



# MEDICAID BULLETIN

North Dakota Department of Human Services  
Medical Services Division  
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Bismarck, ND 58505-0261

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PLEASE ROUTE TO BILLING CLERKS, INSURANCE PROCESSORS, SCHEDULERS AND OTHER APPROPRIATE MEDICAL PERSONNEL. PLEASE MAKE COPIES AS NEEDED.

## Upcoming Changes on Service Limits and Co-pays

The appropriation approved for the Department of Human Services for the upcoming biennium (2003-05) will not allow the Department to maintain the current level of services. In addition, the agency is not allowed to deficit spend; therefore, the Medicaid program staff reviewed services for areas where savings could be realized. This review considered current utilization of services and areas where limits and co-pays could be implemented.

### SERVICE LIMITS

**The following LIMITS will be effective for service dates on or after September 1, 2003. Limits apply to all Medicaid recipients, with exceptions noted.**

Physician visits ~ 12 per year;

Chiropractic manipulation visits ~ 12 per year;

Chiropractic x-rays ~ 2 per year;

Occupational Therapy Evaluation ~ 1 per year (code 97003 or 97004)

Occupational therapy ~ 20 visits per year; (*applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.*)

Psychological Evaluation ~ 1 per year (code 90001 or 90802)

Psychological therapy visits ~ 40 per year;

Psychological testing - four units (hours) per year (any combination of codes: 96100 through 96117)

Speech therapy visits ~ 30 per year; (*applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.*)

Speech evaluation – one per year (code 92506)

Physical therapy evaluation – 1 per year (codes 97001 and 97002)

Physical therapy visits ~ 15 per year; (*applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.*)

Eyeglasses for Individuals 21 and older ~ once every 3 years.

Eye exams for individuals 21 and older – once every 3 years

Authorizations in excess of the above limits may be granted by the Medicaid Utilization staff when medically necessary. As of September 1, 2003, if a recipient is over their allowed amounts of the above services, a prior authorization is required.

### COPAYMENTS

***In addition to the existing copayments, the following CO-PAYS will be effective for service dates on or after September 1, 2003. Co-pays***

***do not apply to children, pregnant women, and persons in institutions.***

- Increase Inpatient Hospital co-pay to \$75 per admission;
- \$1 co-pay for each radiology service;
- \$1 co-pay for each Lab service;
- Increase co-pays for FQHC/RHCs to \$3 per visit;
- \$2 co-pay for each Occupational Therapy visit;
- \$2 co-pay for each optometry visit;
- \$2 co-pay for each Psychological service;
- \$1 co-pay for each Speech Therapy visit;
- \$2 co-pay for each Physical Therapy visit;
- \$3 co-pay for each podiatry visit;
- \$2 co-pay for each Hearing Test visit;
- \$3 co-pay for each Hearing Aid dispensing;

**Increase in co-pay for non-emergent use of the emergency room**

In addition to the co-pays the Department has initiated, the 2003 Legislature passed a bill which requires the Department to assess a \$6.00 co-pay on all non-emergent visits to the emergency room. The intent of this increase is to encourage clients to use the emergency room for appropriate services.

This co-pay will become effective upon approval from the Regional CMS office. Please watch the remark section of the Remittance Advice notices for further details.

**Medicare recipients – Responsibility for Co-Pays**

**PLEASE NOTE:** Medicare recipients are not exempt from co-pays. All co-pays apply to Medicare recipients. The only time Medicare recipients are exempt from paying a co-pay is if they are in an institution.

**Status of Claims Payment (MMIS) System**

In April, the Department of Human Services transferred the first round of HIPAA programming changes to the Medicaid Management Information System (MMIS). The transition to this new code has not been smooth and we have been experiencing ongoing difficulties with the claims payment process.

The state Information Technology Department (ITD) has allocated additional staff members to assist in correcting the problems and help ensure payments are made accurately and timely.

Making provider payments continues to be a top priority of the Medical Services staff. Please refer to other articles in this newsletter on electronic filing of claims, reminders about scanned claims and important updates on billing. If claims are submitted electronically and correctly, the payment process can be more expeditious.

**HIPAA Update**

In an effort to facilitate the transition to the HIPAA-standard ANSI 4010A1 format, we have determined it is counter-productive to set up production tests with new submitters in the ANSI 4010 format.

The Department is nearing the final stages of developing and testing the ANSI 4010A1 HIPAA transactions. Upon completion of certification and thorough final tests of the 4010A1 HIPAA transactions, we will announce our readiness to begin production testing. Our current schedule is to have the 4010A1 transactions ready and in production by mid-September.

The Companion Documents for the ANSI 4010A1 837P and ANSI 4010A1 837I transactions will be available on our web site [www.state.nd.us/human\\_services](http://www.state.nd.us/human_services). In addition, agencies have access to the Trading Partner Agreement (TPA), Electronic Data Interchange (EDI) registration, and the Electronic Funds Transfer (EFT) form via the web. Once all of the forms have been completed and submitted, we will schedule the provider for transaction testing.

Though this current information is subject to change, the Department understands that providers need as much certainty as possible in planning for HIPAA implementation. Providers should check periodically for updates through

[www.state.nd.us/humanservices](http://www.state.nd.us/humanservices). We will give the providers advance notice when a date is set so they have time to make the necessary changes.

Until we have completed our entire process for receiving, testing and accepting production claims, and sending HIPAA compliant ANSI X12 transactions, you will need to continue to electronically file claims using the current method.

\*\* We encourage the use of electronic transactions and payment deposit. Filing claims electronically and receiving electronic payments helps reduce costs for processing claims and will help ensure more timely payments.

The Department of Human Services (DHS) is reviewing all areas of program administration in an effort to reduce our administrative operating expenses. One way you as a provider could help is reducing the use of clearinghouses for filing claims to DHS. Clearinghouses charge DHS up to \$.35 per claim, all of which could be saved, if you use your own purchased software and submit Medicaid claims through the Department's Web File Transfer solution.

[A list of software packages is available on the Medical Services web site.](#)

### **Reminder about reporting inappropriate use of ER services**

Please remember that Physicians need to report the names of Medicaid clients who repeatedly use the Emergency Room for inappropriate purposes. It is important for program integrity and to control program costs, that recipients use the ER for emergency purposes only.

To report a Medicaid client for misuse, please contact Ray Fiest at (701) 328-4024.

### **Medicare Billing Issues**

Since North Dakota Medicaid no longer accepts the Medicare crossover paper claims, there have been several issues raised and questions asked with regards to billing procedures.

1. QUESTION – How do we bill for Certified Registered Nurse Assistants (CRNAs)?

ANSWER - CRNAs may now enroll with ND Medicaid and bill on the HCFA-1500 for

inpatient services. They may continue to bill for services in an outpatient setting either on the UB-92 or the HCFA-1500 claim form. (see related article on CRNAs)

2. QUESTION – Will North Dakota Medicaid continue to pay for co-insurance or deductible charges?

ANSWER – The payment mechanism for crossover claims has changed. If the amount paid by Medicare exceeds the Medicaid allowed amount, no payment will be made.

3. QUESTION-How do we bill for institutional ambulance charges?

ANSWER- Ambulance charges must be billed on the HCFA-1500 claim form with the Medicare Explanation of Benefits attached.

4. QUESTION-Does Medicaid still require revenue code 259 (self-administered drugs) to be billed separately with the Medicare EOB attached?

ANSWER- After July 1, 2003, self-administered drugs code ( 259) will no longer be billed and paid separately. These items should be included on the original claim submitted to Medicare.

5. QUESTION- How do we bill for institutional services provided to Qualified Medicare Beneficiaries (QMB's)?

ANSWER- Charges for Qualified Medicare Beneficiaries(QMB) with Medicaid eligibility should be billed on the UB-92 claim form with the Medicare EOB attached.

6. QUESTION-Will Medicaid cover denied charges or non-covered items after Medicare?

ANSWER -Non-covered/denied charges by Medicare will be reviewed by the Department for determination of payment based on the Medicare EOB.

7. QUESTION-How do we bill for therapies performed in a Nursing Facility?

ANSWER- The co-insurance/deductible charges for therapy in a Nursing Facility are no longer covered services by Medicaid.

## **CRNA Billing**

The Department of Human Services has revised its policies relating to billing and payment procedures for Certified Registered Nurse Anesthetists (CRNAs) and has made changes relating to services that may now be paid separately from hospital payments for inpatient and outpatient services.

***As a result of this change, the Department finds it necessary to also revise our policy on CRNA enrollment in the Medicaid program. Effective July 1, 2003 all CRNAs have the option to directly enroll with the Medicaid program to bill for services or to bill services under a supervising physician's Medicaid provider number. The former option is consistent with Medicare and applies to CRNAs regardless of their employment status and to services provided in both inpatient and outpatient settings.***

As a reminder, when billing any CRNA services on a HCFA-1500, the appropriate modifier code, QX or QZ, must be used with the procedure code.

For more information on enrolling CRNAs please contact Provider Enrollment at (701) 328-4033. If you have questions regarding billing for CRNA services, please call Provider Relations at (701) 328-4030.

### **Your attention is needed regarding scanned claims**

When paper claims are submitted to our office, they are scanned into the system and then verified for various information pieces. We ask for your attention to detail when submitting claims, as this will not only reduce the number of claims that cannot be properly scanned, but will also reduce the claims that are suspended.

Please keep these important reminders in mind as you complete your paper claims:

Do **NOT** use red ink or any type of highlighter. The claims must contain either black or blue ink.

Make sure print is dark enough. Replace printer cartridges regularly.

If claims are handwritten, make sure it is legible. Any handwritten information has to be written dark enough otherwise it is too light after it is scanned.

Make sure the information is typed within the box and on the line.

Do **NOT** use labels with client name and account information. The scanner does not feed these claims correctly.

Do **NOT** submit claims with torn corners.

Ensure the Provider name on the claims matches the Provider name on file with the Department.

On 2-page claims, a TOTAL is needed on page 2 – Please leave the total blank on Page 1. For multi-page claims – all sections of each page must be complete.

### **Message on the Pharmacy Remittance Advice**

You will be noticing the code CR on the Pharmacy Remittance Advice (RA). When this code displays it means that the client has Medical Insurance that has not been reported to the Department. It is the responsibility of the pharmacy to report this insurance information to the Department.

Please ensure all insurance information is reported. It can be sent to the attention of Bev Locken at (701) 328-3507 or [solocb@state.nd.us](mailto:solocb@state.nd.us)

### **What is VERIFY? How do I use VERIFY?**

The VERIFY telephone numbers are 701-328-2891 or 1-800-428-4140. VERIFY can be used to obtain the following recipient information:

Eligibility  
Recipient Liability  
PCP or Lock-in Physician  
Co-Pays  
Third Party Liability  
Vision

### **Primary Care Physician (PCP) Billing Reminder**

When billing for a service for a recipient enrolled with a PCP, indicate the PCP on the original claim in block 17a on the HCFA-1500 or block 82 or 83 on the UB92. DO NOT attach referral letters to the claim or send them under separate cover.

Claims denied for no referral must be adjusted with a copy of the referral letter attached.

### **Reminder to Providers about By-passing Recipient Liability for Recipients in Long Term Care Facilities**

Many Medicaid recipients who reside in Long Term Care (LTC) facilities have a Recipient Liability (RL) that they must meet, before Medicaid benefits will be effective. Typically, this RL is met through the cost of the Long Term Care; therefore, when a LTC facility resident seeks provider services outside the facility, the system is designed to by-pass the RL for the outside service.

Occasionally, the entire RL is not maximized at the LTC facility and it becomes necessary for Medicaid to go back to the outside service provider to recoup the RL.

### **Sterilization**

We continue to experience problems with incorrectly completed sterilization consent forms. The federal government has issued **STRICT REQUIREMENTS** for the completion of the consent forms. If the requirements are not followed, the department **WILL NOT PAY** for the procedures involved with the sterilization. All claims for sterilization must adhere to the guidelines or they will be denied.

Please advise all staff involved with completing the consent forms of the following highlights from the requirements.

- A consent form must be attached to a paper claim form; electronic billings are not allowed for sterilizations.
- The patient must be 21 years old when the consent form is signed; not the next month or week or even the next day but at the time of signature.
- The statement by the person obtaining consent must be dated on or after the date the recipient signed the form, but prior to the surgery date.
- There must be a 30-day wait before the operation is performed and the surgery must be performed before 180 days have lapsed. Surgery has to be done from the 31<sup>st</sup> day to the 179<sup>th</sup> day. The only exception is for premature birth or emergency abdominal surgery which occurs at least 72 hours after the consent is signed.

- Under the physician's statement section, the operation date must be the same as the surgery date.
- The physician must sign and date the consent form on or after the surgery date.
- No changes or additions are allowed; if errors are made, a new consent form must be prepared prior to submission of the original claim to Medicaid. Submission of sterilization consent forms that show evidence of alterations in any of the dates or signatures will be subject to a fraud investigation.

When submitting sterilization claim forms, please keep the following in mind:

- All sterilizations require the V252 diagnosis code.
- On inpatient hospital claims a breakdown of sterilization charges is required in the remarks section on the UB-92 claim form.
- The consent form must be the Federal consent form.

### **INSTRUCTION FOR COMPLETION OF HYSTERECTOMY CONSENT FORM**

Following are the instructions for completing the *Physician Certification for Hysterectomy and Recipient Acknowledgment of sterility*, SFN 614, form.

**PLEASE NOTE:** If section A is completed by the physician, the recipient **MUST COMPLETE** and **SIGN** Section B. For recipients who are already sterile, Section C is to be completed by the physician. For hysterectomies completed in a life threatening circumstance, Section D is to be completed by the physician.

**SECTION A:** This section must be completed by the physician who is performing the hysterectomy. It is necessary to complete this section if the recipient will become sterile as a result of the surgical procedure and no life threatening circumstances existed at the time the procedure was performed. Enter the name of the recipient in the appropriate blank. The physician must sign and date the section, it is recommended, but not necessary that this section be signed before the procedure was completed.

**SECTION B:** This section must be completed by the recipient, or her representative, who will become sterile and incapable of bearing children as a result of the hysterectomy. A signature in this

section is not required if the recipient is already sterile or the hysterectomy was performed because of life threatening circumstances. It is recommended, but not necessary, that the recipient sign this section before the hysterectomy was rendered.

**SECTION C:** This section must be completed by the physician who performed a hysterectomy on a recipient who was already sterile at the time the hysterectomy procedure was rendered. Enter the name of the recipient in the appropriate blank. It is also necessary to state the reason for the sterility (post menopause, previous sterilization, etc). The physician must also sign and date this section if appropriate.

**SECTION D:** This section must be completed by the physician who performed the hysterectomy when a life threatening circumstance prevented the physician from advising the recipient that the hysterectomy would result in sterility. The use of this section is limited to those situations where due to the condition of the recipient and the need for immediate surgery the physician was prevented from informing the recipient about the results of the surgery. This section cannot be used in situations where it could be anticipated that a hysterectomy may be performed such as non-emergency exploratory abdominal surgery.

Enter the name of the recipient. It is also necessary for the physician to state the nature of the emergency which prevented obtaining acknowledgment that the hysterectomy would render the recipient sterile. It is also required that the physician sign and date this section if appropriate.

- The "ND Dept. of Human Services Hysterectomy consent form" must be used.
- We do not accept consent forms that are not attached to a claim form.
- The hysterectomy form can be completed before or after surgery.

### **Emergency Medical Transfers**

The North Dakota Medicaid policy pertaining to emergency medical transfers to out-of-state facilities, requires notification within 48 hours of the transfer.

The information may be faxed to NDMA (701-328-1544) and should include:

1. Recipient's name
2. Transferring physician or facility
3. Destination and date of transfer
4. Method of transfer
5. Discharge summary

Questions or concerns should be directed to Kay Dahl, Administrator, Quality of Care/Disability Programs at 701-328-1966.

### **Reminder about Collecting Recipient Liability (RL)**

Please remember, with the exception of Pharmacy providers, recipient liability (RL) can only be collected after payment is received from Medical Services.

An example: A patient receives an outpatient surgical procedure and their RL is \$200. The outpatient facility requires the recipient to pay the RL. After the procedure, the physician prescribes a medication, priced at \$100. When the recipient goes to have the prescription filled, the pharmacy provider will need to collect the \$100 RL, because pharmacy sales are real time transactions. As a result of the outpatient facility collecting the RL, when they shouldn't have, the recipient may not have the \$100 to pay for the RL at the pharmacy.

It is important that providers do not collect RL at the time of service as this may prevent clients from accessing necessary medications.

### **Medicaid billing Forms available on the internet**

THE FOLLOWING MEDICAID FORMS ARE AVAILABLE NOW ON THE INTERNET AT [WWW.STATE.ND.US/EFORMS/](http://WWW.STATE.ND.US/EFORMS/)

SFN 1115	DME PRIOR APPROVAL
SFN 634	PHARMACY CLAIM FORM
SFN 639	PROVIDER REQUEST FOR AN ADJUSTMENT
SFN 640	PHARMACY REQUEST FOR AN ADJUSTMENT

IF YOU DO NOT HAVE INTERNET ACCESS, YOU MAY REQUEST FORMS FROM:

ND DEPT OF HUMAN SERVICES  
MEDICAL SERVICES DIVISION

600 EAST BOULEVARD AVENUE  
BISMARCK, ND 58505-0250

**REMEMBER THAT DEPENDING ON WHICH FORM IS ORDERED AND THE AMOUNT ORDERED WE MAY REQUIRE A STREET ADDRESS FOR MAILING. BE SURE TO INCLUDE ANY INFORMATION THAT WILL GET YOUR ORDER TO YOU PROMPTLY. FORMS COULD TAKE 7-10 DAYS TO REACH YOU.**

**ALSO, PLEASE NOTE: The SFN 637, Medicare Crossover is obsolete. The HCFA 1500 (CMS 1500) will be used instead of the SFN 637. The UB-92 replaces the SFN 638, Medicare Crossover/Institutional. It is the responsibility of the Provider to supply the necessary HCFA or UB forms. These can be ordered through commercial printing companies.**

#### **Referrals from Rural Health Clinics and Federally Qualified Health Centers**

The Medicaid Primary Care Provider (PCP) program allows Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to be a PCP selection. This serves providers and patients by increasing access to primary care. The VERIFY system states the name of the individual physician, RHC or FQHC.

When a RHC or FQHC is a PCP, referrals for specialty care must come from the physician who supervises the facility or is associated with the facility. While nurse practitioners and physician assistants provide numerous and invaluable services in these facilities, they cannot authorize a referral. When a referral originates from a RHC or FQHC, all claims from providers of referral services must contain the Medicaid provider number or UPIN of the authorizing physician. The RHC, FQHC, nurse practitioner, and physician assistant Medicaid provider number the cannot be used on the claim.

#### **HCFA-1500 Reminders**

Box K needs to be filled out.

Box 29 needs to be filled out or the claim will be returned.

Attach an EOB to each claim. Do not group claims together with one EOB.

**Claims are being reviewed for appropriate coding including surgical, medical, facility fees,**

**bundling issues, modifiers etc. Please see the website for guidelines and limitations for billing Medicaid. New guidelines are added periodically.**

#### **Medicaid Billing Reminders**

To ensure proper reimbursement, please follow the guidelines below:

- **Bilateral procedures need to be billed on two lines.** The first line must be billed without a modifier. The second line would be billed with a 50 modifier. If you bill on one line with the 50 modifier, you will receive ½ payment for one instead of 1½.
- **Multiple procedures need the 51 modifier attached.**
- **Time** must be documented in notes or dictation for time based codes (ie: 99239, 99291, 99292 etc.) Documentation will be requested on all these codes. Time will be verified before payment is made.
- **Sequence modifiers** AS, AK, AL, 80, 50 in the first position and 51, RT, or LT in the second position.
- All **unlisted** procedures should be sent in on a paper claim with a report. If not, documentation will be requested for review.
- NDMA follows Correct Coding Initiative (**CCI edits**) and these should be complied with.
- Bill all services on one claim. Billing two surgeries on two separate claims will result in inappropriate payment and may cause unnecessary denials for the provider.
- **All claims with the 59 modifier will be reviewed.**
- **Assign diagnoses per line item.** Do not put 1,2,3,4 in box E of the HCFA-1500 form as our system will only pick up the first diagnosis and may cause denial if not appropriate.
- The combo-vaccine for Polio-D Tap-Hep B also called **Pediarix** is a VFC (state funded vaccine as of June 1, 2003). The code to use is 90723 with diagnosis V06.8. The XV modifier needs to be used if state supplied.
- NDMA requires modifiers AK, AL, and AU to be utilized on the nurse practitioner and physician assistant services (along with their own PIN number) in order for the system to pay correctly. We recognize these are not HIPAA compliant, and this should be corrected by the October implementation deadline.

NDMA requires modifiers AK, AL, and AU to be utilized on nurse practitioner and physician.

All new coding and billing guidelines can be found on our website:

[www.state.nd.us/humanservices](http://www.state.nd.us/humanservices)

### **Ambulatory Surgical Centers and Outpatient Centers**

**Effective – 8-1-02**

ND Medicaid will be utilizing the Medicare 2003 approved ASC procedures. Those not on this list will be reviewed for payment.

ND Medicaid will be reimbursing at 100%, 50%, 25%, 25%...etc. if different body areas, different sites, or done bilaterally.

If they are the same site or body area reimburse only one facility fee.

- **Dental procedures:** The mouth is considered one facility fee no matter how many procedures were done in the mouth. Ex. 21 teeth extracted = one facility fee not 21. If another procedure is completed at the same time in another body area then another facility fee would be allowed at ½ fee. (41899)
- **Nasal endoscopies:** The nose is considered one facility fee per side no matter how many procedures were done in the nose **unless** separate incisions are made. Ex. Bilateral sinus surgeries(31256, 31256-50, 31267, 31267-50) one facility fee at full fee for the right and one facility fee at ½ fee for the left.
- **If two procedures are done in the exact same area** (lesion removal and then closure of the defect or colonoscopy with biopsy and removal of polyp) only one facility fee will be allowed.

45378-45387 colonoscopies  
43235-43259 egd's  
12001 along with 11400

Tonsil with ear tubes  
43820 – full fee  
69436 – ½ fee  
69436 – ¼ fee

### Tooth extraction

41899 – 6 units

Allow only one facility fee (group 1)

### Nasal sinus surgery

31267 – full fee

31267 – ½ fee

31256 – no fee

31256 – no fee

### Nasal sinus surgery with septoplasty

\*30520 – full fee

31267 – ½ fee

31267 – ¼ fee

31256 – no fee

31256 – no fee

\*This needs to be a different incision

### Lesion removal & closure

11424 – full fee

12031 – no fee

## **TELEMEDICINE BILLING**

**CODE:** Q3014

**Reimbursement:** **\$20.00** which is for the use of the room and the technical set up of the equipment. The reimbursement is the same no matter if the telemedicine room is in the clinic, hospital or ER room. All sites are considered a clinic site of service.

- If a physician is present with the patient he/she can bill for the service he/she is providing. Any supplies that are used are to be provided by the physician doing the procedure even if not employed by the telemedicine facility.
- We currently accept the TM modifier to denote telemedicine services. By October 16, 2003, we will require the HIPAA compliant modifier, which is GT.
- If a separate long distance line charge is required for out-of-network sites, NDMA will reimburse the **actual cost** of the line from the phone company.

**Ex:** A physician from a private clinic doesn't have telemedicine available so he brings the patient to the hospital that offers this service. The private physician debrides a wound per recommendations of the telehealth consulting site. Instead of bringing the patient back to his clinic to debride, he debrides

him in the telemedicine room out of convenience. The hospital will not receive extra reimbursement for this service. The physician will be allowed the procedure performed. Any supplies used are included in the professional fee. The physician should either bring the supplies with him or contract with the hospital to pay for any supplies used. If this isn't possible then the physician should meet the patient at the clinic, after the telemedicine session, to have the debridement done.

**Misc. supplies (99070)**

This code should rarely be used. Most supplies are included in the procedure being performed or included in the E/M service given.

**Same Day Surgery**

Modifier SG is to be used for Same Day Surgery facility fees. Modifier 97 is invalid and will be denied as such.

**Dermabond**

When using Dermabond for wound closure **use the simple repair codes** instead of G0168. The Dermabond supply is included in the fee. **Do not** submit 99070 for the supply.

Please note guidelines are completed for some lab procedures.... more to come.

**Sterile Trays (A4550)**

The following is a reprint of the sterile trays allowed in the clinical setting:

G0105	37609	45383	52282
19101	38500	45384	52300
19120	43200	45385	52301
19125	43202	49080	52305
19126	43220	49081	52310
20200	43226	52005	52315
20205	43234	52007	57520
20220	43235	52010	57522
20225	43239	52204	58120
20240	43245	52214	62270
25111	43247	52224	85095
28290	43249	52234	85102
28292	43250	52235	96440
28293	43251	52240	96445
28294	43258	52250	96450
28296	45378	52260	52283
28297	45378-53	52270	52290
28298	45379	52275	
28299	45380	52276	
32000	45382	52277	

**NEW MEDICAL SERVICES STAFF**

Juli Johnson, Medical Claims Processing Supervisor, began her position in March of 2003. Prior to this, she was employed at Bismarck State College as an Administrative Assistant. In addition, she has 10 years of experience in claims processing and has an AAS in Medical.

Maggie Anderson, Assistant Medical Services Director, started with the agency in February 2003. Before joining the department, she worked for over 13 years with the USDA Nutrition Programs in the Department of Public Instruction.

**Botox and Myobloc Injections**

**Effective Immediately:** Prior Authorization for Botox and Myobloc injections will no longer be required if used under FDA approved indications. All off label uses are non-covered. Botox Cosmetic is a non-covered drug.