clinic as PCP	No	No	No
Nursing facility services	No	No	Yes, must meet level of care	No
Nutritional services	Yes	Yes, 4 visits per year	No	No
Occupational therapy	Yes	20 visits per year for ages 21 and over	Yes, after limit is met	No
Optometric services	No	Some limits apply – see Optometric chapter	Some services require SA – see Optometric chapter	No
Orthodontia	Must be referred by Health Tracks	No	Yes, must be referred by Health Tracks	Up to age 21

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Service	Referral Required from Primary Care Provider	Limits	Need Service Authorization	Age Restrictions
Partial hospitalization program	No	Yes	Yes, after limits are met	No
Personal care services in a member's home	No	Some limits apply	Service limits apply	No
Pharmacy	No	Some limits apply - see pharmacy manual	Some services require SA - see pharmacy manual	No
Physical therapy	Yes	15 visits per year for ages 21 and over	Yes, after limit is met	No
Physician services	Yes, unless care received in same clinic as PCP	No	No	No
Podiatry	No	No	No	No
Private duty nursing providers in non-institutional settings	Yes	Yes	Yes	No
Optometric services	No	Some limits apply - see optometric manual	Some services require SA - see optometric manual	No
Radiology	Yes, unless independent provider	No	No	No
Psychiatric Residential Treatment facilities (PRTF)	No	No	Yes, must meet certificate of need	Under 21 only
Rural health clinics (RHC)	No	No	No	No

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Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Individualized Education Program Medicaid Services billed by Schools	No	No	Some services require SA	Under 21 only
Speech therapy	Yes	30 visits per year for ages 21 and over	Yes, after limit is met	No
Targeted case management	No	No	No	Yes, for child welfare and SED

ABORTION SERVICES

All claims for abortion services must be accompanied by documentation that establishes the reason why it was necessary to perform the abortion procedure. The information provided by the physician will be reviewed by the Medical Services Division's medical consultant and the director of Medical Services to determine to the satisfaction of the Department that the abortion was necessary to save the life of the woman or was the result of an act of rape or incest. If the documentation provided meets Departmental guidelines, payment will be approved. If the documentation does not meet these guidelines, the claim will be denied payment.

DOCUMENTATION REQUIREMENTS

Abortions to Save the Life of the Woman - The treating physician must provide a signed written statement that, in the physician's professional judgment, the life of the woman would be endangered if the fetus were carried to term. The statement must contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term.

Abortions that are a Result of an Act of Rape or Incest - If a member has reported an act of rape or incest to an appropriate law enforcement agency or, in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports, the physician must provide the Department with a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made.

- If the rape or act of incest was not reported to an appropriate agency, the member must sign a written statement indicating that her current pregnancy resulted from either an act of rape or incest. The treating physician must provide a signed written verification that, in the physician's professional judgment, the woman's pregnancy resulted from rape or incest.
- North Dakota statutes specifically describe the crime of "incest." North Dakota statutes do not specifically describe the common law crime of "rape," which is unlawful carnal knowledge of a female without her consent. North Dakota statutes prohibiting "gross sexual imposition," "sexual imposition," and "sexual abuse of a ward" all describe the common law crime of rape. Each of these statutes uses the term "sexual act." You may wish to consult an attorney for

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assistance if you are not certain that the sexual act that produced the pregnancy was an act of rape or incest.

Treatment for infection or other complications of the abortion are covered services.

ADDICTION TREATMENT SERVICES

Services for treatment of addiction are ambulatory services provided to an individual with an impairment resulting from a substance use disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for treatment of substance use disorder may be hospital-based or non-hospital-based.

Licensed addiction counselors may enroll to provide American Society of Addiction Medicine (ASAM) services within their scope of practice. Licensed addiction programs may enroll as Medicaid providers for ASAM levels of care 1, 2.1, 2.5, 3.1 and 3.5, as prescribed in North Dakota Administrative Code chapter 75-09.1.

Licensed addiction counselor includes licensed clinical addiction counselors, licensed master addiction counselors and practitioners possessing a similar license in a border state and operating within their scope of practice in that state. Licensed addiction programs operating in a border state must provide documentation to ND Medicaid of their state's approval for the operation of the addiction program.

Payment for ASAM 3.1 and 3.5 is only for the service component. ND Medicaid payment is not available for room and board.

COVERAGE LIMITATIONS

The following limits have been established for services for treatment of addiction:

ASAM 2.1	30 days per calendar year per member
ASAM 2.5 and 3.5	45 days per calendar year per member

Additional days may be authorized by ND Medicaid if determined to be medically necessary.

SERVICES PROVIDED WITHIN A RECOGNIZED INDIAN RESERVATION

Licensed addiction counselors, operating within their scope of practice, performing ASAM 1, and practicing within a recognized Indian reservation in North Dakota, are not required to have licensure prescribed in North Dakota Administrative Code chapter 75-09.1 for services provided within a recognized Indian reservation in North Dakota.

ALLERGY IMMUNOTHERAPY – ALLERGY TESTING

COVERED SERVICES

- Professional services to administer the allergenic extract;
- Providing injectable allergenic extract;
- Professional services to monitor the member's injection site and observe the member for an anaphylactic reaction;
- Allergy testing; and
- Provision of inhalants (an inhalant is a pharmaceutical).

NONCOVERED SERVICES

ND Medicaid does not cover the administration of oral preparations used to treat food allergies (e.g., food drops, etc.) or other allergy services not recognized as a medical standard for the provision of allergy immunotherapy.

COVERAGE LIMITATIONS

Allergenic extracts may be administered with either one injection or multiple injections. Documentation in the member's health record must support the number of injections administered.

Only physicians who perform the refinement of raw antigens to allergenic extract may bill for the service. This service involves the sterile preparation of an allergenic extract by titration, filters, etc. and checking the integrity of the extract by cultures or other qualitative methods. Purchasing refined antigen, measuring dosages, and adding diluents is not refining raw antigens.

Adding diluents, as in any other medication administration service, is not a separately covered service. This service is an integral part of the professional services for providing an allergenic extract.

The payment of the injection administration will include and will reflect the monitoring of the injection site and the observation of the member for anaphylactic reaction. A

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separate office visit charge for the provision of allergy services is not allowed unless other identifiable services are performed such as physical examinations including vital signs, review of systems, laboratory services or obtaining a history of current symptoms or illness.

AMBULANCE SERVICES

ND Medicaid covers services provided by ambulance providers that are licensed and enrolled with ND Medicaid.

Emergency transport by ambulance is a covered service. Nonemergency transport by ambulance is a covered service only when medically necessary and ordered by an attending practitioner.

AMBULANCE TRANSPORTATION

To receive Medicaid payment on ambulance transportation, the member must receive medically necessary services before and during transport and the transportation must comply with the following conditions:

- The ambulance provider must be licensed under North Dakota statutes as an advanced life support or basic life support.
- The member's transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider.
- Out of state ambulance transport for nonemergency medical services, including follow up visits, may be reimbursed only if the out of state medical services are approved by ND Medicaid and the member's medical condition substantiates transportation by ambulance.

AIR AMBULANCE

Transportation by air ambulance is a covered Medicaid service if the member has a potentially life-threatening condition that precludes the use of another form of transportation.

Providers must submit documentation for medical necessity and the need for air ambulance for transportation to an in-state provider.

For out of state ambulance transport, the transferring facility must follow criteria for emergency out of state transportation. Air ambulance transportation originating outside

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of North Dakota or to a destination outside of North Dakota, must inform ND Medicaid within 48 hours of the transfer. Documentation to ND Medicaid must include:

- Destination and date of transfer;
- Mode of transportation;
- Discharge summary; and
- If trip is less than 50 miles, the facility must verify why air rather than ground ambulance was used.

TRANSPORTATION BETWEEN PROVIDERS

Ambulance transportation of a member between providers is covered as specified:

- Transportation between two long term care facilities must be medically necessary because the health service required by the member's plan of care is not available at the long-term care facility where the member resides.
- Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the member was when the medical necessity was diagnosed.
- Transportation between a hospital and long-term care facility must be medically necessary.

COVERAGE LIMITATIONS

Ambulance transportation must be to or from the site of a covered service to a member. A covered service is one which is provided by a ND Medicaid enrolled health care provider and is a covered under the North Dakota Medical State Plan.

The death of a member is recognized when the pronouncement of death is made by an individual legally authorized to do so by the state where the pronouncement is made.

If a member is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment will be based on:

- Basic life support (BLS) level of service only, for a ground vehicle.
- Fixed wing or rotary wing base rate only, as appropriate, for an air ambulance.

NONCOVERED SERVICES

The costs of items listed below are not covered by ND Medicaid as ambulance transportation:

- Transportation of a member to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when life support transportation is medically necessary;
- Transportation of a member to a facility for alcohol detoxification that is not a medical necessity;
- The member was pronounced dead prior to the time the ambulance is called or dispatched; or
- No load transportation.

AMBULATORY SURGICAL SERVICES

An ambulatory surgical center (ASC) is a facility certified under the Code of Federal Regulation, Title 42 Part 416, to provide surgical procedures, which do not require overnight inpatient hospital care. These include freestanding and hospital-operated ASCs.

AMBULATORY SURGICAL SERVICES

The following services and supplies are included in the ASC facility fee and may not be billed or paid separately:

- Use of facility including operating and recovery rooms, patient preparation areas, waiting rooms and all other areas used by the patient or offered for use by persons accompanying the patient.
- Nursing and technical service including all services provided by employees of the ASC (e.g., nurses, technicians, orderlies).
- Drugs, biologicals, medical supplies and equipment, including:
 - All drugs, medical supplies, dyes and equipment common to the ASC provided in conjunction with a surgical procedure. Drugs and biologicals are limited to those that cannot be self-administered.
 - Urinary supplies, such as collection devices, indwelling and external catheters, drainage bags – any type, leg straps, external urethral clamps, irrigation supplies (bulbs, syringes, tubing, sterile saline or water), insertion trays and perianal fecal collection pouches.
 - Primary surgical dressings which are therapeutic and protective coverings applied directly to the skin or on openings to the skin and required as a result of a surgical procedure.
- Administrative, record keeping, and housekeeping services consisting of general administration and functions necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).
- Blood, blood plasma and platelets.
- Anesthesia and any supplies, whether disposable or reusable, that is necessary for its administration.

SEPARATELY COVERED SERVICES IN THE AMBULATORY SURGICAL CENTER/OUTPATIENT HOSPITAL SURGERY

The following items and services are not included in the ASC fee and may be billed separately. These services are subject to all applicable Medicaid coverage rules including medical necessity, sterilization consent, prior authorization and billing requirements:

- Physician services, including the services of anesthesiologists administering or supervising the administration of anesthesia to a patient and the patient's recovery from anesthesia;
- Second surgical opinion;
- Patient specific laboratory, x-ray or diagnostic procedures performed according to protocol;
- Prosthetic devices (arm, leg, back, braces, artificial limbs, corneal lenses, titanium screws, etc.);
- Ambulance services;
- Durable medical equipment for use in the patient's home;
- Take home supplies, medications, splints and casts. These are separately billable if not furnished at the time of surgery;
- CRNA services; and
- Pathology services.

ANESTHESIA SERVICES

ND Medicaid covers services provided by an anesthesiologist or licensed certified registered nurse anesthetist (CRNA), trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures and are enrolled with ND Medicaid.

COVERED SERVICES

ND Medicaid will pay an anesthesiologist for the supervision of a CRNA.

ND Medicaid pays for anesthesia services personally furnished by an anesthesiologist or CRNA only if the anesthesiologist or CRNA:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies;
- Provides indicated post-anesthesia care; and
- Complies with federal requirements when performing sterilization procedures.

OTHER ANESTHESIA SERVICES

Pre-anesthetic Evaluations and Post-operative Visits: Medicaid uses the CMS list of base values adopted from the relative base values established by the American Society of Anesthesiology. The base value for anesthesia services includes usual pre-operative and post-operative visits. No separate payment is allowed for the pre-anesthetic evaluation regardless of when it occurs unless the member is not induced with anesthesia because of a cancellation of the surgery.

Patient Controlled Analgesia (PCA) used to control a patient's pain with continuous infusion of pain medication facilitated by an infusion pump is a billable service.

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Placement of an intrathecal or epidural catheter is paid separately. The correct unmodified CPT surgical code must be used to bill the catheter placement.

Medically necessary pain management must be conducted face to face and is limited to one service per day. The appropriate CPT/HCPCS code must be used when billing for this service.

Epidural Analgesia for Vaginal or Cesarean Section is used to provide continuous epidural analgesia for labor and vaginal or cesarean delivery. The CPT code that describes this service includes the placement of the epidural catheter. The number of minutes that the provider is physically present with the member must be recorded in the unit's box.

Payment for CPT 01967 will be capped at a maximum of 75 minutes.

Special Services, such as insertion of Swan-Ganz catheters, placement of central venous lines and arterial lines, and performed by an anesthesiologist or CRNA are billable services. These services must be billed as a surgical procedure with no time unit recorded using the appropriate unmodified CPT codes that describe the service.

Conscious Sedation, used to achieve a medically controlled state of depressed consciousness, is not a billable service. The cost of conscious sedation is included in the fee for the procedure.

BILLING GUIDELINES

ND Medicaid uses the specific CPT/HCPCS anesthesia codes with the appropriate modifier for anesthesia services.

The provider must:

- Submit the exact number of minutes from the preparation of the patient for induction to the time when the anesthesiologist or CRNA is no longer in personal attendance or continues to be required.
- Identify the exact nature of the services being provided with one of the following modifiers:

AA = Anesthesia services performed personally by anesthesiologist. (This modifier should be used only when the anesthesiologist is involved on a full-time basis in the administration of anesthesia to one patient, with or without the assistance of a CRNA).

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- QK = Medical direction by a physician of two, three, or four concurrent anesthesia procedures.
- AD = Medical supervision by a physician: more than four concurrent anesthesia procedures.
- QY = Medical direction of one qualified non-physician anesthetist by an anesthesiologist.
- QX = CRNA services with medical direction by a physician.
- QZ = CRNA services without medical direction by a physician.

Every claim for anesthesia must have at least one of the modifiers listed above.

BASIC CARE FACILITIES

ND Medicaid covers services provided by basic care facilities that are licensed and enrolled with North Dakota (ND) Medicaid.

AUTHORIZATION OF SERVICES

ND Medicaid will not cover personal care services unless an Authorization to Provide Personal Care Services form (**SFN 663**) is completed by the individual's case manager. The completed form must be submitted to ND Medicaid.

The Department will not cover room and board services unless a Personal Care Plan (**SFN 662**) is completed by the member's case manager. The completed form must be submitted to the Department.

LIMITS ON LEAVE DAYS

The Department will cover a maximum of 30 days per occurrence for medical leave. The purpose of the medical leave policy is to ensure that a bed is available when a resident returns to the basic care facility. A basic care facility may not bill for medical leave days if it is known that the resident will not return to the facility.

Once the basic care facility accepts payment for medical leave on behalf of a Medicaid resident, the basic care facility must still bill ND Medicaid for medical leave days beyond the 30th day that the resident's bed was held; however, any days exceeding the 30-day limit are noncovered days.

ND Medicaid will cover a maximum of 28 therapeutic leave days per resident per rate year. The rate year begins July 1st.

Once the basic care facility accepts payment for therapeutic leave on behalf of a Medicaid resident, the basic care facility must still bill ND Medicaid for therapeutic leave days beyond the 28th day the resident's bed was held; however, any days exceeding the 28-day limit are noncovered days.

The day of death for a resident is a covered day. The day of discharge for a resident is a noncovered day.

BILLING GUIDELINES

A resident on medical or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of units billed must include the date of discharge or death.

Basic care facility charges must be broken down between personal care and room and board on separate lines on one claim using the following *Revenue Codes* when billing for:

Revenue Code 110	In-House Medicaid Days for Room & Board (private)
Revenue Code 120	In-House Medicaid Days for Room & Board (semiprivate)
Revenue Code 183	Therapeutic Leave Days for Room & Board
Revenue Code 185	Medical Leave Days for Room & Board
Revenue Code 167	Personal Care Services Days

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance has paid for the charges. This allows the Medicaid claims payment system to start applying recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

CARDIAC REHABILITATION

An outpatient hospital or a physician-directed clinic that has a Medicare approved cardiac rehabilitation program may provide cardiac rehabilitation services to ND Medicaid members. A copy of the provider's Medicare notification of cardiac rehabilitation program approval must be provided to Provider Enrollment.

Services of non-physician personnel must be furnished under the direct on-site supervision of a physician.

DEFINITION

Cardiac rehabilitation is defined as a recovery program consisting primarily of monitored cardiac exercise or therapy with member instruction and diagnostic testing services. The member must undergo a comprehensive, base line assessment to evaluate coronary risk factors and exercise capacity. Cardiac rehabilitation staff must review the assessment to outline a medically necessary and realistic individual program with short and long-term goals. Designed to be an aftercare program, it is covered for members recovering from:

- Myocardial Infarction;
- Coronary artery bypass surgery;
- Coronary angioplasty with or without stent;
- Valve replacement/repair surgery;
- Heart and heart/lung transplant and/or have;
 - Stable angina pectoris;
 - Ventricular assistive device.

A physician must be immediately available for an emergency at all times when an exercise program is being conducted.

COVERED SERVICES

ND Medicaid will only cover cardiac rehabilitation services that are provided by a Medicare-approved cardiac rehabilitation program. The program must meet all of the

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requirements mandated by Medicare. Services must be considered reasonable and necessary. ND Medicaid will cover up to 36 sessions consisting typically of three sessions per week in a single 12-week period.

At least one of the following services must be included in a cardiac rehabilitation session:

- A limited examination for physician follow-up to adjust medication or other treatment changes, when performed by a hospital employed physician;
- ECG rhythm strip with interpretation and physician's revision of exercise therapy, when performed by a hospital-employed physician;
- Exercise therapy with continuous ECG telemetric monitoring (excludes physical therapy and occupational therapy);
- Diagnostic and therapeutic services that are reasonable and necessary to perform cardiac rehabilitation services safely and effectively; or
- One new member comprehensive evaluation, when performed by a hospital-employed physician and if the exam has not already been performed by the member's attending physician or if the exam performed by the attending physician is not acceptable to the program's director. The exam should include a history, physical, and preparation of initial exercise prescription. The medical record must document the need for a repeat examination.

The following services provided based on individualized medical needs, may be billed separately:

- Behavioral health services;
- Laboratory services that are not performed to monitor the member's cardiac condition and cardiac rehabilitation program progress;
- ECG stress tests – one is usually performed at the beginning of the program and after three months or at the completion of the program. Performance of these tests more frequently requires medical record documentation demonstrating medical necessity.
- Nutritional counseling by a licensed registered dietician;
- Physician services:
 - That are medically necessary to provide medical care for diagnoses or conditions that are not a part of cardiac rehabilitation;
 - To interpret and report on ECG stress testing; and

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- Consisting of services provided by physicians to evaluate complications of cardiac rehabilitation, other diagnoses and conditions.

NONCOVERED CARDIAC REHABILITATION SERVICES

- Services provided by an outpatient hospital or physician clinic without a Medicare cardiac rehab program.
- Formal lectures and counseling on health education that are normally furnished by the attending physician following a member's acute cardiac episode. Examples include assistance with daily living habits and sexual activity.
- Physical therapy and occupational therapy when furnished in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

PHYSICIAN PROFESSIONAL SERVICES

The following services are not separately payable when performed in conjunction with a cardiac rehabilitation program:

- A physician visit to monitor, read or interpret ECG rhythm strips; or
- A physician visit to adjust medication or the cardiac rehabilitation exercise prescription.

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CHIROPRACTIC SERVICES

ND Medicaid covers chiropractic services provided by a doctor of chiropractic, licensed under North Dakota law and enrolled as a ND Medicaid provider.

See the Chiropractic Services Manual for specific billing and policy information
<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

COORDINATED SERVICES PROGRAM (CSP)

The CSP is utilized by ND Medicaid to:

- Improve the continuity and quality of medical care for members;
- Improve utilization patterns to control Medicaid expenditures; and
- Provide education on the utilization of services at the appropriate level.

CANDIDATES FOR CSP

ND Medicaid uses parameters to determine if a member may be referred to CSP. These parameters include, but are not limited to:

- Use of multiple providers and clinics;
- Early prescription refills and use of multiple pharmacy providers;
- Use of emergency room services for other than emergent care; and/or
- Prescription use that is excessive or potentially threatening to the health of the member indicated by:
 - Multiple prescribing providers;
 - Use of multiple controlled drugs;
 - Overlapping prescriptions with counterproductive therapeutic value

PROGRAM REQUIREMENTS

Members that are referred to the CSP must choose a primary care provider (CSP provider) by selecting one family practice, general practice, nurse practitioner, physician assistant or internal medicine provider of their choice. CSP members are also restricted to one pharmacy of their choice to manage their prescription needs. Based on the usage of dental services, the member may also be restricted to one dentist of their choice.

The member's selection of a CSP provider is subject to approval by ND Medicaid.

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Members who were in a lock-in program from another state will be placed in CSP when their eligibility is transferred to ND Medicaid.

There are different ways in which a review of services can be initiated by ND Medicaid. Some of the most common ways the Service Utilization Review Section (SURS) collects CSP referrals and/or reviews:

1. Member audit of medical and pharmacy services:
 - Once the information is analyzed by staff it is forwarded to the fraud & abuse administrator.
 - The fraud & abuse administrator will review and forward on to the ND Medicaid medical consultant and pharmacist (or two other medical professionals) for their consideration regarding placement into the CSP program.
 - The reasons for placement must be documented including all information used to make that decision.
 - If both medical professionals and the fraud & abuse administrator recommend placement, the member will be placed on CSP.
2. A referral from a physician, pharmacist, nurse, etc., reporting the possible misuse of services:
 - If the complaint of misuse appears to show an element for further review the following can occur:
 - A warning letter may be sent to the member.
 - A review of the member's service utilization and/or the PDMP (Prescription Drug Monitoring Program) to look at general utilization of prescription services outside of Medicaid.
 - Once the information is analyzed and documented by staff it is forwarded to the fraud & abuse administrator.
 - The fraud & abuse administrator will review and forward to the ND Medicaid medical consultant and pharmacist (or two other medical professionals) for their consideration regarding placement into the CSP.
 - The reasons for placement must be documented including information used to make that decision.
 - If both medical professionals and the fraud & abuse administrator recommend placement, the member will be placed on CSP.
3. ND Medicaid staff may request a review of a member's utilization of services:

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- If the complaint of misuse appears to show an element for further review the following can occur:
 - A warning letter may be sent to the member.
 - A review of the member's service utilization and/or the PDMP (Prescription Drug Monitoring Program) may be used to look at general utilization of prescription services outside of Medicaid.
 - Once the information is analyzed and documented by staff it is forwarded to the fraud & abuse administrator.
 - The fraud & abuse administrator will review and forward to the ND Medicaid medical consultant and pharmacist (or two other medical professionals) for their consideration regarding placement into the CSP.
 - The reasons for placement must be documented including information used to make that decision.
 - If both medical professionals and the fraud & abuse administrator recommend placement, the member will be placed on CSP.
- 4. The ND Medicaid physician or pharmacist may recommend a member be immediately placed on the CSP program:
 - If the ND Medicaid physician or pharmacist requests a member be immediately placed on the CSP program, they must document the reason for requesting placement and must include what type of information gathering and/or tools were used to make their immediate referral.
 - The fraud & abuse administrator will review the immediate referral and secure any extra information needed to make a decision to place the member on the CSP program.
 - The reasons for placement must be documented including information used to make that decision.

NOTE: Medical professionals can make the recommendations or immediate referrals for members to be placed in CSP, but the final decision remains with the fraud & abuse administrator and SURS.

PHARMACY TRANSACTIONS

Pharmacy claims payable for a CSP member are those prescribed by the primary CSP provider or billed by the primary CSP pharmacy. Other claims will be denied. The only

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exceptions are prescriptions written by a referred physician or in cases of emergency or after-hours clinic visits. In these situations, the pharmacist may resubmit the claim using the NCPDP emergency override indicator. Providers should contact their software vendor since pharmacy systems may vary as to how this value is recorded on the claim.

Prescriptions not ordered by the CSP/referred prescriber or dispensed by the CSP pharmacy will be monitored by SURS after payment if the emergency override indicator is used.

If the prescription is not from the CSP prescriber or a referred prescriber, the pharmacist must contact the CSP provider to verify the referral and authorize continued dispensing. It is inappropriate to change the prescribing provider to the CSP provider if there is no referral. The CSP provider should be advised to send a copy of the CSP referral to the state office. When a referral is verified, the pharmacist may override the denial using the emergency override indicator and dispense up to a 30-day supply.

If a pharmacist determines that a medical emergency requires immediate dispensing of the drug, then the pharmacist may resubmit the claim using the emergency override indicator. The department will allow a four day supply for most prescriptions from a prescriber for a CSP member who was seen at an emergency room or an after-hours clinic. Also, ND Medicaid will allow a single course of therapy for antibiotics and single unit-of-use products, such as inhalers will be allowed with larger days' supply from a prescriber for a CSP member who was seen at an emergency room or an after-hours clinic. Any additional supply must be authorized by the CSP prescriber.

SERVICES OBTAINED FROM A NON-DESIGNATED PROVIDER

ND Medicaid will not pay for services obtained from a non-designated provider, services obtained without a referral from the member's CSP provider, or visits to the emergency room that are determined to not be emergent. The CSP member is responsible for the costs incurred for services that do not follow these criteria.

TREATMENT BY A SPECIALIST

Only the member's CSP provider can authorize a referral to a specialist. Referrals must be medically necessary and received prior to date of service. ND Medicaid will not approve retroactive referrals. Once authorized by ND Medicaid, the specialist may order

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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 for an extended period of time, the CSP provider should refer the member to another provider to access necessary urgent or emergent care. The member should wait for the return of his/her CSP provider for services that are considered routine care.

The CSP Referral (SFN 231) form is available by calling SURS at 1-800-755-2604 or 701-328-2334. A clinic's referral form is an acceptable referral if the form contains the name of the CSP provider, the referring provider, the name of the member being referred, the duration of the referral and a dated signature of the CSP provider.

The referral form can be mailed or faxed to the following locations:

- Fax – (701) 328-1544
- Mail - Department of Human Services, Medical Services Division, 600 East Boulevard, Department 325, Attn: CSP Referrals, Bismarck, ND 58505-0250

If the CSP referral is urgent please contact SURS at 701-328-2334, 701-646-4559 or 701-328-1626.

COPAYMENT GUIDELINES

Copayments are a set dollar amount and are based on the average Medicaid allowed amount for the service.

A provider cannot deny services to a Medicaid member due to the member's inability to pay the copayment at the time services are provided. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members whose co-payment is delinquent.

COPAYMENTS	
Provider Type	Amount
Audiology	\$2.00 per hearing test
Behavioral health visit	\$2.00 per visit
Chiropractic	\$1.00 per spinal manipulation
Dental (oral examination visit)	\$2.00 per exam
Federally Qualified Health Center (Community Health Center)	\$3.00 per visit
Hearing aid	\$3.00 per dispensing
Hospital (inpatient)	\$75.00 per admission
Office/consultation visit	\$2.00 per visit
Occupational therapy (includes Home Health)	\$2.00 per visit
Optometric (vision exam visit)	\$2.00 per exam
Physical therapy (includes Home Health)	\$2.00 per visit
Podiatry (office visit)	\$3.00 per visit
Prescription drugs (Brand Names only)	\$3.00 per prescription fill
Rural Health Clinic	\$3.00 per visit
Speech therapy (includes Home Health)	\$1.00 per visit

Exemptions from copayments apply if the eligible member receiving the service is:

- Under age 21;
- Pregnant, including 60 days post-partum period;
- Receiving active treatment through North Dakota's Breast and Cervical Cancer Screening program (Women's Way);
- An Indian who receives, or is eligible to receive, services from Indian Health Services (IHS) or through referral by Contract Health Services (CHS);

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- An inmate receiving Medicaid covered inpatient hospital services;
- Terminally ill and receiving hospice care; or
- Residing in institutions such as:
 - Nursing Facility, long term care;
 - Swing bed, long term care;
 - Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
 - State Hospital.

Family planning and emergency services are also exempt from copayments.

NOTE: Dual Eligible Medicare recipients are subject to Medicaid copayments.

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DENTAL SERVICES

ND Medicaid covers dental services provided by an enrolled ND Medicaid provider.

See the Dental Manual for specific billing and policy information at
<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

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DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES, PROSTHETICS, HEARING AIDS

ND Medicaid covers durable medical equipment and supplies, prosthetics and hearing aids provided by an enrolled ND Medicaid provider.

See the DME Manual for specific billing and policy information at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

ELECTIVE STERILIZATION (TUBAL LIGATIONS/OCCLUSIONS AND VASECTOMIES)

Providers that perform sterilization procedures for the primary purpose of permanent birth control must obtain consent prior to the procedure being performed.

WRITTEN CONSENT FOR STERILIZATIONS

ND Medicaid will cover sterilization procedures performed for the purpose of permanent birth control if the member provides voluntary informed consent, is at least twenty-one years of age at the time consent is obtained, is mentally competent, and is not institutionalized. The person obtaining the consent must give the member:

- An opportunity to ask questions about the sterilization procedure;
- An oral explanation about the procedure and any procedural risks in accordance with consent form requirements;
- A copy of the consent form;
- Advice that the decision to be sterilized will not affect future care or benefits and that the sterilization will not be performed until at least 30 days have passed, except in the case of premature delivery.

A member may **not** consent to sterilization when:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion;
- Under the influence of alcohol or other substances that affect the member's state of awareness.

WRITTEN CONSENT FORM

ND Medicaid will accept either of the following:

- SF 989 (Sterilization Consent Form)
<https://www.nd.gov/eforms/Doc/sfn00989.pdf>
- The Federal HHS Consent for Sterilization form
http://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated_0_remediated.pdf

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Effective July 1, 2019 ND Medicaid will no longer accept the ND-specific form (SFN 989); however, until that time, either form is acceptable.

The provider who obtains consent for sterilization must answer the member's questions regarding the procedure, provide a copy of the consent form, and explain the requirements for informed consent that are listed on the consent form. Shortly before the sterilization, the physician who will perform the procedure must explain the requirements for informed consent that are listed on the consent form.

A sign language or foreign language interpreter must be provided to ensure that information regarding the sterilization is communicated effectively to a hearing impaired or non-English speaking member.

The consent form must be signed and dated by all of the following or the claim will not be processed:

- The individual to be sterilized. An informed consent is valid only if at least 30 days have passed, but not more than 180 days have passed from the date of signature, except in cases of premature delivery or emergency abdominal surgery. If a member is sterilized at the time of a premature delivery or emergency abdominal surgery, payment will be made if at least 72 hours have passed since the patient gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been signed at least 30 days before the expected delivery date. An emergency caesarean section can be considered premature delivery but is not emergency abdominal surgery.
- The interpreter, if one was provided. The interpreter must sign and date the form after the patient signs it but before the day of the surgery.
- The person who obtained the consent. The person obtaining consent also must sign and date the form after the patient signs it but before the day of surgery.
- The physician who performed the sterilization procedure. The physician must sign the form the day of surgery, or after the surgery.

The member may not be billed if the provider fails to accurately complete the consent form.

STANDARDS FOR RETROACTIVE ELIGIBILITY

The Sterilization consent form requirements cannot be met retroactively. Providers may want to complete a consent form and allow for the 30-day waiting period when individuals without financial resources or insurance coverage request sterilization and indicate that they are considering application or have applied for ND Medicaid. An alternative approach would be to inform the individual, preferably in writing, that retroactive eligibility does not apply to sterilization procedures unless a consent form is signed and the 30-day waiting period adhered to. Individuals must be informed that they will be held accountable for charges before the service is provided.

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.

PROVIDERS

Physicians, clinics, outpatient hospital departments, pharmacies, nurse midwives, nurse practitioners, physician assistants, certified nurse specialists 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.

A family planning agency provides family planning services and has a medical director who is a physician enrolled in the Medicaid program.

Family planning services including drugs, supplies, and devices may be covered when such services are under the medical direction of a physician or licensed practitioner of the healing arts within their scope of practice as defined by state law.

COVERED SERVICES

Medicaid pays providers for family planning services and supplies for Medicaid eligible individuals of childbearing age, including minors. Members must be free of coercion and free to choose the method of family planning they will use. The provider may not require that an unmarried minor's parent or guardian consent to family planning services for the minor.

ND Medicaid pays for family planning services only when:

- The member has full knowledge of the service and consents to it freely.
- The provider submits a correctly completed consent form with the claim for voluntary sterilization procedures.

The following family planning services are covered:

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- Oral contraceptives;
- Distribution of information on family planning;
- Consultation, examination and medical treatment;
- Genetic counseling;
- Prescriptions for the purpose of family planning;
- Distribution of family planning devices such as latex condoms, thermometers or charts;
- Laboratory examinations and tests; and
- Voluntary sterilization.

NONCOVERED SERVICES

ND Medicaid does not pay for noncovered services including:

- Reversal of voluntary sterilization;
- Artificial insemination or in vitro fertilization;
- Hysterectomies for the purpose of sterilization; or
- Removal of long acting reversible contraceptive devices to regain fertility.

FORENSIC EXAMINATIONS AND INTERVIEWS

ND Medicaid covers forensic services provided to children and adults who may have experienced physical or sexual abuse.

INITIAL FORENSIC MEDICAL EXAMINATION

Initial forensic medical examination performed on an alleged victim of child physical abuse completed by an enrolled practitioner of the healing arts under their scope of practice is a covered service and should be billed with the appropriate level E/M CPT® Code 99201-99215 appended with modifier 32 with one of the following ICD10-CM codes:

- T76.12xA – Child Physical Abuse, suspected, initial encounter
- Z04.72 – Encounter for examination and observation following alleged child physical abuse.

FORENSIC INTERVIEW

A forensic interview is a single session, recorded interview designed to elicit a child's unique information when there are concerns of possible physical or sexual abuse. The forensic interview is conducted in a supportive and non-leading manner by an ND Medicaid enrolled licensed mental health professional with specialized training in conducting forensic interviews.

Forensic Interviews should be reported with CPT® code 99499 appended with modifier 32 with one of the following ICD10-CM codes:

- T76.22xA - Child sexual abuse, suspected, initial encounter
- T76.12xA - Child physical abuse, suspected, initial encounter
- T76.52xA - Child sexual exploitation, suspected, initial encounter
- Z04.42 Encounter for examination and observation following alleged child rape

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- Z04.72 Encounter for exam and observation following alleged child physical abuse

NONCOVERED SERVICES

Acute forensic examination conducted for the purpose of gathering evidence from suspected children or adults of sexual abuse are not covered by ND Medicaid and must be billed directly to the Attorney General's Office per N.D.C.C.12.1-34-07.

HOME HEALTH AND PRIVATE DUTY NURSING

ND Medicaid covers services provided by home health agencies that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

HOME HEALTH SERVICES

Home health services are skilled nursing services, as defined in the Nurse Practice Act, that are provided on a part-time or intermittent basis. All services are provided based on a licensed physician's orders and a written plan of care. Other services include home health aide services, physical therapy, occupational therapy, speech pathology, audiology services, medical supplies, equipment and appliances suitable for use in the home and telemonitoring.

PRIVATE DUTY NURSING SERVICES

Private duty nursing services means nursing services for members who require more individual and continuous care than is available from a visiting nurse. The services must be provided by a registered nurse or a licensed practical nurse in a member's home under the direction of his or her physician.

For skilled nursing needs that exceed four hours per day, ND Medicaid will review for medical necessity and determine an hourly fee with the home health agency or private duty nurse.

HOME HEALTH ELIGIBILITY REQUIREMENTS

To qualify for coverage of any home health services, the member must meet the criteria listed in this section.

- The member must need skilled nursing care on a part-time or intermittent basis, (at least one skilled nursing service every 60 days), or physical therapy or speech therapy or occupational therapy to qualify for home health services.

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- The physician must certify that the member requires skilled nursing care in the home. Services must be medically necessary and the member service is considered the most appropriate setting consistent with meeting the member's medical needs.
- Services must be provided at the member's place of residence. A residence may be the member's own dwelling, an apartment, a relative's home or temporary housing such as a motel/hotel room.

A face to face encounter for the initial ordering of home health services, which is related to the primary reason the member requires home health services, must occur no more than 90 days before or 30 days after the start of home health services. This face-to-face encounter may be performed by a physician, nurse practitioner, clinical nurse specialist or physician assistant, all who must be working under the supervision of a physician. The practitioner performing the face-to-face must communicate the clinical findings of the encounter to the ordering physician. Communication between the practitioner conducting the face-to-face and the ordering physician is to be documented in the medical record.

Medical necessity for the home health services must be supported in the medical record. The visit may be performed via telehealth or in person; telephone encounter is not sufficient.

COVERED SERVICES

The home health agency must provide the following services:

- Skilled nursing by a registered nurse or licensed practical nurse under the supervision of a registered nurse.
- Home health aide under the direction of a registered nurse.
- Physical, occupational and speech therapy services provided by licensed therapists.

NONCOVERED SERVICES

Individual procedures:

- Eye drops or ointment instillations;

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- Routine glucose monitoring and insulin administration;
- Routine foot care;
- Stasis ulcer maintenance care;
- Pediatric maintenance care;
- Routine medication setup;
- Other services that become self-care activities after the member or family members or others have been taught how to do the procedure(s) in a reasonable amount of time.

Personal care services not directly related to the condition requiring skilled nursing care:

- Light housekeeping
- Transportation
- Meal preparation
- Laundry
- Shopping
- Child care
- Respite care

Respiratory therapy services (as a separate category of services). A registered nurse may provide respiratory therapy as a nursing service.

Observation and assessment by a skilled nurse are not reasonable and necessary to the treatment of the illness or injury when indications are that it is a long standing pattern of the member's condition and no clinical progress is demonstrated.

REQUESTING HOME HEALTH SERVICES

Home health agency visits are limited to an initial 50 visits per member, per calendar year, for all covered home health services. These visits are not subject to prior approval. These visits do not apply to extended hour visits as these requests must be prior authorized by ND Medicaid.

Prior authorization for services will be required where it is medically necessary for the member to exceed the home health visit limitation. ND Medicaid uses utilization review

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parameters for evaluating and determining medical necessity for the type of service(s) requested and the number of visits required to appropriately treat the member's condition.

Each service authorization is valid for 60 days. Requests for additional visits beyond the initial 50 visits must be submitted prior to the last visit of the 50-day limitation. Home health providers are required to track and request additional home health visits prior to the utilization of the 50-visit limit.

If the same level of care or a more intense level of care (i.e. more skilled nurse visits, addition of another service) is necessary beyond the initial 50 visits, the agency must submit a service authorization. Subsequent requests after the first 60-day period must also have prior authorization.

Requests for additional visits must be submitted by the home health agency. The additional visits must substantiate medical necessity and be received by the ND Medicaid prior to the service being provided, or before the next 60 day period request. If the service authorization is not received by ND Medicaid prior to the 60 day time period the visits will be denied. All requests for authorization of additional visits must be submitted with the following information:

- The service authorization (SFN 15);
- A legible copy of the current Home Health Certification and Plan of Treatment Form (CMS 485) or certified plan of treatment with the most recent 60-day summary or a copy of the original physician's order; and
- Any pertinent documentation to substantiate the need for additional visits.

The home health agency must keep on file copies of all documents submitted to ND Medicaid. Approved service authorizations are dependent on the member's eligibility during the approved service authorization period. If a member requires additional services in an approved period, the home health agency is responsible for requesting a service authorization for the expanded services.

Facsimile copies will be accepted and a response given in the same manner. Return fax numbers must accompany the request.

Payment to Home Health Agencies for covered services furnished to Medicaid patients is made per encounter. The term "encounter" is defined as a face-to-face visit between the patient and one or more home health professionals during which services are rendered. An encounter for each type services is defined as:

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- Skilled Nursing Visit – An encounter is a continuous period of time not to exceed a two-hour period in which the nurse remains at the residence of a member for the purpose of providing ongoing skilled nursing services.
- Home Health Aide Visit – An encounter is a continuous period of time not to exceed a two-hour period in which the aide remains at the residence of the member for the purpose of providing necessary ongoing home health aide services.
- Therapy Services – All therapy services will be reimbursed per encounter.

Encounters with more than one home health professional and multiple encounters with the same home health professionals on the same day and at a single location constitute a single visit for each discipline.

HOSPICE SERVICES

ND Medicaid covers services provided by hospice providers that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

HOSPICE ELECTION

A hospice election must be submitted for a member who is eligible for hospice care and who wishes to elect hospice.

HOSPICE CARE ELIGIBILITY REQUIREMENTS

A member must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill or until the member or representative revokes the election of hospice.

A member may live in a home in the community or in a long-term care facility while receiving hospice services. A long-term care facility is a nursing facility, swing bed facility or intermediate care facility for the intellectually disabled.

A dually eligible member must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

PHYSICIAN CERTIFICATION

A written certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the member's attending physician, if the member has one, should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated if a verbal certification was provided.

If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the member's medical prognosis is a life expectancy of six months or less.

COVERED SERVICES

The hospice must provide the services listed below. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

1. Core Services
 - a. Nursing services provided by or under the supervision of a registered nurse.
 - b. Social services provided by a social worker under the direction of a physician.
 - c. Services performed by a physician, dentist, optometrist or chiropractor.
 - d. Counseling services provided to the member and family members or other persons caring for the member at the member's home to assist in minimizing the stress and problems that arise from the terminal illness, related conditions and the dying process.
2. Supplemental Services
 - a. Inpatient hospice care including procedures necessary for pain control and acute or chronic symptom management.
 - b. Inpatient respite care.
 - c. Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the member's terminal illness must be provided by the hospice for use in the member's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the member's terminal illness.
 - d. Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the supervision of a register nurse.
 - e. Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

INPATIENT HOSPICE CARE

A member may need care as an inpatient on a short-term basis during a period of crisis. To meet this need, the hospice or facility under contract to provide inpatient hospice care must provide 24-hour nursing services. Nursing services must be sufficient to meet the total nursing needs and be consistent with the member's plan of care. The inpatient facility must provide treatments, medications and diet as prescribed, and keep the member comfortable, clean, well-groomed and protected from accident, injury and infection. The inpatient facility must employ a registered nurse on each shift to provide nursing care.

INPATIENT RESPITE CARE

Inpatient respite care may be provided on an occasional basis to give the member's family or caregiver a break from the full-time responsibility of providing care. Payment for inpatient respite care may not exceed five consecutive days of inpatient respite care at a time.

BEREAVEMENT COUNSELING

The hospice must make bereavement services available to the member's family for at least one year after the member's death. Family includes persons related to the member or those considered by the member to be family because of close association. No payment is made for bereavement counseling.

PAYMENT FOR PHYSICIAN SERVICES

The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and service, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the

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hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a member's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR MEMBER IN LONG TERM CARE FACILITY

When hospice care is furnished to a member residing in a long-term care facility, payment to the long-term care facility by ND Medicaid is no longer available, and the hospice is responsible for paying for room and board furnished by the long term care facility. The hospice is responsible for including the room and board charges on the claim for the amount equal to the Medicaid rate payable to the long-term care facility at the time the services are provided. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates.

If a member has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the member. The hospice may make arrangements with the long-term care facility to collect the recipient liability. ND Medicaid will not reimburse the hospice for any uncollected recipient liability.

A hospice claim must be submitted for all individuals electing hospice who reside in a long-term care facility even if no payment is due from ND Medicaid and payment is made entirely by Medicare, insurance, or any other payment source.

PAYMENT

The hospice provider will be reimbursed at one of four predetermined rates for each day a member is under the care of the hospice. The four rates exclude payment for physician services that are separately paid.

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The hospice provider will be reimbursed an amount applicable to the type and intensity of services provided each day to the member. The four levels of care into which each day of care is classified are:

- Routine Home Care – This level of care is used for each day the member is under the care of the hospice and the member is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
- Continuous Home Care – This level of care is used for each day the member receives nursing services on a continuous basis during a period of crisis in the member's home. The hospice is paid an hourly rate for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.
- Inpatient Respite Care – This level of care is for each day a member is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but, excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a member resides in a long-term care facility.
- General Inpatient Care – This level of care is for each day the member receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that can't be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the member is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the resident's home; however, payment for general inpatient care can be made to another long-term care facility.

Payment for inpatient care days will be limited according to the number of days of inpatient care furnished to Medicaid members by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of days of hospice care provided to all Medicaid members by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate, and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to members diagnosed with acquired immunodeficiency syndrome (AIDS).

HOSPITAL SERVICES

ND Medicaid covers inpatient and outpatient services provided by hospitals that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

COVERED HOSPITAL SERVICES

Covered hospital services are subject to the following requirements:

- Ambulance services are not payable to hospitals on UB-04 form and must be billed on a CMS 1500 claim form.
- Readmission to inpatient care on same day as discharge must be levied as one inpatient stay except when readmission is unrelated to original inpatient stay diagnosis and treatments.
- Outpatient services provided on the day of discharge may not be separately billed and must be included on the inpatient claim.
- Separate payments will be made for the mother and a newborn.
- Charges should reflect the usual and customary charge of the hospital. Only the patient due amount is subject to payment by Medicaid.
- Miscellaneous codes need a description and supporting documentation.

NONCOVERED HOSPITAL SERVICES

The following is a list of noncovered services that must be identified as noncovered if billed on a UB-04 claim form:

- Admission Kits
- Ambulance Charges
- Barber/Beauty
- Biofeedback
- Books/Tapes
- Guest Tray
- Late Discharge
- Leave of Absence Room
- Lifeline
- Nursing – Outpatient
- Patient Convenience Items
- Postage
- Private Room
- Social Services
- Take Home Drugs
- Take Home Supplies
- Tax
- Technical Support Charges

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- Linen
- Non-Patient Room Rent
- Telemetry in ICU
- TV/Telephone/Radio

Please refer to the Noncovered Services chapter for further information.

THIRD PARTY LIABILITY

Medicaid is considered a payer of last resort. Therefore, all third-party liability must be utilized before Medicaid can be billed.

Medicare claims should be billed as follows:

- If the patient has Part A Medicare, charges for an inpatient stay must be billed entirely on a UB-04 claim form.
- If the patient has only Medicare Part B and incurs charges during an inpatient stay, the Part B charges must first be submitted to Medicare. The claim should then be submitted to Medicaid on a UB-04 claim form and include all charges for the inpatient stay. The UB-04 claim must include the Medicare Part B payment amount.
- If the patient receives Medicare Part B services on an outpatient basis, all charges must be billed on a UB-04 claim form.

IN-STATE PROSPECTIVE PAYMENT SYSTEM HOSPITALS INPATIENT SERVICES

Payment to in-state acute prospective payment system (PPS) hospitals is based on All Patient Refined - Diagnosis Related Groups (APR-DRG) for inpatient services.

The APR-DRG system classifies patients into clinically consistent groups with similar length-of-stay (LOS) patterns and utilization of hospital resources. Payment for an acute hospital stay is based on these groups which are comprised of diagnosis and procedure codes reported by the provider.

Claims for services that will be reimbursed using APR-DRG cannot be submitted until the patient is discharged or transferred.

3-DAY PAYMENT WINDOW

When a patient is admitted to a short-term acute care hospital, the hospital must review up to three days prior to the inpatient admission to see if any related outpatient services, diagnostic and non-diagnostic, were provided to the patient by the hospital and/or facility that is owned/operated by the hospital. These services are not covered as separate services and must be included on the inpatient claim along with other related services.

OUTPATIENT SERVICES

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments.

Each HCPCS code billed that is reimbursed under the OPPS which is assigned to an ambulatory payment classification (APC). A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting.

All outpatient services or visits occurring on same day for a member must be billed on one claim.

IN-STATE CRITICAL ACCESS HOSPITALS INPATIENT SERVICES

Payment for inpatient services provided by in-state critical access hospitals (CAH) is made on a per diem rate.

- Claims must be submitted each calendar month on a separate claim form.
- Room and board (revenue codes 100-219) will be reimbursed on a per diem basis. The number of units billed for room and board revenue codes should include the date of discharge or death.
- Revenue codes 300-319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

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OUTPATIENT SERVICES

Payment for outpatient services provided by a CAH is made on a percentage of charges.

ND Medicaid does not recognize Method II billing for CAH.

- Emergency room services should be billed as outpatient services on a separate claim form.
- Observation days and inpatient days cannot overlap.
- Physician services should be billed on a CMS-1500 claim form.
- Revenue codes 300-319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

OUT OF STATE HOSPITALS

An out of state hospital is defined as a hospital that is located in the United States and is more than 50 miles from a North Dakota border.

Payment to out of state hospitals is based on a percentage of charges for both inpatient and outpatient services.

The patient must obtain prior approval from ND Medicaid for out of state services.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (revenue codes 100-219) should include the date of discharge or death.
- Revenue codes 300-319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

REHABILITATION FACILITIES

Payment for inpatient services provided by a rehabilitation facility is made on a per diem basis. Payment for outpatient rehabilitation services is made on a percentage of

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charges. Inpatient rehabilitation stays are subject to a limit of 30 days per stay for patients 21 years of age and older.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (revenue codes 100-219) should include the date of discharge or death.

LONG TERM CARE HOSPITALS

Payment for services provided by a long-term care hospital (LTCH) is made based on a percentage of charges.

The patient must obtain prior approval from ND Medicaid for LTCH services.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (revenue codes 100-219) should include the date of discharge or death.

PSYCHIATRIC HOSPITALS

Payment for inpatient services provided by a psychiatric hospital is made on a per diem basis.

ND Medicaid will cover inpatient psychiatric services for individuals under 21 years if the individual meets certificate of need criteria.

Inpatient psychiatric services are not covered for individuals 22-64.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (revenue codes 100-219) should include the date of discharge or death.

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KIDNEY DIALYSIS SERVICES

Kidney dialysis claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 634	Erythropoietin (OPE) < 10,000 units
Revenue Code 771	Vaccine Administration
Revenue Code 821	Hemodialysis Composite or Other Rate
Revenue Code 831	Peritonea/Composite or Other Rate
Revenue Code 841	CAPD/Composite or Other Rate
Revenue Code 851	CCPD/Composite or Other Rate

IMMUNIZATIONS

COVERED SERVICES

North Dakota Medicaid covers immunizations that are medically necessary and approved by the Federal Drug Administration (FDA). The population includes both children and adults. ND Medicaid also covers immunization administrations when the vaccine/toxoid is covered.

Please refer to the coding guideline for further information on Immunizations (vaccine/toxoids) and immunization administration. The coding guidelines are available at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html.

The following list includes some, but may not include all current valid coding guidelines pertinent to immunizations (vaccines/toxoids):

- Gardasil (HPV) Vaccine
- Synagis (Palivizumab)
- Zoster (Shingles) Vaccines
- Immunization Administration for Vaccines/Toxoids

COVERAGE GUIDELINES

Vaccinations required for out-of-country travel are not covered by ND Medicaid as the travel is not considered medically necessary.

Vaccines for Children (VFC, state supplied) vaccines/toxoids supplied by the North Dakota Department of Health (NDDoH) must be administered to ND Medicaid members, 0 – 18 years of age. Providers administering vaccines/toxoids to children in this age group must be enrolled in the NDDoH VFC program and receive the vaccines/toxoids at no charge.

VFC vaccines/toxoids and the administration of the same is exempt from the Primary Care Case Management (PCCM) referral requirements.

The Vaccine Coverage table is available on the ND Department of Health's Immunization page at www.ndhealth.gov/immunize.

INDIAN HEALTH SERVICES AND TRIBALLY OPERATED 638 FACILITIES

Indian Health Service (IHS) facilities and tribally-operated 638 facilities meeting the state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, a Medicaid agency or state licensing authority may not take into account an absence of licensure of any staff member of the facility.

COVERED SERVICES

ND Medicaid covers the same services for members who are enrolled in Medicaid and IHS as those members who are enrolled in Medicaid only. Coverage and payment of services provided through telemedicine is on the same basis as those provided through face-to-face contact.

Payment to IHS facilities and tribally-operated 638 facilities will be on a daily encounter basis and based on the approved all-inclusive rates published each year in the Federal Register by the Department of Health and Human Services.

Each encounter includes covered services by a health professional and related services and supplies.

One encounter per day is covered unless another separate and distinct encounter is medically necessary.

Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single visit except when one of the following conditions exist:

- Multiple visits for different services on the same day with different diagnosis. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
- Multiple visits for different services on the same day with the same diagnosis. The diagnosis code may be the same on the claims, but the services provided must be distinctly different and occur within different units of the facility.

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- Multiple visits for the same type of service on the same day with different diagnosis.

BILLING GUIDELINES

IHS claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 100	In-House Medicaid Days
Revenue Code 250	Pharmacy
Revenue Code 490	Ambulatory Surgical Center
Revenue Code 500	Outpatient
Revenue Code 510	Vision
Revenue Code 512	Dental
Revenue Code 513	Mental Health (Psychiatrist/Psychologist)
Revenue Code 519	EPSDT Screening
Revenue Code 509	Telemedicine (clinic/physician)
Revenue Code 900	Behavioral Health
Revenue Code 961	Telemedicine (mental health)
Revenue Code 987	Physician Inpatient Services

A procedure code must be billed with revenue codes that require a CPT/HCPC code according to NUBC guidelines.

INDIVIDUALIZED EDUCATION PROGRAM MEDICAID SERVICES BILLED BY SCHOOLS

Schools, for purposes of billing ND Medicaid for health services, means a public school district or special education unit.

The Department of Human Services (DHS), Medical Services Division (ND Medicaid) is responsible for the payment of services for Medicaid-eligible children who receive Medicaid covered health services that are described in the child's Individualized Education Program (IEP), per the Individuals with Disabilities Education Act (IDEA).

ND Medicaid will pay the school for services based on claims submitted by the school. Payment will be based on fee schedules developed by ND Medicaid.

To receive ND Medicaid payment, the services must be part of a special education program and otherwise covered by ND Medicaid. ND Medicaid will not directly pay private schools but can make payments to the public school district for IEP-related services for children in that district who are attending private educational facilities.

Medicaid-covered services must be provided by school personnel who meet ND Medicaid provider qualifications as well as all applicable state licensing standards and are enrolled as ND Medicaid providers. Personnel can be either an employee of or contracted through the school; however, all claims must be submitted by the school.

Qualified services must:

- Be provided to student who is eligible for Medicaid on the date of service;
- Be authorized or prescribed in the eligible Medicaid student's Individualized Education Program (IEP); o The IEP must be updated as Medicaid-eligible services are initiated or discontinued.
- Be rendered by an enrolled Medicaid provider who is either an employee of or contracted through a school;
- Be a service covered under the North Dakota Medicaid State Plan;
- Be documented appropriately; and
- Be billed to Medicaid by the school.

COVERED SERVICES

Services must be medically necessary and outlined within an IEP that has been developed by the school's IEP team. Nursing services require a written order that documents medical necessity. Other health-related services must be authorized by a licensed practitioner of the healing arts operating within their scope of practice.

- Therapies (physical therapy, occupational therapy and speech-language pathology)
- Audiology;
- Behavioral Health;
- Nursing Services that support the child's needs to access free appropriate public education provided by Registered Nurses to children with complex medical needs.
 - T1000 - Private duty / independent nursing service(s) – licensed, up to 15 minutes.
 - Written order can be from a physician, nurse practitioner or physician assistant.
- Transportation from school to IEP services provided at an offsite location, and transportation back to school. Inclusion of the service in the child's IEP is mandatory; and
- Applied behavior analysis for children with an Autism Spectrum Disorder (see Medicaid Applied Behavior Analysis policy for additional coverage and service authorization requirements at <http://www.nd.gov/dhs/autism/docs/autism-aba-service-policy-and-procedures.pdf>). NOTE: Service authorization must be received and approved prior to services being rendered.

TELEMEDICINE

Health Services billed by schools can be delivered via telemedicine; however, no originating site fee is allowed. See Services Rendered via Telemedicine chapter for additional information.

SCHOOL PSYCHOLOGISTS

The Centers for Medicare and Medicaid Services (CMS) has clarified that they would expect the Medicaid agency to ensure the practitioner qualifications for services furnished in all community locations, including schools, are minimally the same. Because School Psychologist qualifications are not minimally the same as Psychologists who are licensed by the Board of Psychological Examiners, North Dakota Medicaid is not able to recognize school psychologists as a Medicaid provider.

NONCOVERED SERVICES

- Services provided that are not documented in the Medicaid-eligible student's IEP.
- Services not authorized by the appropriate authorization or written order.
- Services that are not provided directly to the child such as attendance at staff meetings, IEP meetings, staff supervision, member screening, development and use of instructional text and treatment materials.
- Communications between the provider and child that is not face-to-face.
- Transportation to and from home to school.
- Population screenings such as lice checks.
- Services considered experimental or investigational.
- Services considered educational or instructional in nature.
- Medication administration.

FREE CARE AND THIRD-PARTY LIABILITY

Services provided to Medicaid-eligible children that are part of an IEP are not subject to the same Medicaid Free Care and third-party liability requirements. A 2014 State Medicaid Director Letter (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>) provided clarification to Medicaid agencies. The guidance clarifies that the Medicaid statute contains an exception at section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to services provided by schools to Medicaid-eligible children in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the IDEA. Public agencies (schools) with general responsibilities to ensure health and welfare are not considered liable third parties.

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

ND Medicaid covers services provided by Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that are certified, licensed and enrolled with ND Medicaid.

LEVEL OF CARE

ND Medicaid will not cover ICF/IID services unless the individual meets ICF/IID level of care criteria.

LIMITS ON LEAVE DAYS

ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. The purpose of the hospital leave policy is to ensure that a bed is available when a member returns to the facility. A facility may not bill for hospital leave days if it is known that the member will not return to the facility.

Once the facility accepts payment for hospital leave on behalf of a Medicaid member, then the facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held; however, any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 30 therapeutic leave days per member per calendar year.

Once the facility accepts payment for therapeutic leave on behalf of a Medicaid member, then the facility must still bill ND Medicaid for therapeutic leave days beyond the beyond the 30th day that the resident's bed was held; however, any days exceeding the 30-day limit are noncovered days.

BILLING GUIDELINES

A member on medical or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of units billed must include the date of discharge or death.

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ICF/IID claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Adult Licensed Facility

Revenue Code 110	In-House Medicaid Days
Revenue Code 180	Therapeutic Leave Days
Revenue Code 182	Hospital Leave Days

Children's Licensed Facility

Revenue Code 120	In-House Medicaid Days
Revenue Code 183	Therapeutic Leave Days
Revenue Code 185	Hospital Leave Days

A facility must submit a claim for every month a Medicaid eligible member is in the facility, even if insurance has paid for the charges. This allows the system to start applying recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make any payment for ICF/IID services to the ICF/IID provider if an individual has elected hospice care. The hospice is paid the rate applicable to the member and is responsible for paying the facility for services provided to the member. Once a member has elected hospice benefits, the ICF/IID provider may not submit a claim for services provided while the member is on hospice.

LAB, RADIOLOGICAL, AND DIAGNOSTIC SERVICES

ND Medicaid covers services performed by a provider of (independent) laboratory services, (independent) x-ray services, or portable x-ray services, who are certified by Medicare and enrolled with ND Medicaid.

INDEPENDENT LABORATORIES, MEDICARE CERTIFIED

The Centers for Medicare and Medicaid Services (CMS) CLIA directives that require Medicaid to identify the independent laboratory and check certification for procedures they are authorized to perform. Medically necessary services provided by certified independent laboratories are covered by ND Medicaid if those services fall within the range of Medicare certified specialties and subspecialties for that laboratory. Hospital laboratory services also must be certified by Medicare for ND Medicaid coverage. Services that are not certified will not be covered.

CODING GUIDELINES

ND Medicaid follows CMS National Coverage Determination (NCD) and specified Local Coverage Determination (LCD) guidelines for some laboratory, radiological and diagnostic procedures.

COMPONENTS OF AND BILLING FOR RADIOLOGIC SERVICES

Both professional and technical components may be billed to ND Medicaid. The professional component is applicable in any duration in which the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities. To bill for the professional component, use the applicable procedure code appended with modifier 26 in the appropriate modifier field of the CMS1500 claim form or the electronic equivalent. When more than one provider is involved with providing and billing the procedure the providers should establish a written agreement as to which component each provider will be billing. Duplicate billing is considered fraudulent.

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The professional component represents the professional services of the physician. The professional component includes: examination of patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination.

The technical component includes the charges for personnel, materials, including usual contrast media and drugs, film or xerograph, space, equipment and other facilities but excludes the cost of radioisotopes. (Technical components may be billed by providers owning the equipment). To identify a charge for the technical component, enter the procedure code and append modifier TC in the appropriate modifier field.

When a physician or physician clinic is billing for services performed, and the equipment used is owned by the physician or clinic, the service should not be separated into a technical and professional component. Bill the appropriate CPT code but do not modify the code.

LABORATORY SERVICES IN A PHYSICIAN'S OFFICE

Providers eligible for payment of laboratory services in a physician's office are physicians or physician extenders under the direct supervision of the physician.

Physicians also may send laboratory specimens to independent or outpatient hospital laboratories. However, claim submission must be done by the independent or outpatient hospital laboratory.

CT SCAN / MRI

ND Medicaid will cover medically necessary MRI and CT scans. MRI and CT scans can be used for the diagnosis of many medical conditions. Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Medicaid does not cover CT or MRI scans that are not medically necessary.

LOCAL PUBLIC HEALTH UNITS (LPHUS)

COVERED SERVICES

ND Medicaid pays for medically necessary covered Medicaid services provided by the local public health units.

Billed services must be based on a specific service provided to an eligible ND Medicaid member. Local public health units must maintain records to document the actual time spent delivering services to eligible members.

ND Medicaid will cover the following services provided by LPHUs:

HCPCS/ CPT Code	Description
S0302	Completed EPSDT service (Health Tracks Screening)
S0390	Routine foot care
T1001	Nursing assessment / Evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1015	Clinic visit / encounter, all-inclusive service (OPOP visit)
T1030	Nursing care, in the home, by RN, per diem
T1031	Nursing care, in the home, by LPN, per diem
V5008	Hearing screening w/ report (cannot be reported with EPSDT service or nursing assessment or service.)
D1206	Topical application of fluoride varnish (ages 6 months through 20 years only)
36415	Collection of blood by venipuncture
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)
69210	Removal impacted cerumen, on ear both ears
92567	Tympanometry (impedance testing)
94760	Non-invasive ear or pulse oximetry for oxygen saturation; single
95115	Professional service for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	; two or more injections
96110	Developmental testing; limited (e.g. Developmental Screen Test II, with scoring and documentation, per standardized instrument.
96127	Brief emotional/behavioral assessment (e.g. depression inventory, ADHD scale with scoring and documentation, per standardized instrument.
96372	Therapeutic, prophylactic or diagnostic injection (specify the material injected); subq or IM

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97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face w/ patient, each 15 minutes (Services must be rendered by a Licensed Registered Dietitian (LRD) or Certified Diabetic Educator (CDE)).
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face w/ patient, each 15 minutes (Services must be rendered by a Licensed Registered Dietitian (LRD) or Certified Diabetic Educator (CDE)).
97804	Medical nutrition therapy, group (2 or more individuals), each 15 minutes (Services must be rendered by a Licensed Registered Dietitian (LRD) or Certified Diabetic Educator (CDE)).
96161	Maternal Depression Screening
Laboratory Services	
80061	Lipid panel
81002	Urinalysis, non-automated, without microscopy
82270	Occult blood feces
82465	Assay blood serum cholesterol
82947	Assay glucose blood quantitative
82948	Blood glucose, reagent strip
83655	Assay of lead
85018	Hemoglobin
85610	Prothrombin time
86580	TB skin test
87430	Strep, group A
Vaccines / Toxoids	
Complete Vaccine / Toxoid coverage information can be found at http://www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html	

INDIVIDUALIZED EDUCATION PROGRAM (IEP) RELATED SERVICES

Services provided to Medicaid-eligible children in a school setting that are authorized or prescribed in the child's IEP must be billed to ND Medicaid by the school district. Refer to Individualized Education Program Medicaid Services Billed by Schools chapter.

NONCOVERED SERVICES

- Mass screenings i.e. lice checks, hearing screenings, scoliosis screenings.
- Medication administration (supervision of oral medication).

MEDICAID ELIGIBILITY OF MEMBER

Medicaid is a program designed to provide health coverage for low-income people. Medicaid is authorized under Title XIX of the Social Security Act.

WHERE TO APPLY FOR MEDICAID BENEFITS

Applications for Medicaid benefits can be completed online, manually or by mail. Instructions are available at www.nd.gov/dhs/services/medicalserv/medicaid/apply.html.

WHO IS ELIGIBLE FOR MEDICAID?

Medicaid provides coverage to:

- Low-income individuals from birth
- Children in foster care or subsidized adoption
- Former foster care children up to age 26, under certain circumstances
- Children with disabilities (birth to 19)
- Pregnant women
- Women with breast or cervical cancer
- Workers with disabilities
- Other blind and disabled individuals
- Low-income Medicare beneficiaries (Medicare Savings Programs)

More information on Medicaid eligibility requirements can be found at www.nd.gov/dhs/services/medicalserv/medicaid/eligible.html

MEDICALLY NECESSARY (NON-ELECTIVE) STERILIZATION (HYSTERECTOMY, OOPHORECTOMY, ORCHIECTOMY)

WRITTEN CONSENT FOR STERILIZATION AND MEMBER ACKNOWLEDGEMENT OF STERILITY

ND Medicaid covers medically necessary sterilization unless it is performed for the primary purpose of making the member sterile. The member and his or her representative, if applicable, must sign an acknowledgment of receipt of both oral and written information that the genital system surgical procedure (e.g. hysterectomy, oophorectomy, orchiectomy) would make the member permanently incapable of reproducing children. The Physician Certification for Sterilization and Member Acknowledgment of Sterility **SFN 614** form (consent form) and instructions for completing are available at

www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Do not use the Sterilization Consent Form (SFN 614) for tubal ligations.

The Physician Certification for Sterilization and Consent form (SFN 614), when signed by the member or his or her representative indicates that the provider informed the member (and his or her guardian if applicable), that the procedure would cause sterility.

The member or member's guardian may sign the consent form before or after the genital system surgical procedure. Guardians must sign the consent form for mentally incompetent members. A member residing in an institution may sign the acknowledgment for themselves unless he or she has been found incompetent by a court.

INSTRUCTIONS FOR COMPLETING THE PHYSICIAN CERTIFICATION FOR HYSTERECTOMY AND MEMBER ACKNOWLEDGEMENT OF STERILITY FORM

Section a and b. Prior to surgery, member was advised both orally and in writing that the surgical procedure known as a hysterectomy would cause permanent sterility. Both the physician and member must certify this acknowledgment with written signatures.

Section c. A hysterectomy performed on a member who was sterile before the surgery is subject to the written acknowledgment statement. The claims submitted by the physician who performed the hysterectomy, the anesthesiologist and the hospital must

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be accompanied by written physician certification of the member's sterility and the cause of her sterility.

Section d. The written acknowledgment statement does apply when a member needs a hysterectomy because of a life-threatening emergency situation in which a physician determines that prior acknowledgement is not possible. A written physician certification that prior acknowledgment was not possible, and a description of the nature of the emergency must accompany all claims for services associated with the hysterectomy.

MEDICARE COVERAGE

MEMBERS WITH MEDICARE

Medicaid members enrolled in the federally administered Medicare program are referred to as dual eligible. Medicare currently consists of three parts. Medicare Part A includes coverage for inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care; Medicare Part B includes coverage for doctor and other health care providers' services, outpatient care, durable medical equipment, home health care and some preventive services; and Medicare Part D includes drug coverage.

Medicare is the primary insurer for all dual eligible members. Medicaid may be required to pay some or all of the member's Medicare premium, deductible and coinsurance costs, depending on the following type of eligibility under the Medicare Savings Program that consists of:

- **Qualified Medicare Beneficiaries (QMB)** Medicaid will pay Part B premium and will make payments only toward Medicare coinsurance and deductibles.
- **Special Low-Income Medicare Beneficiaries (SLMB)** Medicaid will pay the Part B premium only.
- **Qualifying Individual (QI1)** Medicaid will pay Part B premium only. These individuals cannot be eligible for Medicaid.

NONCOVERED MEDICAID SERVICES

This list refers to services that are not covered by the ND Medicaid program. Please note: This is **not** an all-inclusive list.

- Abortions (exceptions are: rape, incest or to save the life of the mother).
- Acupuncture
- Alcoholic beverages
- Artificial insemination
- Autopsies
- Body piercing
- Care Plan Oversight Services
- Dental implants
- Drugs that are not approved by the FDA
- Drug testing
- Equine therapy
- Experimental services and procedures
- Gender reassignment surgery
- Health services paid by another source i.e. Workers Compensation claims, eye glasses covered by Fraternal Organization
- Health services which require service authorizations that were not obtained prior to service delivery
- Health services that do not comply with guidelines and limitations
- Health services, other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian
- Health services for which a physician's order is required but not obtained
- Health services not in the member's plan of care
- Health services not documented in the member's health/medical record
- Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers. (Providers of services, which are determined to be of low quality, must bear the cost of these services)

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- Home modifications to accommodate mobility (example: wheelchair ramp, etc.)
- Hypnotherapy
- Infertility (testing, treatment, diagnostics or any related services)
- Interpreter services
- Massage therapy
- Missed appointments (providers may bill clients for missed appointments, if this is the normal practice for all patients)
- More than one office, hospital, long-term care facility, or home visit by the same provider, per member per day, except for an emergency
- Music therapy
- Non-CLIA certified lab services
- Non face to face services (i.e. telephone, email)
- Out of state services that were not prior approved
- Paternity testing
- Patient convenience (example: moving patient to facility closer to home)
- Reversal of sterilization
- Routine circumcisions
- Routine physical examination except for members in an ICF/IID
- Services for detoxification unless medically necessary to treat an emergency
- Services for members between the ages of 21-64 in an Institution for Mental Disease (IMD)
- Services provided by Alcoholics Anonymous
- Services performed outside of the practitioner's scope of practice as defined by state laws
- Services that are not medically necessary
- Services received by a member on the Coordinated Services Program (CSP) that were not referred by the CSP provider
- Services rendered to a member without a Primary Care Provider (PCP) referral
- Services that were denied by a third party payer because third party requirements were not followed

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- Surgery primarily for cosmetic purposes
- Tattoo or tattoo removal
- Transportation for non-medical appointments
- Weight loss programs and exercise programs
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services

NONEMERGENCY MEDICAL TRANSPORTATION (INCLUDING MEALS AND LODGING)

GENERAL REQUIREMENTS

Nonemergency medical transportation (NEMT) is the transporting of a member for the purpose of obtaining a covered service. Medicaid covered transportation consists of:

- Handicap transportation is defined as the transport of a member who, because of a physical or mental impairment, is unable to use a common carrier. The impairment must be a physiological disorder, physical condition, or mental disorder that prohibits access to or safe use of common carrier transportation. Special transportation is designed for a member such as the wheelchair-bound individual who needs a special vehicle with tie-down apparatus.
- Common carrier transportation is defined as the transport of a member by a bus, taxicab, or other commercial carrier or by private automobile.

A transportation service provider must be enrolled as a provider in the ND Medicaid program and can be an individual, or other commercial form of transportation.

To be eligible for payment, nonemergency medical transportation must be to or from the site of a covered service to a member. A covered service is one which is provided by a ND Medicaid enrolled health care provider and is a reimbursable service.

Providers may only bill for distance travelled with the member in the vehicle (loaded miles). Providers may not bill for the distance travelled in order to pick up the member or the return trip to the provider's home after the member has been dropped off.

The county agency must determine the most efficient, economical, and appropriate means of NEMT to meet the medical needs of the member. The county agency is responsible for authorizing travel, with the exception of travel conducted by NEMT providers that are also foster parents.

Travel services may be provided by the county agency as an administrative activity.

The cost of travel provided by a parent, spouse, or any other member of the member's medical assistance unit may be allowed as an expense of necessary medical or remedial care for recipient liability purposes. No parent, spouse, friend, household member or family member of the member may be paid as an enrolled provider for

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transportation to that member unless all other transportation options have been exhausted.

A member may choose to obtain medical services outside the member's community. If similar medical services are available within the community and the member chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the member.

HANDICAP-ACCESSIBLE TRANSPORTATION

Three primary criteria must be met for handicap transportation to be considered for payment:

- The member must have a mobility impairment of a severity that prevents the member from safely accessing and using a bus, taxi, private automobile or other common carrier transportation;
- The trip must be to or from a North Dakota covered service;
- The trip must be authorized by the county.

Providers must bill ND Medicaid the usual and customary fee charged to their largest share of business other than Medicaid members and sliding fee-scale-type riders. Any handicap accessible transportation provider whose business includes riders in addition to Medicaid and sliding fee scale riders cannot charge Medicaid more than the provider charges its non-Medicaid business that makes up the largest share of business (excluding sliding fee scale riders). If transportation providers offer free rides or reduced fees to non-Medicaid riders, those providers must charge the same rates or offer free rides to Medicaid members. If a provider serves only Medicaid and sliding fee-scale schedule riders, then the Medicaid rate charged to Medicaid members is the usual and customary fee.

This policy includes multiple rider trips. If a special transportation provider discounts multiple rider trips for non-Medicaid riders, the provider also must discount Medicaid rides.

TAXI TRANSPORTATION

Taxi vouchers (SFN 170) are required to be given to the taxi driver upon taking a ND Medicaid member to a medical appointment and upon taking them home from their appointment. The county social service staff or eligibility worker arranges this with

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members. When a provider bills ND Medicaid for taxi services, a taxi voucher must be obtained and kept on file. In the event of an emergent or urgent medical situation, the taxi provider is responsible for acquiring the taxi voucher from the appropriate county worker within 72 hours of providing the transportation. Only the state-created taxi voucher (SFN 170) will serve as proper documentation; no substitutions of this form are allowed. The form is available at <https://www.nd.gov/eforms>.

Taxi service will only be allowed from the member's home, school, or work to their medical appointment. The return trip from the medical appointment will only be allowed to the member's home, work, or school.

ND Medicaid would allow exceptions to the pickup location when an emergency arises at a location other than those listed above, e.g., a Medicaid member becomes ill while at a restaurant and needs medical attention with no other means of transportation available.

TRANSPORTATION BY PRIVATE VEHICLE

Non-commercial/volunteer (private) vehicle mileage compensation is limited to the amount on the fee schedule. This limit applies even if more than one member is transported at the same time. Providers may bill for only one member, regardless of the number of members being transported during a trip. Mileage is determined by map miles from the residence or community of the member to the medical facility. When necessary, to ensure volunteer drivers continue to provide transportation services to a member, the county agency may request authorization from ND Medicaid to make payment for additional mileage. Private vehicle mileage may be billed to ND Medicaid only upon completion of the service. Private vehicle mileage may be allowed if the member or a household member does not have a vehicle that is in operable condition or if the health of the member or household member does not permit safe operation of the vehicle. Private vehicle mileage will not be allowed if free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member.

Providers may only bill for distance travelled with the member in the vehicle (loaded miles). Providers may not bill for the distance travelled in order to pick up the member or the return trip to the provider's home after the member has been dropped off.

OUT OF STATE TRANSPORTATION

All medical transportation to a site located more than 50 statute miles from the nearest North Dakota border requires prior approval. Exceptions include emergency transportation or transportation provided to a member for whom the state makes adoption assistance or foster care maintenance payments.

All out of state transportation must have a state authorized out of state medical procedure. If the out of state procedure is not authorized by the state, any transportation expenses associated with that out of state visit is not authorized and becomes the expense of the member. Contact the county social service agency for assistance in approving the service. Upon approval the provider will receive a service authorization that contains a list of procedure codes that may be billed.

Transportation provided by private automobile, bus or other commercial carrier must be authorized by the local county social service agency. Limitations on travel expenses for medical purposes are addressed in NDAC 75-02-02-13.1.

MEALS AND LODGING

Meal compensation is allowed only when medical services or travel arrangements require a member to stay overnight. Payment is limited to the amount on the fee schedule. Enrolled meal providers shall bill ND Medicaid directly. Payment will not be made to the member.

Lodging expense is allowed only when medical services or travel arrangements require a member to stay overnight. Payment is limited to the amount on the fee schedule. Enrolled lodging providers shall bill ND Medicaid directly. Payment will not be made to the member.

Travel expenses may be authorized for a driver. No travel expenses may be authorized for an attendant unless the referring provider determines an attendant is necessary for the physical or medical needs of the member. Travel expenses may not be authorized for both a driver and an attendant unless the referring provider determines that one individual cannot function both as driver and attendant. No travel expenses may be allowed for a driver or an attendant while the member is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area.

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Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized for another driver, attendant, or parent unless the referring provider determines that person's presence is necessary for the physical or medical needs of the child.

Payment for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by ND Medicaid. The attendant must be an enrolled ND Medicaid provider.

NONCOVERED SERVICES

The costs of items listed below are not covered by ND Medicaid as medical transportation:

- Charges for luggage, stair carry of the member, and other airport, bus, or railroad terminal services;
- Transportation of a member to a noncovered health service (e.g. grocery store, health club, school, church, synagogue); and
- Parking fees.

NORTH DAKOTA HEALTH TRACKS EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Health Tracks is the name of North Dakota Medicaid's EPSDT program. EPSDT is a federally required program that requires states to ascertain, for individuals under age 21, the physical and mental level of wellness and to provide care, treatment and other corrective health measures as necessary.

The federal guidelines for EPSDT are available at www.medicaid.gov.

OVERVIEW

ND Health Tracks is a comprehensive child health program consisting of supportive, operational components to:

- Assure the availability and accessibility of required health care resources; and
- Help ND Medicaid members and their parents or guardians to effectively use services.

These components enable Health Tracks to manage a comprehensive child prevention and treatment system, to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the types of assistance available;
- Help them and their families use health resources;
- Assess the child's health needs through initial and periodic examinations; and
- Assure that health problems found are diagnosed and treated early, before they become complex and their treatment becomes more costly.

HEALTH TRACKS SERVICE REQUIREMENTS

All screening tools must be evidence-based. The Health Tracks benefits include the following benefits:

- Screening services:
 - A comprehensive health and developmental history including assessment of both physical and mental health development, (see [Recommended Tools](#)).

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- A comprehensive unclothed physical exam,
 - Appropriate immunization – (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccine),
 - Lead Toxicity Screening – All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 5 ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample,
 - Laboratory tests, and
 - Health Education – Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of health lifestyles and practices.
- Vision services including diagnosis and treatment for defects in vision.
 - Dental services including relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.
 - Hearing services including diagnosis and treatment for defects in hearing, including hearing aids.
 - Other necessary health care to provide diagnosis and treatment to correct or improve defects, physical and mental illnesses and conditions discovered by the screening services.

PERIODICITY SCHEDULE

The recommendation for frequency of Health Tracks assessments is according to the following schedule. Please consult the Bright Futures Well Child Periodicity Schedule for a description of visits at www.brightfutures.org.

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Newborn	2-5 days	1 month	2 months	4 months
6 months	9 months	1 year	15 months	18 months
2 years	30 months	3 years	4 years	5 years
6 years	7 years	8 years	9 years	10 years
11 years	12 years	13 years	14 years	15 years
16 years	17 years	18 years	19 years	20 years

DIAGNOSIS

When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services. The referral should be made without delay and follow-up to make sure that the member receives a complete diagnostic evaluation.

TREATMENT

Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level.

DOCUMENTATION REQUIREMENTS

Providers are encouraged to use the Bright Futures forms.

Documentation requirements can also be met using an internal form as long as the information contains all of the components listed above in the Health Tracks Service Requirements. These documentation requirements include:

- Comprehensive health and developmental history, to include mental health screening;
- Health education/anticipatory guidance;
- Comprehensive unclothed physical examination;
- Immunizations received;
- Lead screening;

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- Hearing screening;
- Vision screening;
- Dental screening; and
- Laboratory tests and results.

COVERED SERVICES

Vision, hearing and dental screenings are considered part of the Health Tracks assessment and cannot be billed separately. The following may be billed separately using the appropriate CPT code:

- Immunizations and administration,
- Laboratory tests, and
- Other necessary diagnostic and treatment services.

Providers must submit the applicable revenue code (521 for RHC or FQHC) or (519 for IHS) along with HCPC S0302.

Local Public Health Units must submit a claim form with HCPC S0302.

All other providers must submit a claim form with one of the appropriate Preventative Visit CPT Codes (9938x/9939x) or HCPC S0302.

ND Medicaid will not reimburse both S0302 and the preventative visit code on the same day and will not pay for more than one encounter visit for these services on the same day.

When members under 21 years of age receiving a preventive screen also require evaluation and management of a focused complaint, the provider may deliver all medically necessary care and submit a claim for both the preventive service (CPT 9938x / 9939x) or S0302 and the appropriate level of focused, E/M service (CPT 9920x/9921x).

When providing evaluation and management of a focused complaint (CPT 9920x / 9921x) during a Health Tracks visit, the provider may claim only the additional time required above and beyond the completion of the comprehensive Health Tracks visit (CPT 9938x / 9939x) to address the complaint.

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The provider's electronic signature on the claim is the attestation of the medical necessity of both services. All requirements in this section regarding documentation of the additional, focused service must be adhered to by the provider.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

- Provider documentation must support billing of both services. Providers must create separate notes for each service rendered in order to document medical necessity.
- In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during the Health Tracks visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.
- All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.
- The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph that clearly describes the specific condition requiring evaluation and management.
- The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

Modifier 25 must be appended to the appropriate E/M code. Modifier 25 indicates that 'the patient's condition required *a significant, separately identifiable E/M service above and beyond the other service provided*'.

NURSE PRACTITIONERS

A nurse practitioner is an advance practice registered nurse (APRN) who is currently licensed to practice in the state and is certified as a nurse practitioner by the appropriate national certifying entity.

Medicaid billable services consist of services otherwise covered as a physician service that are within the scope of practice of the nurse practitioner's license as an advance practice registered nurse.

Nurse practitioners may serve as primary care providers (PCP) within the Primary Care Case Management (PCCM) program.

Nurse practitioners must enroll and obtain their own ND Medicaid provider number.

NURSING FACILITIES

ND Medicaid covers services provided by nursing facilities (NF) that are certified to participate in the Medicare program, licensed and enrolled with North Dakota (ND) Medicaid.

LEVEL OF CARE

ND Medicaid will not cover nursing facility services unless the individual meets nursing facility level of care criteria.

LIMITS ON LEAVE DAYS

ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. The purpose of the hospital leave policy is to ensure that a bed is available when a resident returns to the nursing facility. A nursing facility may not bill for hospital leave days if it is known that the resident will not return to the facility.

Once the nursing facility accepts payment for hospital leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held; however, any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 24 therapeutic leave days per resident per rate year. The rate year begins January 1st for in-state long term care (LTC) nursing facilities.

Once the nursing facility accepts payment for therapeutic leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for therapeutic leave days beyond the 24th day that the resident's bed was held; however, any days exceeding the 24-day limit are noncovered days.

Hospital and therapeutic leave days, occurring immediately following a period when a resident received Medicare Part A benefits in the facility, are noncovered days.

The day of death is paid for in all instances except when a resident is in a Medicare benefit period, in which case the day of death is a noncovered day. The day of discharge to any location for a resident is a noncovered day.

BILLING GUIDELINES

A resident on hospital or therapeutic leave on the last day of the month whose bed is being held by the facility is “Still a Patient”.

The number of units billed must include the date of discharge or death.

A separate claim line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed.

Claims must be submitted using the following *Revenue Codes* when billing for:

Revenue Code 110	In-House Medicaid Days (private)
Revenue Code 120	In-House Medicaid Days (semiprivate)
Revenue Code 160	Medicare Full Benefit Period Days
Revenue Code 169	Medicare Coinsurance Days
Revenue Code 182	Medicare Noncovered Leave Days
Revenue Code 183	Therapeutic Leave Days
Revenue Code 185	Hospital Leave Days

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance (including Medicare) has paid for the charges. This allows the system to start applying recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make any payment for nursing facility services to the nursing facility provider if a resident has elected hospice care. The hospice is paid the rate applicable to the resident and is responsible for paying the nursing facility for services provided to the resident. Recipient liability, if any, is applied to the hospice provider's claim. Once a resident has elected hospice benefits, the LTC nursing facility provider may not submit a claim for services provided while the resident is on hospice.

A hospice provider must submit a revocation of election form to ND Medicaid before payment can be made to a nursing facility for a resident who no longer is receiving hospice benefits. The facility should contact the hospice provider to ensure that a revocation notice has been filed with ND Medicaid prior to billing for nursing facility services.

IN-STATE NURSING FACILITIES

The rate established for in-state nursing facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the in-state nursing facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

OUT-OF-STATE NURSING FACILITIES

The rate for out-of-state nursing facilities is based on the rate established by the Medicaid agency in the state where the facility is located. The routine services included in the rate are determined by the rate established by that state's Medicaid agency, such as; supplies, therapies, nursing facility supplies, equipment, nonemergency transportation and non-legend drugs. Ancillary charges that are not included in the out-of-state nursing facility rate must be billed by the provider furnishing the service.

NUTRITIONAL SERVICES

Nutritional services consist of counseling and supplies for individuals in relation to the nutritive and metabolic processes of the body. Nutritional counseling may be provided by licensed registered dietitians or certified diabetes educators according to the American Diabetes Association criteria.

A complete list of Medicaid covered diagnoses and procedure codes are available for nutritional services and diabetic education at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html.

COVERAGE LIMITATIONS

To receive payment, a licensed registered dietitian must enroll as an independent Medicaid provider or be part of a clinic or physician practice. Certified diabetes educators may not enroll independently and must be part of a clinic or physician practice for services to be covered.

Nutritional services are allowed up to four (4) visits per calendar year without prior authorization. ND Medicaid does not pay for:

- Exercise classes
- Nutritional supplements for the purpose of weight reduction
- Instructional materials and books
- Diet pills with the exception of Xenical

OCCUPATIONAL THERAPY

An occupational therapist is an individual who has graduated from an approved program and is registered by the American Occupational Therapy Association as an occupational therapist, meets licensing requirements and is licensed to practice occupational therapy in the state in which the services are provided.

COVERED SERVICES

Occupational therapy services encompass evaluation and re-evaluation of an individual's deficits in occupational performance, consultation, motor skills, cognitive skills, sensory integrative skills, preventive skills, therapeutic adaptations and activities of daily living.

Occupational therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and meet the primary care provider requirements, if applicable.

The following must be documented in the member's plan of care:

- The member's medical diagnosis and any contraindications to treatment;
- A description of the member's functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the member's progress toward the objectives.

Occupational therapy services must be prescribed and a plan of care must be signed by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. Recertification of the treatment plan must occur within 60-days from the date of the initial evaluation or encounter. Subsequent recertification must occur at 60-day intervals throughout the course treatment. ND Medicaid requires a copy of the recertification when the provider is requesting encounters which are over the service limits. In all situations, a copy of the recertification must be kept by the provider for auditing purposes.

Occupational therapy services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge and skills of a qualified occupational therapist.

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Services must be directly and specifically related to an active written treatment plan prescribed by a physician. The services must be anticipated to progress toward or achieve the objectives in the member's treatment plan within a relatively short amount of time, not likely to exceed 90 days.

Occupational therapy provided on an ongoing basis for members who have a condition due to congenital abnormality, trauma, deprivation or diseases that interrupt or delay the sequence and rate of normal growth, development and maturation is a covered service unless it is considered maintenance. The therapy must be medically necessary to prevent the loss or digression of the member's functional level. The member must have one of the following:

- Spasticity or severe contractures that interfere with the member's activities of daily living or the completion of routine nursing care;
- A chronic condition that results in physiological deterioration and that requires specialized rehabilitative therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living or positioning necessary for completion of the member's activities of daily living;
- An orthopedic condition that may lead to physiological deterioration and require therapy intervention by a physical or occupational therapist to maintain strength, joint mobility and cardio graphic function;
- Chronic pain that interferes with functional status and is expected by the physician to respond to therapy; or
- Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

For individuals ages 21 and over occupational therapy is limited to 20 visits per calendar year, and one evaluation per year. Prior authorization is required for visits exceeding this limit.

The following is a list of ND Medicaid covered CPT codes for restorative and rehabilitative services:

97165	Occupational therapy evaluation 30 minutes	1 unit
97166	Occupational therapy evaluation 45 minutes	1 unit
97167	Occupational therapy evaluation 60 minutes	1 unit
97168	Occupational therapy reevaluation	1 unit
97010	Application of a modality to one or more areas; hot or cold packs	1 unit
97022	Application of a modality to one or more areas; whirlpool	1 unit

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97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 min./1 unit
97035	Application of modality to one or more areas; ultrasound, each 15 minutes	15 min./1 unit
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 min./1 unit
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	15 min./1 unit
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	15 min./1 unit
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	15 min./1 unit
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 min./1 unit
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 min./1 unit
G0152	Services of occupational therapist in home health setting, each 15 minutes	15 min / 1 unit
All other services for physical therapy and rehabilitation are noncovered by ND Medicaid.		

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 20 visits per calendar year for individuals ages 21 and over. The provider must complete and submit **SFN 481** to ND Medicaid, prior to the member's receipt of additional services. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed is:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals;
- New long-term goals.

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals;
- Progress;

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- Reasonable new goals;
- Maintenance care.

If the services are determined necessary to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

ND Medicaid will not cover services that are provided without submitting required information.

NONCOVERED SERVICES

- Occupational therapy that is provided without a prescription from a physician;
- Services for contracture that are not severe and do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Bowel and bladder retraining programs;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary by the member's attending physician;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's Individualized Education Plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;

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- Occupational therapy services provided in a nursing facility or ICF/MR. Medicaid pays for those service through the rate established for the facility;
- Maintenance therapy.

OPTOMETRIC AND EYEGLOSS SERVICES

ND Medicaid covers services provided by an ophthalmologist, optometrist or optician who is licensed and is enrolled with ND Medicaid. Services are covered when they are within the scope of the provider's practice and are also a covered service by ND Medicaid.

DISPENSING SERVICES

Dispensing services may be provided by ophthalmologists, optometrists and opticians.

SERVICES FOR MEMBERS WITH LIMITED MEDICAID COVERAGE

Medicaid generally does not cover eye exams or eyeglasses for members with Qualified Medicare Beneficiary (QMB) coverage. Always check member eligibility before providing services. However, ND Medicaid may cover eye exams for these members under the following conditions:

- Following cataract surgery: Members who have QMB only coverage are only eligible for eyeglasses following cataract surgery when Medicare approves the eyeglasses claim. ND Medicaid considers the Medicare coinsurance and deductible for this claim.
- Diabetic diagnosis: Eye exams for members with basic Medicaid coverage, not QMB, who have a diabetic diagnosis (see following table). Eyeglasses are not covered for these members.
- Medically Necessary Eye Examinations: Eye exams for members with basic Medicaid coverage, not QMB, who have certain eye conditions (see following table). Eyeglasses are not covered for these members.

NONCOVERED SERVICES

Services that not covered include the following:

- Services considered experimental or investigational.
- Dispensing fees for a member who is not eligible for lenses and/or frames within the two (2) year time period for adults, one (1) year for children.

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- Services that the provider did not personally provide. The main exception is that the dispensing service may be performed by the provider's employee when it is allowed by law.

RETROACTIVE ELIGIBILITY

ND Medicaid does not cover eyeglasses for members who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, eye exams are covered for retroactively eligible members. For example, a member had an eye exam and purchased eyeglasses on July 15. On September 1, the member was determined eligible for Medicaid retroactive to July 1. ND Medicaid would pay for the eye exam but not for the eyeglasses.

CONTACT LENSES – PRIOR AUTHORIZATION AND INVOICE REQUIRED

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees. The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. When billing for services after prior approval has been obtained, the claim must be submitted with an invoice. ND Medicaid covers contact lenses when the member has one of the following conditions:

- Keratoconus;
- Sight that cannot be corrected to 20/40 with eyeglasses;
- Aphakia; or
- Anisometropia of 2 diopters or more.

EYE EXAMS

Members ages 21 and over are limited to one eye examination and refraction every two years. Members ages 20 and under are limited to one eye examination and refraction every 365 days. ND Medicaid allows exceptions to these limits when one of the following conditions exists. Prior authorization is required:

- Following cataract surgery, when more than one exam during the respective period is medically necessary;
- Adult diabetic members may have exams every 365 days.

EYEGLOSS SERVICES

Adults ages 21 and older are eligible for eyeglasses every two years. Children ages 20 and under are eligible for eyeglasses every 365 days.

If the member has a diagnosed medical condition that prohibits the use of bifocals, an exception may be made allowing eyeglasses to be dispensed outside of the limit requirement. Providers are required to submit a prior authorization. The provider must document the member's inability to use bifocals.

FRAME SERVICES

ND Medicaid will only cover eyeglasses and frames purchased through ND Medicaid's eyeglass contractor. The eyeglass contractor will provide a list of Medicaid covered frames to dispensing providers.

Members have the option of using their "existing frames" and ND Medicaid will cover lenses. The existing frame is a frame that the member owns or purchases. When a member chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the member), ND Medicaid will pay for a contract frame, but not new lenses. The member can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.
- Code 92370, repair and refitting of spectacles, requires prior authorization.

Lens Add-Ons		
Lens Feature	Covered for Children (Ages 20 and Under)	Covered for Adults (Ages 21 and Older)
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary with Prior Authorization	Yes – if medically necessary with Prior Authorization
Photochromic - Glass (i.e. photogray, photo-brown)	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization

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Progressive	No	No
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes	Yes
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	No
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Ultraviolet	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Slab-off and fresnell prism	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this chapter will be billed to the dispensing provider at the eyeglass contractor's normal and customary charges.

LENS STYLES AND MATERIALS

All eyeglass lenses fabricated by the eyeglass contractor for members must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

ND Medicaid covers the following lens styles:

- Single vision;
- Flattop segments 28;
- Round 22;
- Flattop trifocals 7 x 28;
- Executive style bifocals.

ND Medicaid covers the following lens materials (no high index):

- Glass;
- CR-39;
- Polycarbonates.

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REPLACEMENT LENSES AND FRAMES

All frames provided by the eyeglass contractor carry a 12-month manufacturer warranty on replacement fronts and temples. Members must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses or breaks his or her eyeglasses within the 24 months, ND Medicaid will not cover another pair.

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, ND Medicaid will replace one pair of eyeglasses within the 12-month period. All replacement requests must be prior authorized.

EYEGLOSS ORDERING PROCEDURES

Providers must complete the ND Medicaid Rx form to order eyeglasses from the eyeglass contractor. Prescription change is used when a lens is ordered due to a prescription change, which meets Medicaid guidelines.

BILLING GUIDELINES

Mail or fax the order form to the eyeglass contractor. Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.

Errors in the fabrication of eyeglasses made by the eyeglass contractor will be corrected by the contractor at no additional charge.

PARTIAL HOSPITALIZATION PROGRAM SERVICES

Partial hospitalization program services are psychiatric services provided to an individual with an impairment resulting from a psychiatric, emotional or behavioral disorder by a multidisciplinary team of health care professionals, designed to stabilize the health of the individual with the intent to avert inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization services must be hospital based.

Level A is an intense level of services by at least three licensed health care professionals for at least four hours and no more than eleven hours per day for at least three days per week. The services must be under the supervision of a licensed physician.

Level B is an intermediate level of services by at least three licensed health care professionals for three hours per day for at least two days per week. The services must be under the supervision of a licensed physician.

COVERAGE LIMITATIONS

The following limits have been established for services for treatment of partial hospitalization services.

Level A	45 days per calendar year per member
Level B	30 days per calendar year per member

Additional days may be authorized by ND Medicaid if determined to be medically necessary.

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PHARMACY

ND Medicaid covers prescription drugs provided by an enrolled ND Medicaid provider.

See the Pharmacy Manual for specific billing and policy information at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

PHYSICAL THERAPY

A physical therapist is an individual who has graduated from an approved school of physical therapy or has equivalent training and is licensed to practice physical therapy in the state in which the individual provides services.

GENERAL INFORMATION

Physical therapy departments and their personnel must adhere to the “APTA Standards for Physical Therapy Services and Physical Therapy Practitioners”, the “North Dakota Physical Therapy Practice Act established in ND Century Code 43-26.1 and the NDPTA Guidelines for Physical Therapists”.

Physical therapy services consist of evaluation and re-evaluation, treatment planning, provision of treatments, instruction and consultative services.

Physical therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the member’s physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and meets primary care provider requirements, if applicable.

The following must be documented in the member’s plan of care:

- The member’s medical diagnosis and any contraindications to treatment;
- A description of the member’s functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the member’s progress toward the objectives.

Physical therapy services must be prescribed and a plan of care must be signed by the member’s physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, and meet primary care provider requirements if applicable. Recertification of the treatment plan must occur at 60-day subsequent intervals from the date of the initial evaluation or encounter. Subsequent recertification must occur at 60-day intervals throughout the course of treatment. ND Medicaid requires a copy of the recertification when the provider is requesting encounters which are over the service limits. In all situations, a copy of the recertification must be kept by the provider for auditing purposes.

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COVERED SERVICES

Physical therapy services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge and skills of a qualified physical therapist.

Restorative physical therapy must be medically necessary, ordered by a physician, anticipated to result in substantial improvement of the member within a predictable period of time, generally not exceeding 90 days.

Physical therapy considered rehabilitative is typically provided for members with conditions due to congenital abnormality, trauma, deprivation, or diseases that interrupt or delay the sequence and rate of normal growth, development, and maturation. Medicaid does not cover these services if they are maintenance in nature. However, if they were needed to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

For individuals ages 21 and over, physical therapy is limited to 15 visits per calendar year. Prior authorization is required for visits exceeding this limit.

The following is a list of ND Medicaid covered CPT codes for restorative and rehabilitative services:

97161	Physical therapy evaluation 20 minutes	1 unit
97162	Physical therapy evaluation 30 minutes	1 unit
97163	Physical therapy evaluation 45 minutes	1 unit
97164	Physical therapy reevaluation	1 unit
97010	Application of a modality to one or more areas; hot or cold packs	1 unit
97022	Application of a modality to one or more areas; whirlpool	1 unit
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 min./1 unit
97035	Application of modality to one or more areas; ultrasound, each 15 minutes	15 min./1 unit
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 min./1 unit
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	15 min./1 unit
97113	Aquatic therapy with therapeutic exercises	15 min./1 unit
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	15 min./1 unit

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97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 min./1 unit
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 min./1 unit
G0151	Services of physical therapist in home health setting, each 15 minutes	15 min./1 unit
All other services for physical therapy and rehabilitation are noncovered by ND Medicaid.		

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 15 visits per calendar year for individuals ages 21 and over. The provider must complete and submit **SFN 481** to ND Medicaid, prior to the member's receipt of additional services. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed is:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals;
- New long-term goals.

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals;
- Progress;
- Reasonable new goals;
- Maintenance care.

If the services are determined necessary to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

NONCOVERED SERVICES

- Physical therapy that is provided without a prescription from a physician;

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- Services for contracture that are not severe and do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Bowel and bladder retraining programs;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary as part of a re-certification process;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's individualized education plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Physical therapy services provided in a nursing facility or ICF/MR. Medicaid pays for those service through the rate established for the facility;
- Maintenance therapy.

PHYSICIAN SERVICES

ND Medicaid covers medically necessary services provided by physicians enrolled with ND Medicaid. Physicians must receive an individual provider number even if the physician is a member of a group, clinic or is employed by an outpatient hospital or other organized health care delivery system that employs physicians.

SERVICES

Services that may be provided by a physician are not restricted to a specific place of service unless specified by a CPT code description. Physicians may provide services in the member's home, a nursing home, outpatient hospital, inpatient hospital, etc. Physicians may not bill separately for performing administrative or medical functions that are reimbursed through an institution's per diem rate.

In order to be a covered service, the health service must be medically necessary. A service that is medically necessary is a service that:

- Is recognized as the prevailing standard or current practice by the provider's peer group; and
- Is provided in response to a life-threatening condition or pain; or to treat an injury, illness or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
- Is a preventative health service.

PREVENTATIVE HEALTH SERVICES

Preventive health services are services provided to a member to avoid or minimize the occurrence of illness, infection, disability or other health conditions. Preventive health services are covered when the following conditions are met:

- The service is provided to the member in person;
- The service affects the member's health condition rather than the member's physical environment;
- The service is not otherwise available to the member without cost as part of another preventive health program funded by a government or private agency;

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- The service is not part of another covered service;
- The service minimizes an illness, infection or disability that will respond to treatment;
- The service is generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness;
- The service is ordered in writing by a physician and included in the plan of care approved by the physician.

Services that are not covered as preventive health services:

- Services that are only for a vocational purpose or an educational purpose that is not health related;
- Services dealing with external, social or environmental factors that do not directly address the member's physical or mental health;
- Annual exam ordered by a group home with a routine diagnosis;
- Preventive health counseling that is provided to a member to promote health and prevent illness or injury.

INCIDENTAL SURGICAL PROCEDURES

Incidental surgical procedures performed at the same time as other major surgery is not a billable item and ND Medicaid will not pay separately for these procedures. The removal of healthy tissue organs is not a covered service. Organ removal from a living donor to a member is considered part of the transplant procedure.

ADDITIONAL SURGICAL PROCEDURES

Additional medically necessary surgical procedures performed at the time of a major medical procedure are covered at a reduced rate.

The medical reason for the surgery must be substantiated with an ICD-10-CM code supported with documentation in the member's medical record.

CONCURRENT CARE

Concurrent care services are those provided by more than one physician when the member's condition requires the service of another physician. If a consulting physician

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subsequently assumes responsibility for a portion of patient management, they provide concurrent care.

ND Medicaid reimburses concurrent care when the medical condition of the member requires the services of more than one physician. Generally, a member's condition that requires physician input in more than one specialty area establishes medical necessity for concurrent care.

ND Medicaid will not pay for concurrent care when:

- The physician makes routine calls at the request of the member and family or as a matter of personal interest; or
- Available information does not support the medical necessity or concurrent care.

When the member's condition requires concurrent care, each physician providing services identifies their services by entering the CPT code and his/her NPI and taxonomy code on the claim form.

PROLONGED CARE

ND Medicaid covers prolonged services involving direct (face-to-face) patient contact. ND Medicaid does not cover prolonged services that do not involve providing direct (face-to-face) care. The only time that operative standby services would be covered is in the case of a documented existing risk or distress, such as documented fetal distress.

TELEMEDICINE

See Services Rendered via Telemedicine chapter for additional information.

ONCOLOGY DRUG TRIALS

ND Medicaid will pay for chemotherapy when administered via a protocol that is registered with one of the main regional oncology research organizations provided the FDA has approved each medication in the regimen. FDA approval can be for any indication. If any chemotherapeutic agent in the regimen is not FDA approved, the entire treatment will not be paid.

If the member has a primary payer, the primary payer must be billed before requesting payment from ND Medicaid. If the primary payer denies coverage of the product because they consider the use "experimental", ND Medicaid will also deny the claim.

OTHER COVERED PHYSICIAN SERVICES

Laboratory Services: Refer to the Laboratory, Radiological and Diagnostic Services manual for specific information regarding laboratory, radiologic, diagnostic services, laboratory handling fees and specimen collection fees.

When a physician or physician clinic is billing for services performed and the equipment used is owned by the physician or clinic, the service should not be separated into a technical and professional component. Bill the appropriate CPT code but do not add a modifier to the code separating the professional and technical components.

NONCOVERED SERVICES

ND Medicaid does not pay for noncovered services including:

- Care plan oversight services;
- Team conference without patient present;
- Telephone calls, including telephone consultations;
- Preventative medicine counseling;
- Advance care planning.

PRIOR AUTHORIZATION FOR OUT OF STATE SERVICES

WHAT ARE OUT OF STATE SERVICES

Out of state services are care or services rendered by a provider that is located more than fifty statute miles outside of North Dakota. An out of state provider may be an individual or a facility but may not be located outside the United States.

MEDICAID COVERED SERVICES FOR OUT OF STATE CARE

Service provided to a ND Medicaid member by an out of state provider must be medically necessary and be a billable Medicaid service. The provider of the service must be enrolled as a ND Medicaid provider and abide by all program provisions. In addition, out of state providers may receive payment only under the following circumstances:

- The health service has received prior authorization from ND Medicaid;
- The health service is provided in response to an emergency while a member is out of the state; or
- The health service is provided to a Non-Title IV-E child for whom North Dakota makes adoption assistance payments through the state Adoption Subsidy Program, or state foster care payments.

REQUESTING OUT OF STATE MEDICAL SERVICES

The member's North Dakota primary care provider and/or North Dakota specialty provider must submit a written request to ND Medicaid for authorization of each out of state service at least two weeks before scheduling an appointment.

Requests must include a SFN 769 Request for Service Authorization of Out-of-State Services, indicating:

- Member's name, date of birth and Medicaid number;
- Diagnosis;
- Reason for out-of-state care;
- The in-state primary care provider and/or specialist;
- The out-of-state physician and/or the facility being referred to;
- Current (within three months) medical information supporting the need for out-of-state services;

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- A written second opinion from an appropriate in-state board certified (?) specialist; and
- Assurance that the service is not available in North Dakota.

Upon receipt of the above information, ND Medicaid will determine if the referral meets state requirements and denies or approves the request in writing to the requesting in-state provider(s), member, out of state provider(s) and county social service office. Payment for out of state services is dependent on an approved prior authorization. The county social service board is responsible for assisting members with travel, lodging and meal arrangements.

ADOPTION AND FOSTER CARE

Children residing out of state and receiving a state funded adoption subsidy may be eligible for Medicaid until the age of 26. The child may be eligible to receive Medicaid in his/her state of residence through the provisions of the Interstate Compact on Adoption and Medical Assistance (ICAMA). When moving out of state, the adoptive parent is to notify the county social service office administering their subsidy payment of their move. If the residence state has facilitated joinder in the Interstate Compact and gives reciprocity to other member states, the child will qualify for Medicaid in the state of residence. The state of residence is then notified of the child's eligibility for Medicaid through the ICAMA notification process. This is done through the state office, Children and Family Services Division. If the child is not eligible for Medicaid in the residence state, they may continue to receive Medicaid through North Dakota. It is the responsibility of the adoptive parents to approach the out of state provider about enrolling in Medicaid. Children in out of state placements with Title IV-E adoption subsidy or foster care payments are eligible for Medicaid in the state in which they reside. This includes temporary foster care placements. For children with a North Dakota subsidy agreement, funds for services not covered by the Medicaid program may be available through the subsidy program.

The costs of foster care placements not covered by the Medicaid program are reimbursed by a public agency and/or family. However, if the child is placed in a foster care setting, such as a treatment center, is eligible for Medicaid, out of state providers must enroll as a North Dakota provider in order to bill for covered services.

OUT OF STATE EMERGENCY SERVICES

Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to North Dakota Medicaid review. The transferring facility must notify North

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Dakota Medicaid within 48 hours of transfer. Documentation must include: a completed SFN 769 Request for Service Authorization for Out-of-State Services, date of transfer, mode of transportation and medical documentation, including the discharge summary. The in-state facility must provide medical evidence for the need for air ambulance whenever it is used.

When a member receives emergent medical or surgical care when traveling outside of North Dakota, the out-of-state facility must submit the admission history and physical and discharge summary to North Dakota Medicaid for review to determine the medical necessity of the service.

TRAUMATIC BRAIN INJURY (TBI) PROGRAM

Out of state placement for an individual with a traumatic brain injury into a specialized program requires the referral source to send a written request for prior authorization for out of state services. Requirements include:

- A letter of medical necessity from the attending physician;
- Complete documentation of clinical history;
- Treatment and test results;
- A listing of past placements and placement date; and
- Information regarding attempt to place in state.

The clinical information furnished by the referral source will be reviewed to determine if out of state placement is appropriate and medically necessary. If approval is granted, ND Medicaid will send an approval notice.

If the placement is a Minnesota nursing facility specializing in TBI, an out of state placement is not required. However, the admitting Minnesota nursing facility must obtain a level of care determination from the Department's current contractor. Information regarding level of care procedures and screening forms are available at www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html.

OUT OF STATE PSYCHIATRIC SERVICES FOR CHILDREN UNDER 21

Out of state psychiatric placement for children under 21 requires prior approval by ND Medicaid. A North Dakota agency requesting out of state placement for a child under 21 must validate the unavailability of appropriate placement in North Dakota. The referring agency must be able to substantiate that:

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- Treatment options within North Dakota have been provided with little to no improvement in the child's behavioral disorder (e.g., outpatient, acute inpatient, residential treatment centers); and
- The child has been denied admission to available North Dakota facilities; or
- The program out of state is so unique that similar services are not available in North Dakota and previous treatment attempts have failed.

After ND Medicaid approval and prior to the child's admission, the out of state facility must complete an admission review with the department's current contractor to assure the child's cares and conditions meet the minimum medical necessity of North Dakota's certificate of need (CON) criteria. Additional information and CON forms are available in the manuals for children under 21 located on the web at

www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html

EMERGENCY SERVICES FOR MEMBER'S TEMPORARILY OUT OF THE STATE/COUNTRY

In certain circumstances, health care coverage may be available for a member who is temporarily traveling outside of North Dakota and the local trade areas or outside of the United States and who remain eligible for Medicaid. If a member receives medical care, the out of state provider must enroll as a ND Medicaid provider in order to receive payment for services provided. The provider must submit supportive medical reports.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

ND Medicaid covers services provided by Psychiatric Residential Treatment Facilities (PRTFs) that are licensed and enrolled with North Dakota (ND) Medicaid.

CERTIFICATE OF NEED

ND Medicaid will not cover PRTF services unless the member meets certificate of need criteria.

IN-STATE PRTFs

The rate established for in-state PRTFs is an all-inclusive rate for routine services. Routine services include supplies, therapies, personal supplies, equipment, transportation and non-legend drugs. Separate billings for these items will not be paid. Enter only the room and board charges. Do not enter ancillary charges.

OUT-OF-STATE PRTFs

The rate for out-of-state PRTFs is based on the rate for comparable services established by the Medicaid agency in the state where the facility is located.

Before a child can be considered for placement in an out-of-state PRTF, the following information must be submitted to ND Medicaid:

- Current diagnosis and combined symptoms that indicate why in-state PRTFs are unable to meet the treatment needs;
- How will the out-of-state PRTF meet the treatment needs of the child;
- Written denials from all in-state PRTFs;
- Current documentation from any inpatient psychiatric placement or outpatient therapy; and
- Name of ND Medicaid enrolled provider (facility) and contact individual.

The request and all supporting documentation must be faxed to (701)-328-1544.

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BILLING GUIDELINES

Claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code **110**

In-House Medicaid Days

Revenue Code **183**

Leave Days

Leave days are noncovered days. Payment is not available for any day that a member does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance has paid for the charges. This allows the system to start applying member liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

REHABILITATIVE SERVICES

Rehabilitative services are designed to provide a group of needed mental health services to Medicaid members in order to restore these individuals to their highest possible functioning level. Rehabilitative services are limited to individuals in families that are in crisis with risk of major disruption, to individuals who are at risk of entering or reentering a mental health or hospital facility, services provided to individuals who have discharged from inpatient psychiatric treatment and services provided by Human Service Center (HSC) staff, that are not otherwise other licensed practitioners, in settings outside the HSC.

COVERED SERVICES

Rehabilitative services include behavioral intervention services that consist of developing and implementing a regimen that will reduce, modify or eliminate undesirable behaviors and/or introducing new methods to induce alternative positive behaviors and management including improving life skills. Specific services are available on the fee schedule at [Medicaid Fee Schedules](#).

Services rendered must be within the enrolled practitioner's scope of practice. Providers enrolled to render rehabilitative services are not allowed to bill service codes outside of those noted above. Providers interested in seeking the ND Medicaid's approval for additional codes must submit the following form <http://www.nd.gov/eforms/Doc/sfn00905.pdf>

Medicaid-eligible children under EPSDT are able to receive these and all other medically necessary services.

Rehabilitative services must be provided to, or directed exclusively toward, the treatment of the Medicaid member.

There is no duplication of billed services.

Rehabilitative services do not include:

- Room and board;
- Services provided to residents of institutions for mental disease;
- Services that are covered elsewhere in the State Medicaid plan;
- Educational, vocational and job training services;
- Recreational and social activities;

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- Habilitation services; or
- Services provided to inmates of public institutions;
- Services rendered in schools as part of a child's Individualized Education Program.

MEMBER ELIGIBILITY FOR SERVICES

The following requirements must be met before rehabilitative services can be provided through the Medicaid program:

- The member must be eligible for the Medicaid program.
- Other than *Screening, Triage, and Referral Leading to Assessment, Behavioral Assessment, Crisis Intervention and Forensic Interview*, the service must be recommended by a practitioner of the healing arts within the scope of their practice under state law.
- The member must be in need of mental health or behavioral intervention services that are provided by qualified entities.
- The member must have a mental health disorder, and must:
 - Be at risk of entering or reentering a mental health facility or hospital and demonstrate a score of moderate or above based on the WHODAS 2.0; or
 - Be from a household that is in crisis and at risk of major dysfunction that could lead to disruption of the current family makeup; or
 - Be in family that has experienced dysfunction that has resulted in disruption of the family.

PLAN OF CARE

Each member should have a primary point of contact at the entity. The primary point of contact should be delineated and easily identifiable in the member's plan of care. The minimum contents for the plan of care are:

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting

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- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of member
- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners that are providing care/services to the member
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

PROVIDER QUALIFICATIONS

Individual practitioners must meet the qualifications in the Provider Qualifications table and must be employed by an entity that has a provider agreement with ND Medicaid. The practitioner is responsible for ensuring services are allowed to be provided within their scope of practice and is responsible for maintaining the individual qualifications outlined in the Provider Qualifications table.

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Provider Qualifications

Provider Types	Licensure/ Certification Authority	Education/ Degree Required	Position requires Supervision Y/N	Position Supervises others Y/N
Licensed Addiction Counselor, Clinical Addiction Counselor, or Master Addiction Counselor (only for Behavioral Health Counseling and Therapy)	Requires licensure as an Addiction Counselor, Clinical Addiction Counselor, or Master Addiction Counselor by the ND Board of Addiction Counseling Examiners.		Supervision requirements dictated by ND Board of Addiction Counseling Examiners.	Supervision requirements dictated by ND Board of Addiction Counseling Examiners.
Licensed Exempt Psychologist	Eligibility for licensure exemptions as determined by the ND Board of Psychologist Examiners.		Yes-supervision is provided by a Licensed Clinical Psychologist	No
Behavior Modification Specialist		Master's degree in psychology, social work, counseling, education, child development and family science or communication disorders. Or a bachelors' degree in one of the above fields and two years of work experience in the respective discipline.	Supervised by Licensed Clinical Psychologist, or a clinician in one of the identified eligible professions in the preceding column with at least two years' experience.	No
Licensed Social Worker enrolled prior to November 1, 2018. After November 1, 2018, only enrolled to provide Behavioral Health Counseling and Therapy and Skills Integration.	Licensure as LSW by the ND Board of Social Work Examiners.		The LSW is supervised by an LICSW, LCSW or LPCC.	No
Licensed Certified Social Worker	Licensure as LCSW by ND Board of Social Work Examiners.		No	Yes. May supervise LSW.

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Registered Nurse	Licensure as a Registered Nurse by the ND Board of Nursing.		No	Yes. The RN may supervise Mental Health Technicians.
Licensed Professional Counselor	Licensure as LPC by the North Dakota Board of Counselor Examiners.		No	May supervise less experienced LPCs.
Licensed Associate Professional Counselor, if enrolled prior to November 1, 2018. After November 1, 2018, will only enroll to provide Forensic Interview, Behavioral Health Counseling and Therapy and Intensive In-Home for Children.	Licensure as LAPC by the ND Board of Counselor Examiners.		No	No
Mental Health Technicians	Certification as a Mental Health Technician.	Requires a high school degree or general equivalency diploma (GED).	Requires supervision by a licensed practitioner within their scope of practice.	No

RECIPIENT LIABILITY

Medicaid is a health care program for qualifying North Dakotans with lower incomes. Some people may qualify for full Medicaid benefits while others may be responsible for a part of their medical bills. This is called recipient liability or client share.

Recipient liability is the monthly amount a person must pay in medical bills before the Medicaid program will pay for care received. It works like a monthly deductible.

The recipient liability amount is based on the difference between an individual's or family's monthly net income and the Medicaid income limits.

Certain medical costs such as health insurance premiums, Medicare premiums, and co-pays can be used to lower an individual's monthly recipient liability if he or she submits proof to their county eligibility worker.

Each month, Medicaid applies an individual's recipient liability to medical bills based on the order in which the bills are presented and approved. When the recipient liability is used up, Medicaid begins to pay.

When a recipient liability is applied to a medical bill, Medicaid sends a notice to the individual showing the provider's name, and the cost and date of the services. The individual is responsible for paying the recipient liability to the provider(s) listed on the notice.

Based on the amount, the recipient liability may be applied to one or more medical providers.

Most of the time, Medicaid is the payer of last resort. In other words, if an individual has other medical coverage, that coverage would have to pay for the medical bills before Medicaid would pay.

REVIEW BY QUALITY HEALTH ASSOCIATES

OVERVIEW

The Department of Human Services (DHS) contracts with Quality Health Associates (QHA) to perform reviews and prior authorizations of services provided by participating hospitals to ND Medicaid members. These include hospitals located within 50 statute miles of the North Dakota border.

ND Medicaid requires a service authorization and a retrospective review of various procedures for all North Dakota hospitals as part of its utilization and quality control measures.

PREAUTHORIZATION PROCESS

The following procedures require preauthorization:

- cosmetic surgery
- obesity procedures
- breast reconstruction
- facial procedures
- ear procedures
- nose procedures
- eye procedures

QHA will also review all of the above procedures (principal or secondary) retrospectively on an inpatient or outpatient basis.

Preadmission and pre-procedure review are a responsibility of QHA and the practicing physicians of North Dakota. The areas of required review listed above are identified to the state and will not be paid unless the claim denotes review has been performed and the admission is necessary and the setting is appropriate. The primary responsibility of initiating preadmission review rests with the admitting physician or his/her designee.

- Physicians or their designees are encouraged to review and be familiar with the required areas of review. When a physician decides to schedule a procedure/admission either inpatient or outpatient, which is within the identified areas of review, he/she or other designated personnel should mail the required information to QHA. Minimal information to include for QHA review consists of:
 - Patient information (Medicaid ID, Name, Address, Age)
 - Dates of Service (Admission/Procedure dates)
 - Contact person (Name, Phone Number)

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- Procedure to be performed (complete narrative of the procedure and CPT/ICD-10-CM code if available)
- Physician name, North Dakota license number and NPI
- Provider name and number of the facility where procedure is being performed
- Criteria (utilize criteria in QHA's manual)
- Supportive documentation which must consist of, but is not limited to medical history, previous treatment, and present treatment.
- QHA cannot approve an admission or procedure if the data is incomplete. QHA recommends that the information be submitted prior to the scheduled admission or surgery date. A request for cosmetic surgery must be submitted two weeks prior to the surgical procedure and four weeks must be allowed for obesity procedures.
- The QHA case review coordinator (CRC) needs the necessary patient, physician, outpatient, or hospital information and will require medical indications for the admission or surgical procedure as appropriate. When the CRC is able to determine that the criteria is met based on the information received, the following will occur:
 - The admission is authorized for payment. The admitting physician will need to wait for the QHA preadmission authorization form to admit the patient or perform the procedure.
 - A computer generated form identified as a "Request for Preadmission/ Pre-procedure Review" is then completed by the CRC and copies are mailed to the admitting physician and hospital or hospital outpatient department within one business day.
 - Upon receipt of the authorization form, the hospital or hospital outpatient department should maintain the document with the medical record. The QHA authorization number must be included on the UB-04 or CMS-1500 billing form to assure payment. The QHA authorization number is verified, and if not valid, the claim will be denied until corrected, and/or retrospectively reviewed by QHA.
- When the CRC is unable to approve the admission or procedure, the CRC contacts the Physician Reviewer (PR) to discuss the case. The PR subsequently contacts the admitting physician and provides an opportunity to discuss the case. If the PR approves the case, the CRC is informed and the review is completed.
- If the PR, after consultation with the admitting physician, determines that the admission or procedure is inappropriate or not medically indicated, or is not at the appropriate level, the admitting physician will be informed in writing that the

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proposed admission or procedure is not authorized and a letter of adverse determination will be issued. The admitting or attending physician may then:

- Perform the procedure in an outpatient setting if the PR determined that the procedure could be safely performed on an outpatient basis;
- Cancel the procedure if medical necessity was not determined. If the attending or admitting physician chooses to proceed, he/she may admit the patient or perform the procedure. Upon receipt of denial for payment, the admitting or attending physician may request a reconsideration from QHA.

RURAL HEALTH CLINICS (RHC) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

ND Medicaid covers services provided by Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC) that are certificated from the Center for Medicare and Medicaid Services and enrolled with ND Medicaid.

COVERED SERVICES

Payment to RHCs and FQHCs for covered services furnished to ND Medicaid members is made by means of an all-inclusive rate for each encounter. Each encounter includes covered services by a medical professional and related services and supplies.

For RHCs and FQHCs, the term “encounter” is defined as a face-to-face visit between the member and one or more of the following medical professionals during which an RHC/FQHC service is rendered:

- Physician
- Physician Assistant
- Nurse Midwife
- Visiting Nurse
- Nurse Practitioner

For FQHCs only, a visit may also include a separately billable medical nutrition therapy visit or a diabetes outpatient self-management training visit.

An encounter for other health reasons is a face-to-face visit between a member and a qualified mental health professional such as a clinical psychologist or clinical social worker.

Dental services may also be provided at an FQHC. Dental visits are reimbursed by means of an all-inclusive rate for each encounter. Each encounter includes covered services and supplies.

Behavioral health services may also be provided at an FQHC. Behavioral health visits are reimbursed by means of an all-inclusive rate for each encounter.

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Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

- After the first encounter, the member suffers an illness or injury requiring additional diagnosis or treatment; or
- The member has more than one type of visit: a medical visit, other health visit or a dental visit.

When submitting claims for more than one encounter on the same day at a single location, the facility must bill the correct revenue code for each encounter and include the appropriate diagnosis codes (when applicable) on each claim.

VACCINES

ND Medicaid will cover injections and/or the administration of the injection if these services are billed alone using revenue code 771 (immunization alone) with an appropriate CPT code. These services cannot be billed with the revenue codes below or ND Medicaid will reimburse only the visit as the injection services are considered as part of the visit.

ND Medicaid will cover the immunization administration of vaccines within the scope of the Vaccine for Children (VFC) program. ND Medicaid will not cover the cost of pediatric vaccine materials.

Other vaccines currently covered by ND Medicaid, but outside the scope of the VFC program, will continue to be reimbursed according to the Medicaid fee schedule using the appropriate CPT codes. For further information, refer to the immunizations guidelines.

PRIMARY CARE PROVIDER (PCP) DESIGNATION

While RHC and FQHC can be designated as a PCP these facilities cannot be used as a referring physician on claims. Referrals from these clinics must contain an authorization of the referral (signature, initials) from a physician associated with the clinic or a supervising physician of the clinic.

Primary care provided by a colleague of the designated PCP (same clinic and same specialty) does not require a referral from the PCP. Services that require a referral,

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even in the same clinic as the PCP, must have a referral from the PCP if payment is expected.

BILLING GUIDELINES

Claims must be submitted using the following *Revenue Codes* when billing for:

Revenue Code 512	Dental Clinic (FQHC only)
Revenue Code 521	Clinic Visit by Member to RHC/FQHC
Revenue Code 522	Home Visit by RHC/FQHC Practitioner
Revenue Code 524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility (SNF)
Revenue Code 525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) of NF or ICF MR or other residential facility
Revenue Code 529	Behavioral Health (FQHC only)

SPEECH-LANGUAGE PATHOLOGY

A speech-language pathologist is an individual possessing a master's degree or its equivalent in the area of speech-language pathology or audiology and is licensed to practice in the state in which the individual provides services. The speech-language pathologist must adhere to applicable state requirements established for speech-language pathology.

COVERED SERVICES

Speech-language pathology includes diagnostic, screening, preventative, consultative or corrective services provided by or under the directions of a speech-language pathologist.

Speech-language pathology services must relate directly and specifically to a written treatment regimen established by the physician, after any needed consultation with the qualified speech-language pathologist, or by the speech-language pathologist providing services.

The following must be documented in the member's plan of care:

- The member's medical diagnosis and any contraindications to treatment;
- A description of the member's functional status;
- The objectives of the speech-language pathology service;
- A description of the member's progress toward the objectives.

The member's physician must sign the plan of care. Recertification of the treatment plan must occur at 60-day subsequent intervals from the date of the initial evaluation or first encounter.

Speech-language pathology includes services necessary for the diagnosis and treatment of speech, hearing and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphasia) regardless of the presence of a communication disability.

The following is a list of ND Medicaid covered CPT codes for speech-language pathology services.

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92507	Treatment of speech, language, voice, communication, and / or auditory processing disorder; individual
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	with evaluation of language comprehension and expression (e.g., receptive and expressing language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and / or oral function for feeding
G0153	Services performed by a qualified speech-language pathologist in the home health setting

NONCOVERED SERVICES

- Speech-language pathology that is provided without a prescription from a physician;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary as part of a re-certification process;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's individualized education plan;
- Speech-language pathology services provided in a nursing facility or ICF/IID. ND Medicaid pays for those services through the rate established for the facility;
- Maintenance therapy.

SERVICE AUTHORIZATIONS

For individuals ages 21 and over, a service authorization is required for services exceeding the limit of 30 visits and one evaluation per calendar year. The provider must complete and submit **SFN 481** to ND Medicaid, prior to the member's receipt of additional services. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed is:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals;
- New long-term goals.

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals;
- Progress;
- Reasonable new goals;
- Maintenance care.

If the services are determined necessary to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

ND Medicaid will not pay for services that are provided without submitting required information.

SURVEILLANCE UTILIZATION REVIEW SECTION (SURS)

THE FUNCTION OF SURS

The Surveillance/Utilization Review Section (SURS) is dedicated to carrying out program integrity functions and is a federally mandated program that conducts reviews to safeguard against unnecessary and inappropriate use of Medicaid services. The Code of Federal Regulations 42 CFR § 456.3 stipulates that each state Medicaid agency utilize a surveillance and review process to protect the integrity of the program. The purpose of this requirement is to avoid unnecessary costs to the program due to fraud, waste or abuse and assure that eligible members receive quality and cost effective medical care.

The SURS unit is governed by North Dakota Administrative Code Chapter 75-02-05.

TYPES OF REVIEWS

The SURS staff conducts preliminary studies which may include but are not limited to ad hoc reviews, member or provider analysis, focused quarterly reviews, compliance reviews and investigations in instances of suspected fraud.

Provider and member reviews are a necessary and routine function conducted by the Program Integrity Unit. While the methods for reviews may vary, the desired outcome is always to identify areas that may warrant more attention.

Reviews and/or investigations may lead to sanctions, recoupments, referral to law enforcement or other penalties per North Dakota Century Code 50-24.1-36 and NDAC 75-02-05.

Some reviews may reveal an error caused by an unknown billing system issue or human error with the provider. These types of situations generally reveal no intent to defraud the Medicaid program.

If the above mentioned errors caused an overpayment, SURS will begin the process of recouping the overpayment.

PROVIDER OBLIGATIONS

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A provider is required to release information to ND Medicaid as part of the Medicaid Provider Agreement form. The Provider Agreement form (SFN 615) can be found at www.nd.gov/eforms. The form specifies that as part of the provider agreement to participate in the Medicaid Program, the provider agrees to, upon reasonable request, release information needed to support the services billed to ND Medicaid.

ND Medicaid is a covered entity under HIPAA and is acting within its authority to request documentation. Providing the requested documentation is not a HIPAA violation. 45 CFR §164.506 speaks to the uses and disclosures to carry out treatment, payment, or health care operations. Additionally, 45 CFR § 164.512(d) permits the disclosure of Protected Health Information to a health oversight agency. ND Medicaid is considered a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; license or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight.

42 CFR § 456.23 speaks to the ND Medicaid's authority to conduct a post payment review. North Dakota Administrative Code 75-02-05-04(2) speaks to provider responsibilities which includes providing documentation upon request.

In addition, 42 CFR § 431.107(a)(2), Required Provider Agreement, speaks to providing information regarding payments claimed by the provider for furnishing services.

KEY POINTS

- The provider is ultimately responsible for their documentation and accurate billing of services which includes but is not limited to diagnosis codes, healthcare common procedure coding system (HCPCS), current procedural terminology (CPT) and procedure coding system (PCS).
- SURS is entitled to recover payments made to providers when a claim was paid incorrectly for any reason.
- Reviews may be subject to five years of claims history except in instance of a credible allegation of fraud in which there is no limitation on reviews.
- SURS may withhold payment, suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid provider agreement, federal and state laws, regulations and policies.

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- A prior authorization does not guarantee payment; a claim may be denied or money paid to providers may be recovered even if a prior authorization was obtained.

SWING BED FACILITIES

ND Medicaid covers services provided by swing bed facilities who are licensed and enrolled with North Dakota (ND) Medicaid.

LEVEL OF CARE

ND Medicaid will not cover swing bed facility services unless the individual meets nursing facility level of care criteria.

BILLING GUIDELINES

Leave days are noncovered days. Leave day status is determined at midnight. Payment is not available for any period that a resident does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

Swing bed claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 110	In-House Medicaid Days (private)
Revenue Code 120	In-House Medicaid Days (semiprivate)
Revenue Code 160	Medicare Full Benefit Period Days
Revenue Code 169	Medicare Coinsurance Days
Revenue Code 183	Leave Days

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance (including Medicare) has paid for the charges. This allows the system to start applying recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make payment for swing bed services to the swing bed provider for a resident who is receiving hospice care. The hospice is paid the swing bed rate and the hospice is responsible for payment of the swing bed services provided to a Medicaid member. Once a member has elected hospice benefits, the swing bed provider may not submit a claim for services provided while the member is on hospice.

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ALL-INCLUSIVE RATE

The rate established for swing bed facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid. Only the room and board charges should be submitted on the claim, do not enter ancillary charges. Ancillary charges that are not included in the swing bed rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

SERVICES RENDERED VIA TELEMEDICINE

Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. Telemedicine involves two collaborating provider sites: an “originating site” and a “distant site”. The client/patient is located at the originating site and the practitioner is located at the distant site and provides those professional services allowed/reimbursed by ND Medicaid.

The totality of the communication of the information exchanged between the physician or other qualified healthcare professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

COVERED SERVICES

Qualified services for telemedicine must:

- Maintain actual visual contact (face-to-face) between the practitioner and patient.
- Be medically appropriate and necessary with supporting documentation included in the patient’s clinical medical record.
- Be provided via secure and appropriate equipment to ensure confidentiality and quality in the deliver of the service. Skype or other other devices or video conferencing platforms that are not secure are not acceptable or allowed to be used for telehealth services.

Use appropriate coding as noted in table:

Applicable Modifier(s)	GT; and 95	Via interactive audio and video telecommunication systems
Applicable Revenue Codes(s)	780	Telemedicine – facility charges related to the use of telemedicine
HCPCS Code(s)	Q3014	Telehealth originating site facility fee
Place of Service	02	Telehealth - the location where health services and health related services are provided or received, through a telecommunication system

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PAYMENT LIMITATIONS

Payment will be made only to the distant practitioner during the telemedicine session. No payment is allowed to a practitioner at the originating site if his/her sole purpose is the presentation of the patient to the practitioner at the distant site.

Payment will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional payment for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Payment is made for services provided by licensed professionals enrolled with ND Medicaid and within the scope of practice per their licensure only.

All service limits set by ND Medicaid apply to telemedicine services.

Except for noncovered services noted below, telemedicine can be used for services covered by Medicaid, and otherwise allowed, per CPT, to be rendered via telemedicine.

INDIAN HEALTH SERVICES AND TRIBAL 638 FACILITIES

Telemedicine services provided by an Indian Health Service (IHS) facility or a Tribal 638 Clinic functioning as the distant site, are reimbursed at the All-Inclusive Rate (AIR), regardless whether the originating site is outside the “four walls” of the facility or clinic.

NONCOVERED SERVICES

- Therapies provided in a group setting
- Store and Forward
- Targeted Case Management for High Risk Pregnant Women and Infants
- Targeted Case Management for Individuals in need of Long-Term Care Services

REFERENCE CITATIONS

42 CFR 410.78 - Telehealth services <https://www.law.cornell.edu/cfr/text/42/410.78>

Telemedicine coverage from Medicaid.gov
<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>.

THIRD-PARTY LIABILITY (TPL)

In 1986, federal law required state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid.

Providers must obtain information about a member's health care coverage from the member, the member's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits. Providers may also obtain an assignment of benefits from the member to ensure direct payment from the third party payer.

For Medicaid purposes, health insurance is defined as any third-party benefit that is available to the eligible Medicaid members for medical treatment and related services.

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS

Providers and Medicaid eligible members are required to follow the third party payer's policies and procedures to maximize the available benefit. If the third party payer applies a penalty because the member or provider did not follow the third party policies, ND Medicaid will not pay the penalty amount. If the third party payer does not pay anything on the claim because policy and procedures were not followed, ND Medicaid will not pay the claim.

Billing ND Medicaid and another third-party payer for the same service at the same time is considered a violation under Medicaid rules. Medicaid is the payer of last resort and can only be billed after the third party has paid its legal liability.

Specific prenatal and preventive pediatric care services billed to ND Medicaid within 90 days after the date the provider of these services has initially submitted a claim to the third-party payer will be denied.

Services for which payment has been denied by the third-party payer for reasons other than noncompliance may be eligible for ND Medicaid payment. Explanation of benefits (EOB) or other documentation must accompany the claim.

Payment received from accident liability insurers, i.e. auto, business and homeowners must be entered on the claim form in the space noted for insurance or other payments. The EOB or other documentation must be included with the claim.

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Medicaid covers co-pays to the extent that the third-party payment and the co-pay do not exceed the ND Medicaid allowed amount.

If the provider has third party information that is not on ND Medicaid's system, the provider must advise the Medicaid program by sending an EOB from the third-party payer. The provider must adequately identify the EOB by writing the provider number, member's name and Medicaid ID number on the EOB. If ND Medicaid has third party information that the provider is not aware of, ND Medicaid will supply the provider with adequate information for the provider to bill the third party if the third party payer is not known to the provider at the time of billing. The fax number to send an EOB when reporting third party information is (701) 328-1544, attention TPL Unit.

Providers are not allowed to bill the Medicaid member for any balances after payment is received from the third party and ND Medicaid. Medicaid payment is the last adjudication of the claim, and if there is a balance left after Medicaid has made a payment determination, this constitutes a write-off to the provider. Medicaid payment is considered payment in full, even if payment is zero.

Providers may bill a member to recover payments made by the third-party payer directly to the member.

Providers cannot refuse services because a Medicaid eligible member has third-party coverage. Providers cannot demand payment, and require the member to bill the third party, unless specific terms of the third party require that benefits be paid to the member. ND Medicaid may be billed only to the extent there is a member legal obligation to pay.

MEMBER COOPERATION WITH TPL BILLING

If a Medicaid member is non-cooperative or fails to cooperate with the third party payer, the provider may contact the applicable county social service office or the TPL Unit at 701-328-2347 or medicaidtpl@nd.gov for assistance.

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program consisting of women between the ages of 30 and 64 who:

- Are uninsured and not otherwise eligible for Medicaid;
- Have been screened for breast and cervical cancer through Women's Way under the Centers for Disease Control and Prevention's breast and cervical cancer early detection program and have been found to require treatment for breast cancer, cervical cancer, or a pre-cancerous condition relating to breast cancer or cervical cancer;
- Have family income below 200% of the poverty level; and
- Meet the residence citizenship, social security number, and inmates of public institutions requirements.

The earliest date of eligibility is the month of diagnosis, but not more than three months prior to the month of application. Eligibility can continue until the woman reaches age 65, is no longer a state resident, is admitted to a public institution, is eligible for Medicaid through a different category, becomes insured, or no longer needs treatment for breast or cervical cancer.

Eligibility for this group is determined by the Women's Way program of the North Dakota Department of Health and the Medicaid Eligibility Unit of North Dakota Medicaid.

Individuals determined to be eligible for Women's Way are entitled to receive the entire array of services permitted under the Medicaid program.

For more information call 1-800-44WOMEN or go to <http://www.womensway.net/>.