



MEDICAID BULLETIN

North Dakota Department of Human Services
Medical Services Division
600 East Boulevard Dept 325
Bismarck, ND 58505-0261

DAVID J. ZENTNER, DIRECTOR

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

Checkwrite Exception Dates

There are several dates for the remainder of calendar year 2005 where the regular checkwrite dates will be postponed. Typically, checkwrite occurs every Monday evening; however, there will be the following exceptions:

NO Checkwrite	Rescheduled Date
May 30	June 1
July 4	July 5
September 5	September 6
October 31	November 1
December 26	December 27

Medicaid Provider Manual on Website

The North Dakota Medicaid provider manual is now available on the internet:

1. Go to www.state.nd.us/humanservices/
2. On the left side of the screen, select "**Providers**"
3. On the 'Providers' screen, select "**Medical Services**"
4. If you agree to the 'End Users Agreement for Providers' select "**Accept**" at the bottom of the screen
5. On the 'Medicaid Provider Information' screen, select "**Provider Manuals**"
6. Under 'All Providers' select "**General Information for Providers - Medicaid and Other Medical Assistance Programs.**"

Information such as covered services, copayments and billing requirements are included in the manual. New information is being added to the manual on a monthly basis, as completed. The most recent information is posted on the website. Information for **Managed Care** providers is included from pages 74 to 95.

Pharmacy Prior Authorization Update

As most providers know, ND Medicaid may require prior authorization on certain medications upon recommendation from the Drug Use Review (DUR) Board. The Board consists of 6 physicians and 6 pharmacists for voting members, and they have recommended the following for the Department:

1. Prior authorize prescription anti-histamines and only cover if over-the-counter Claritin was not effective in the past two years.
2. Prior authorize prescription proton-pump inhibitors and only cover if the over-the-counter Prilosec OTC was not effective in the past two years. If Prilosec OTC (or Rx) wasn't effective, allow Protonix or Prevacid to be used. If those are not effective, then allow Aciphex or Nexium.
3. Prior authorize Brand Name Necessary prescriptions to encourage use of generics. Specifically, unless a patient has a documented (www.fda.gov/medwatch) adverse reaction to the generic medication, they cannot receive its brand counterpart. This obviously only applies to medications that have generics available.
4. Prior authorize all brand name NSAIDs (including COX-II's). Only approve brand name NSAIDs if the patient has failed two generic alternatives. Use of Prilosec OTC may be tried to offset stomach irritation of standard NSAIDs.
5. Prior authorize all brand name ACE-inhibitors (with the exception of Altace). Use of brand name ACE-inhibitors would be reserved for those patients that have tried and failed two different generic ACE-inhibitors. Trials would have to be at typical therapeutic doses for 30 days.

Anti-histamines and Proton Pump Inhibitors have been prior authorized for nearly a year. Costs for these categories are down 50% and 33%, respectively with no noticeable increase in other medical services. With continued direction from the DUR Board, we expect to continue to see good results.

The step-wise approach with PPIs (Prilosec OTC first, Protonix or Prevacid next, Aciphex or Nexium last) is effective immediately. Brand Name Necessary prior authorization will begin on April 5, 2005. Brand name NSAIDs/COX-II's will begin April 19, 2005. There is no implementation date for ACE Inhibitors.

Prior authorization request forms are available on the web at www.hidndmedicaid.com and the fax and phone numbers are available on the forms.

Coordinated Services Program (CSP)

Previously we announced the name change of the "Medicaid Lock-In Program" to the Coordinated Services Program (CSP). We are reminding you of the name change and the program rules.

The CSP is a Managed Care Program, but does have stricter guidelines than the Department's Primary Care Provider program. Those eligible Medicaid recipients who are referred to the CSP generally have a pattern of abuse or misuse of services. It is the objective of the program to ensure that clients access and receive quality care within medically accepted standards. The program is designed to work with medical providers to educate and guide the patient in using services appropriately.

We encourage patients to make appointments and keep them. We also advise them to notify the practitioners in advance of any appointments being cancelled for valid reasons. We discourage services on demand. Urgent and emergent care is covered when the need is apparent, otherwise the patient should be making appointments accordingly. We also discourage routine telephone contact for medicine on a regular basis. There should be face-to-face examination and care.

The CSP patient is required to choose one physician, whose specialty is in primary care, to manage the patient's medical needs. When other specialty services are needed, the primary physician should be evaluating the patient's needs and referring the patient to the appropriate specialty as medically needed. Again, this should be a face-to-face process and not by demand or self-referral.

Over time, we have noted some common questions and problems with referrals that we would like to address.

1. The primary physician should make a referral to the appropriate specialty after face-to-face evaluation of the patient and a determination that the primary physician cannot meet the patient's needs and specialized services are needed. The referral should be sent to the referred specialist prior to the appointment or with the patient for Medicaid coverage purposes. **A copy of the referral must also be sent to the State Medicaid office.**
2. Unless urgent or emergent care is demonstrated, there should not be a retroactive referral because the client accessed services prior to evaluation and referral by the primary physician.
3. There has been some confusion when making referrals to other primary physicians for routine medical problems. If the patient's condition is a complex situation where a second opinion is needed, the primary physician may refer the patient for a second opinion. The records should reflect the reason for the second opinion.
4. Primary physicians are not always available due to illness, vacations and continued education requirements. Even though a colleague within the same facility may be covering for the absent primary care physician, there must be a referral to the covering physician. The referral need not be for every appointment, it can cover a time period. **Example:** Dr. X is on two-week vacation and Dr. Y will be seeing his patients from July 1 through July 14. If the policy in a large clinic is that the on-call physician will cover Dr. X's patients, the referral form should reflect this. From our experience, it is best if one physician is designated as the covering physician.
5. When a primary physician has a day off, clients should be encouraged to make an appointment with the primary physician when he or she is available. If it is urgent or emergent care and is appropriately documented, Medicaid would cover the visit based on medical necessity, or appropriate referral.
6. Referrals should designate the time period in which the referral is in effect, i.e. May 4, 2004 or if it involves exam, evaluation and treatment, it should reflect the appropriate time frame, i.e. Physical therapy 3 months from date of referral or May through July. There may be referrals that are indefinite and may need to be ongoing, i.e. psychiatry or cancer treatment. These referrals can be reflecting a year or more. The expectation is that when the referral is made the primary physician will be coordinating care and treatment with the specialist.
7. North Dakota Medicaid (Medical Services) has provided each provider entity with preprinted

referral forms. This form can be duplicated each time a referral is needed. If you have your own referral forms, they will also be accepted. The referral should be sent to the provider who will be providing the service so that he or she can bill and be paid. Without the referral, the non-primary physician/practitioner will not be paid. The referral must also be sent directly to the State Medicaid Office. When the bill comes in, the referral will have been noted and the bill will be paid. In situations where time is of the essence, the referring physician can telephone or fax the referral to Medicaid staff. The fax number is (701) 328-1544. CSP staff members can be reached at: Barb (701) 328-2334 or Brenda (701) 328-4010.

8. Retroactive referrals are not accepted without appropriate documentation indicating the referral was in place prior to the service being provided.
9. If a CSP recipient has additional insurance coverage such as Medicare or a private insurance company, there must be a referral in place prior to the service being provided to avoid denial of any remaining balances.
10. The purpose of the referral is: 1) to ensure that the patient is being seen and evaluated by the primary physician and specialty services are not being accessed unless there is a medical need. 2) the patient is being referred to the appropriate specialty and not accessed inappropriately by the client 3) to ensure that program requirements are met and the referred specialist will be paid for the services rendered.

If there are any questions or concerns we have not covered in this article, you may contact the CSP Administrator, Ray Feist at (701) 328-4024.

MMIS Replacement Project

Stakeholders Meeting

On September 21, 2004, the Department of Human Services hosted a MMIS Replacement Stakeholders Meeting. The meeting was also webcast and continues to be available for viewing on the DHS web site.

If you would like to view the meeting, please go to: www.state.nd.us/humanservices. From the home page, click on 'September 21 MMIS Stakeholders Meeting.' You will need to have Windows Media Player installed in order to view the meeting.

If you have questions about the MMIS Replacement Project, please contact Maggie Anderson or Erik Elkins at (701) 328-2321.

Claims Adjustments

Adjust the claim only when:

- The claim is overpaid or underpaid
- The claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure [CPT] code, diagnosis [ICD-9] code, units, etc.).
- An adjustment submitted as an appeal for payment must be submitted with supporting documentation (i.e. progress notes, operative report, discharge summary, etc.).

When completing an adjustment form, the information in blocks 2 through 16 must be completed as shown on the remittance advice. Corrections to be made should be noted in block 17. (Please see the "Provider Request for an Adjustment" and "Pharmacy Request for an Adjustment" insert in this newsletter for reference.)

An adjustment that is missing information or filled out incorrectly will be returned to the provider for further clarification.

Processing adjustments takes about 3 - 4 weeks. Please call Provider Relations after that time if you would like to check the status of your adjustment.

Adjustments must be submitted within one year of the last remittance advice date.

Electronic Claims Adjustments

North Dakota Medicaid has facilitated the processing of electronic adjustment transactions with the implementation of HIPAA changes. Providers are now able to submit adjustments to claims electronically. We will accept valid 837 adjustments on all previously adjudicated claims regardless of the claim format used to submit the original claim. This is accomplished through the 837 Health Care Claim Transaction, which allows for the electronic submission of adjustments to previously processed claims. The field required on the 837 transaction for submission of electronic adjustments would consist of:

2300 REF (REF02 equal to Original ICN Number)

When an adjustment is submitted electronically through the 837 transaction, it is in essence a reversal of the incorrect claim and the submission of a new, corrected claim at the same time. At the time an 837 electronic adjustment transaction is received, the MMIS will create

a reversal against the original claim. It will then use the new, corrected claim as a replacement claim. Electronic adjustments should have the corrections already made to the replacement claim when submitted. If the correction(s) to the replacement claims takes care of the errors, the claim should go straight to pay without manual intervention. An electronic adjustment will need manual review only if an error is detected in the adjudication process. By submitting claims adjustments electronically, the speed in which your corrections/adjustments are processed will be enhanced greatly.

Coordination of Benefits (COB) Billing Using the EDI 837 Transaction

The Department strongly recommends using the ANSI X12 4010A1 837 Health Care Claim transactions to handle COB submissions. Using electronic data interchange COB offers the potential to achieve administrative cost savings. Some of the benefits realized are: reduction in paper and postage; quicker claims turnaround time which improves cash flow; claims entered electronically are edited for accuracy and consistency before being processed. This leads to less of a chance your claim will suspend for errors and/or the need for adjustments or resubmissions.

If using the HIPAA 837 transaction to bill, the provider can enter the COB amounts using the CAS segments in Loop 2320 (*contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.*) By billing COB payments using the 837 transaction, our system is able to differentiate between the prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. The system is able to calculate Medicaid's liability and distinguish the actual patient responsibility and contractual obligations per detail line.

Please note that in order for Medicaid to process the COB information, we must receive the transaction with the CAS segment appropriately filled out. The CAS segments are necessary for us to adjudicate a claim with COB properly. If we receive an 837 transaction with other insurance at the detail of the header level but the transaction does not contain the appropriate CAS segment information, we will reject the claim with Reason code **22** " *Payment adjusted because this care may be covered by another payer per coordination of benefits*" and/or Remark Code **MA04** " *Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.*"

Home Health Agencies – Medicare TPL Exception Coding Change

Please note there has been a change to the occurrence code used for submission of Home Health Care claims utilizing the Medicare TPL exception. Home Health agencies were previously instructed to use occurrence code **27** in form locators 32-36 of the UB-92 or the corresponding appropriate data segment/field in the electronic claim format (ANSI X12 4010A1 837 Institutional). The correct code to now use is occurrence code **24** "**Date Insurance Denied**".

Home health agencies are required to bill private or federal insurance prior to billing Medicaid. There is an exception for Medicare. The home health agency can enter occurrence code **24** in form locators 32-36 of the UB-92 and the date Medicare denied payment as it was determined the services did not meet Medicare criteria. Claims will be accepted for dates of service within one year of this date. For services that continue beyond one year, providers will have to resubmit their claim to Medicare or review the case to determine if it meets Medicare criteria and enter the new date with occurrence code **24**.

We will continue to accept occurrence code **27** for a short period of time as this code has been established in your usual billing practice to Medicaid per our billing instructions. However, it is an important change to correct occurrence code **24** as soon as possible, as occurrence code **27** will soon be considered unacceptable for the Medicare TPL exception use.

Billing Procedures for Instate and Out-of-State Nursing Homes

FL6 (STATEMENT COVERS PERIOD):

Enter the first date of service **through** the last date of service for the monthly billing period for this claim. The dates must be continuous. Enter the "From" and "Through" dates of service in MMDDYY format. If the claim covers only one day of service, the "From" and "Through" dates must be equal. The "statement covers period" includes the first date of service through the last date of service, which would **include** the actual discharge date, the hospice election date, or date of death, whichever is applicable. ND Medicaid will automatically calculate and disallow any non-covered days by using the Revenue Code field and Discharge Code field.

Payment problems are occurring when claims are billed without including the last day in these fields since our system automatically calculates the non-covered day depending on the discharge code. If a claim is billed

without including the non-covered day in the total, the system will calculate one less day in the payment. Also, given that the system is calculating the non-covered days using the Revenue Code and Discharge Code, **DO NOT** use the “**Non-covered Days**” field (Form Locator 8). Doing so will cause an error to occur and the claim will suspend.

FL7 (COVERED DAYS):

Enter the total number of covered days, which would **include** the actual discharge date, the hospice election date, or date of death, whichever is applicable. The number should **equal** the statement covers period (FL6). ND Medicaid will automatically calculate and disallow any non-covered days by using the Revenue Code field and Discharge Code field.

FL42 (REVENUE CODE):

Enter appropriate revenue codes for services provided. List all *non-ancillary (Room & Board)* revenue codes in ascending *Service Date* order (**FL45**), followed by **001** for the Total Charge Line.

North Dakota Medicaid will require use of *Revenue Code 120* when billing for In-House Medicaid Days, *Revenue Code 160* for Medicare Full Benefit Period Days, *Revenue Code 169* for Medicare Coinsurance Days, *Revenue Code 182* for Medicare Non-Covered Leave Days, *Revenue Code 183* for Therapeutic Leave Days, and *Revenue Code 185* for Hospital Leave Days.

Please note: You **must** enter Revenue Codes for *non-ancillary* charges in *Service Date* order or the claim will reject. (Example: Revenue Code **185** for DOS 06/01/04 – 06/04/04 would be billed *before* Revenue Code **120** for DOS 06/05/04 – 06/30/04) on your claim. List all ancillary charges and Revenue codes **after** the *non-ancillary (Room & Board)* codes.

FL45 (SERVICE DATE):

You **must** enter the first date of service for the specific Revenue code you are billing on that line item. If you do not enter the first date of service in this field, the claim will be rejected.

FL46 (UNITS OF SERVICE):

Enter the units of service applicable to each revenue code billed. The total number of units for all *non-ancillary (Room & Board)* revenue codes billed on the claim should equal the statement covers period (FL6), and should equal the covered days (FL7).

FL54 (PRIOR PAYMENTS):

Enter payments from other payers, excluding Medicare, corresponding to the payers listed in FL50 A, B, and C, if applicable. Medicare payments are considered by ND Medicaid using the appropriate Revenue Code (**160** or **169**). If a recipient receives proceeds from an insurance policy that covers in-state LTC nursing facility services or

a supplemental policy, enter the appropriate amount(s) that apply to the total charges billed on each authorization. The amount must be subtracted from the total charges in FL47. **DO NOT** subtract Medicare payments from FL47. **DO NOT** enter prior North Dakota Medical Assistance payments or Recipient Liability amounts.

FL55 (ESTIMATED AMOUNT DUE):

Enter the difference between the **Total Charges** (FL47) and the **Prior Payments** (FL54). An entry in this block is always required. If there is not an entry in the Prior Payments (FL54), it is **required** that the total charges entered in FL47 also be entered in **Estimated Amount Due** (FL55). A claim for a Medicaid recipient must be submitted for each month the individual is in the in-state LTC nursing facility even if the balance due is zero after insurance or Medicare payments. Other Medicaid providers cannot be paid until the in-state LTC nursing facility claim is processed.

Billing Procedures for ICF-MR & Swing Bed Facilities

Please note: when billing for non-ancillary (Room & Board) services, the “**Statement Covers Period**” (Form Locator 6 on the UB-92 form) must include the first date of service **through** the last date of service. The last date of service would **include** the actual discharge date, the hospice election date, or date of death, whichever is applicable. ND Medicaid will automatically calculate any non-covered days by using the Revenue Code field and Discharge Code field. In accordance with including the discharge date, the hospice election date, or date of death in the ‘statement covers period,’ you need to enter the total number of days in the “**Covered Days**” field (Form Locator 7). This would **include** the actual discharge date, the hospice election date, or date of death in the total covered days amount. The number should equal the statement covers period (FL 6.)

Providers Who Bill Vaccines for Children (VFC) Immunizations Using PC-ACE

For providers who bill Vaccines for Children (VFC) claims with PC-ACE, Noridian has a software update that will allow a zero charge line item for the vaccine.

Providers may now bill VFC immunizations with a \$0.00 billed amount. Previously, PC-ACE would not allow providers to bill a zero line charge, but now Noridian has a software update. If your office requires this software update, please contact Noridian.

Relative Value Unit Fee Schedule Update

The Department has implemented the 2005 relative value units for dates of service on or after January 1, 2005. Based on the previous 12 months claims volume, the new relative value units would result in a 3.5% fee increase. To keep RVU-reimbursed provider expenditures cost neutral, we adjusted the conversion factor to \$33.14.

Based on the changes to the relative value units, some fees will increase while others may stay the same or decrease. Following are some examples of frequently used codes we have calculated the Medicaid fees for:

		as of 04/01/2004		as of 01/01/2005	
Conversion Factor:		\$34.00		\$33.14	
Procedure Code	Description	RVU	Fee	RVU	Fee
99212	Office/outpatient visit, est	0.93	\$31.62	0.94	\$31.15
99231	Subsequent hospital care	0.82	\$27.88	0.86	\$28.50
99243	Office consultation	2.94	\$99.96	3.01	\$99.75
43235	Uppr GI endoscopy, diagnosis	6.87	\$233.58	7.00	\$231.98
59409	Obstetrical care	19.30	\$656.20	20.01	\$663.13
59515	Cesarean delivery	25.78	\$876.52	26.61	\$881.86
69210	Remove impacted ear wax	1.17	\$39.78	1.19	\$39.44
71020	Chest x-ray	0.85	\$28.90	0.85	\$28.17

~ BILLING REMINDERS ~

Audiology

CPT code Description

92592 Hearing aid check; monaural
92593 Hearing aid check; binaural

North Dakota Medicaid will allow/reimburse the above services once every two (2) years for patients 19 years of age and over.

Note: North Dakota Medicaid will allow/reimburse CPT codes 92592 and 92593 once every 12 months for patients age 0 through 18 years.

Casting Supplies

North Dakota Medicaid recognizes and separately reimburses for casting supplies (Q4001-Q4048). North Dakota Medicaid will not reimburse A4580 or A4590. See MEDICAID CODING GUIDELINES for **Casts, Splints, and Strapping** guideline at:

<http://www.state.nd.us/humanservices/services/medicalserv/medicaid/agreement.html>

Chemotherapy Administration

Effective for dates of service on or after January 1, 2005, North Dakota Medicaid will **not** accept the billing of "G" codes (G0345-G0362).

The provider must continue to use the valid CPT codes for billing IV infusion for therapy/diagnosis and/or chemotherapy administration.

EXCEPTION: ONLY when **Medicare is the primary payer** and Medicaid is secondary, will North Dakota Medicaid allow/reimburse claims submitted with G0345-G0362.

Chiropractors – New Patient – E/M Office and Other Outpatient Services (99201-99203)

Effective for dates of service on or after January 1, 2005, North Dakota Medicaid will allow reimbursement to chiropractors for E/M Office and Other Outpatient Services - **New Patient (99201-99203)**. These E/M services may be billed in addition to the chiropractic manipulative treatment (98940-98942) **ONLY** when the patient has not received any professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice, within the past three years.

Consultations (99241-99275)

North Dakota Medicaid **does not** allow/reimburse nurse practitioners (NP), physician assistants (PA), or clinical nurse specialists (CNS) for Consultation E/M services (99241-99275).

Dentists – Drug Reimbursement

Dental claims must identify/describe the specific drug administered (including route of administration) when billed to North Dakota Medicaid (i.e. – D9630 – Valium 10 mg, IV). Claims submitted with D9630 without the specific drug name and route of administration will be denied requiring more specific information.

Therapeutic drug injection, by report (D9610) should be billed in addition to the specific drug/medicament **injected**.

NOTE: If no *injected* route of administration (i.e. IV, IM) is identified, North Dakota Medicaid will not allow/reimburse D9610.

Example:

HCPCS code **Drug name & route of administration**

D9630 diazepam (Valium) 10 mg, IV
D9610 (Therapeutic drug injection, by report)

North Dakota Medicaid does not reimburse:

D9248 – Non-intravenous conscious sedation
D9630 – When used to describe “oral sedation”
“relaxed dentistry”

Direct Face-to-Face Service Required

E/M services allowed/reimbursed by North Dakota Medicaid require a face-to-face service with the patient.

North Dakota Medicaid will only allow/reimburse E/M services when there is direct face-to-face service(s) rendered to the patient. Providers are not to bill North Dakota Medicaid for E/M services when the patient is not present during an encounter.

Essure® Procedure

CURRENTLY North Dakota Medicaid will NOT allow/reimburse CPT procedure code 58565 - Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Essure® scalpel-free sterilization procedure for women.)

Immunization Administration

Effective for dates of service September 1, 2004 and after, North Dakota Medicaid will reimburse for immunization administration AND vaccines/toxoids as follows:

Immunization Administration For Vaccines/Toxoids

90471 – Immunization **administration**; one vaccine (single or combination vaccine/toxoid). The allowed Medicaid fee is \$8.00.

90472 – Immunization **administration**; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) The allowed Medicaid fee is \$5.50.

The following CPT codes will be reimbursed for **dates of service on or after January 1, 2005**.

90465 – Immunization **administration under 8 years of age** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels

the patient/family; first injection (single or combination vaccine/toxoid), per day. The allowed Medicaid fee is \$8.00.

90466 – Immunization **administration under 8 years of age** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure). The allowed Medicaid fee is \$5.50.

The administration code(s) (90465, 90466, 90471, 90472) MUST be billed with a vaccine/toxoid code(s) (90476 – 90748).

Vaccines, Toxoids

Codes 90476-90748 identify the vaccine product only. To report the administration of a vaccine/toxoid, the vaccine/toxoid product codes MUST be used **in addition to an immunization administration code(s) 90465, 90466, 90471, 90472.**

When the vaccine/toxoid product (90476-90748) is a state supplied vaccine, you must append the vaccine/toxoid product with modifier - SL.

Example 1: Patient 0 -18 years of age is given state supplied vaccine/toxoid

90471
90648-SL (-SL indicates this vaccine is state supplied). Medicaid does not pay for the vaccine, as it is available through Vaccines for Children (VFC)

90472
90669-SL (-SL indicates this vaccine is state supplied) Medicaid does not pay for the vaccine, as it is available through Vaccines for Children (VFC)

90472
90658-SL (-SL indicates this vaccine is state supplied) Medicaid does not pay for the vaccine, as it is available through Vaccines for Children (VFC)

Example 2: Patient 19 years of age and older (does not qualify for state supplied vaccine/toxoid)

90471
90746 (must be medically necessary and supported by documentation)

90472
90732 (must be medically necessary and supported by documentation)

IMPORTANT: Effective September 1, 2004, when Medicaid is the secondary payer, the provider must submit the claim according to Medicaid guidelines;

therefore it is acceptable for providers to change/add the appropriate CPT code(s) on the claim (i.e. 90465-90466 or 90471-90472).

Medicaid does not reimburse 90467-90468 and 90473-90474.

J Codes

Effective for dates of service January 1, 2005 and after, the J-Codes fees have been reviewed and updated to reflect the Medicare rates for these codes. In the past, North Dakota Medicaid has used the Medicare J-Codes rates as a basis for payment; this process involved a comprehensive review to ensure all rates reflected the actual Medicare fees for the J-Codes.

Laboratory Fee Schedule Update

The Department has revised our Laboratory Fee Schedule using the 2005 Medicare Clinical Diagnostic Fee Schedule amounts for dates of service on or after January 1, 2005.

Nurse Practitioner Enrollment

North Dakota Medicaid will enroll nurse practitioners (NP) of all "specialties." Completed applications may be submitted to ND Medicaid Provider Enrollment (including completed questionnaire, current ND license, program provider agreement and ND Board of Nursing approved scope of practice).

Upon receipt of the Medicaid provider number, the nurse practitioner will bill under his or her Medicaid provider number and services rendered within his or her scope of practice will be reimbursed at 75% of the North Dakota Medicaid fee schedule.

Nurse Practitioners who do not enroll **must** bill North Dakota Medicaid for services under a physician provider number and **must** append all services (CPT codes) billed with modifier -SA. Reimbursement is at 75% of the North Dakota Medicaid physician fee schedule.

NOTE: When the nurse practitioner, physician assistant, or clinical nurse specialist is the assistant at surgery, append the procedure (CPT) code with modifier -AS only.

Outside Lab Services

When the provider is billing for laboratory test(s) performed by an outside lab, the POS (Place of Service) should be 81 (Box 24B on HCFA 1500) and a modifier -90 must be appended to the procedure (CPT) code (i.e. 8____-90).

LICSW/LCSW Allowed Services

CPT CODE	DESCRIPTOR	UNIT
90801	Psychiatric diagnostic interview examination	1
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or the mechanisms of communication	1
90804	Individual psychotherapy , insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	1
90806	Individual psychotherapy , insight oriented, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	1
90808	Individual psychotherapy , insight oriented, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	1
90810	Individual psychotherapy , interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	1
90812	Individual psychotherapy , interactive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	1
90814	Individual psychotherapy , interactive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	1
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	15 min
90853	Group psychotherapy (other than of a multiple-family group)	15 min

Effective for date of service June 1, 2004 and after, North Dakota Medicaid will reimburse the enrolled

LICSW/LCSW (using his or her own North Dakota Medicaid provider number) for CPT codes listed above at 75% of North Dakota Medicaid physician fee schedule.

NOTE: The LICSW/LCSW who has not enrolled with North Dakota Medicaid and is billing under a physician provider number **MUST** append the CPT code with modifier-AJ and will be reimbursed this same range of CPT codes at 75% of the North Dakota Medicaid physician fee schedule.

PET Scans for Myocardial Perfusion Imaging

HCPCS codes G0030-G0047

Effective for date of service January 1, 2005 and after North Dakota Medicaid will allow/reimburse PET scans for the perfusion of the heart, HCPCS code series G0030-G0047.

North Dakota Medicaid will follow Medicare's **covered diagnoses:**

410.00-414.9 Acute myocardial infarction, other acute and subacute forms of ischemic heart disease, old myocardial infarction, angina pectoris, other forms of chronic heart disease

Radiopharmaceuticals provided during a PET scan are not paid separately and are included with the reimbursement for the PET scans.

Retroactive Eligibility

If a recipient is approved for retroactive eligibility, please make reference to this on the claim. Place your remark in box 19 on a HCFA 1500 claim form, box 84 on a UB-92 claim form or box 20 on a Pharmacy claim form.

Speech Therapy Coding Changes

Effective for **date of service June 1, 2005 and after**, North Dakota Medicaid will allow Evaluation of speech (92506) and Treatment of speech, (92507, 92508) on a per visit (per date of service) basis.

Beginning on date of service June 1, 2005 and after, North Dakota Medicaid will no longer allow the Speech Evaluation and Therapy codes to be billed in 15 minute increments.

The CPT codes 92506-92508 will be allowed with 1 unit per date of service. The reimbursement methodology for

these codes will be converted to the 2005 ND relative value units system for dates of service on or after June 1, 2005.

NOTE: Limits previously set for Speech evaluation (1 per year) and Speech therapy visits (30 per year) *rendered in a clinic or outpatient hospital setting* are still in effect.

Topical Fluoride Application (Varnish)

REVISION: EFFECTIVE 4/1/05 North Dakota Medicaid will extend the age limit to cover the topical application of fluoride (D1203) for children, age six (6) months **to thirteen (13) years.**

Effective for date of service July 1, 2004 and after, North Dakota Medicaid will cover the topical application of fluoride (prophylaxis not included) for **children**, age six (6) months **to thirteen (13) years.** A maximum of two (2) applications per year will be allowed. It is highly recommended that this service be rendered during a well child check versus a separate visit. The following professionals can apply the topical fluoride, after receiving the appropriate training: physician, nurse practitioner, physician assistant and registered nurse*. CPT code: D1203 – Topical application of fluoride (prophylaxis not included) – **child**

Covered ICD-9-CM code: V07.31 – Prophylactic fluoride administration

*The registered nurse must work under the direct supervision of the physician and the claim must be submitted under the physician's provider ID number (PIN).

EXCEPTION: North Dakota Medicaid will reimburse topical fluoride varnish application when rendered by a registered nurse in the Public Health clinics without the direct supervision of a physician. They must have verification that they completed the **Dental Health Screening and Fluoride Varnish Application Course** (see <http://meded1.ahc.umn.edu/fluoridevarnish/>).

NOTE: This service is presently covered when rendered by a dentist.

Please go to NDDHS website to view other Medicaid Coding Guidelines:
<http://www.state.nd.us/humanservices/services/medicalserv/medicaid/cpt.html>



Family Voices Receives Grant

Health and Human Services Secretary Tommy G. Thompson announced \$31 million in grants to 31 states to help families of children with special needs and people with disabilities or long-term illnesses live in their homes and participate fully in community life.

Family Voices of North Dakota received funding to develop and implement an information and referral network for parents of children with special health care needs. Family Voices of North Dakota Health Information and Education Center is where you can find answers for children and youth with special health care needs! Because...

*Families need information to make good decisions for their children.

*Families must know how to survive in our changing health care environment; and

*Families can learn best from other families who have "been there."

*Family Voices of ND features: Toll-free number, newsletters, links to other organizations, training and workshops, resources and information and much more.

*Run by and for families, the Center will:

*Assist families and providers as they navigate public and private health systems in the state and communities.

*Help families and providers understand options for health insurance.

*Educate families and providers about ways to make good choices of health providers and resources.

*Listen to families as they describe their encounters with systems and help guide them to possible solutions.

*Work with families, providers, public and private agencies and advocacy or support groups to promote family-centered care and medical homes for all children with special health care needs.

*Act as a link among families, providers, managed care programs and government to better serve the health care and related needs of children and families in ND.

*Work with government agencies to gather and share information, monitor health care and identify ways to improve public and private health.

Family Voices of North Dakota can assist families and professionals by contacting them at PO Box 163, Edgeley, ND 58433, or by calling 1-888-522-9654, by e-mail at feist@daktel.com or locate them on the web at www.geocities.com/ndfv/ director Donene Feist.

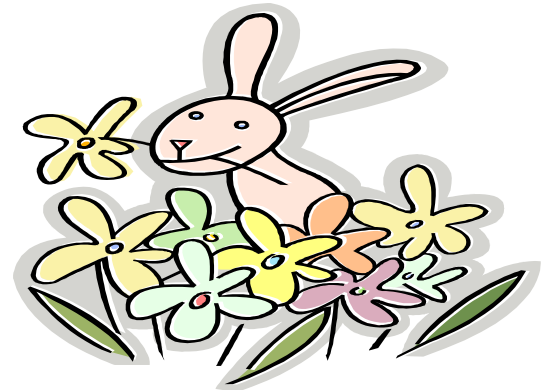
The grants are a part of President Bush's "New Freedom Initiative," which promotes the goal of community living for individuals with disabilities and long-term illnesses. Under this initiative, which began in 2001, 10 federal agencies work with states and community organizations to remove barriers to community living.

"We are committed to removing the barriers preventing the 54 million Americans living with disabilities from leading full lives. These grants will help those living with disabilities make their own choices on what services they get, who provides those services and how and where to live," said Centers for Medicare & Medicaid Services Administrator Mark B. McClellan.

Inserts

Inserts are being included to provide information on the following topics:

- Adjustment examples: [Provider Request for an Adjustment](#) (SFN 639) and [Pharmacy Request for an Adjustment](#) (SFN 640)
- Procedures requiring Preauthorization through North Dakota Health Care Review
- Recipient Liability
- Referrals for Out-of-State services



Guidelines for Submission of Paper Claims
February 2005

Following these guideline will help ensure that your claims can be scanned and processed in a timely manner. If claims and attachments are not submitted according to these guidelines, they will be returned to the provider.

1. Use only blue or black ink. Do **not** use Red ink to complete claims or attachments. Make sure the ink is dark enough to be picked up by the scanner.
2. Times New Roman font is preferred.
3. All information must be legible, preferably typed or printed, and within the boxes on the claim form. Please make sure information does not touch or cover lines or pre-printed information on the claim.
4. Do not highlight information on the claim or attachments.
5. Submit claims and attachments on 8½ x 11 paper. If any item is smaller or larger, you will need to copy it on 8½ x 11 paper.
6. Do not submit carbon copies of claims or attachments.
7. The claim or attachments cannot have any dark smudges or dark print that runs together.
8. Do not place any stickers or labels on the claim.
9. Do not submit two-sided documents.
10. If whiteout is used for corrections, make sure it is applied thick enough to cover. Write the correct information beside the area where whiteout was used, NOT over it. If information does not fit in the box, use a different claim.
11. Only one line of service is allowed per detail line on the claim form. Do not bill with two service lines compressed into one detail line.
12. Do not use dashes or slashes in the Recipient ID, Patient Account Number or other fields.
13. The Revenue Code cannot be greater than three positions. Do not enter a leading zero.
14. If there is an individual doctor's name in the provider area, the **last name MUST** be first.
15. When submitting multiple-page claims, you MUST follow these guidelines:
The following fields must match on all pages of a multiple page UB-92:
 - Statement Covers Period (UB 6)
 - Provider ID (UB 51 -- 1, 2 or 3)
 - SSN (UB 60 – 1, 2 or 3)
 - Diagnosis codes and principle procedure code

** Special Note regarding Total Charges. Total Charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in.

The following fields must match on all pages of a multiple page HCFA 1500:
 - SSN (HCFA 1a)
 - Patient Account Number (HCFA 26)
 - Provider ID (HCFA 33)

** Special Note regarding Total Charges. Total Charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in.
16. Do not staple or paperclip any items. This includes two page claims and attachments.

MEDICAID BULLETIN
Medical Services Division
ND Department of Human Services
600 E. Boulevard Ave. Dept. 325
Bismarck, ND 58505-0261

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BUSINESS/OFFICE MANAGER

THIRD PARTY PAYMENT BILLING INSTRUCTIONS

Please Note: Any claims with TPL received after May 1, 2005, will need to be billed to ND Medicaid in the following manner:

Provider must bill their usual and customary charge to ND Medicaid.

- The **TOTAL CHARGES** would be the provider's usual and customary charges.
- The **AMOUNT PAID** would be the actual payment received from the primary payer.
- The **BALANCE DUE** would be the TOTAL CHARGES less the AMOUNT PAID.

If the AMOUNT PAID amount is less than the ND Medicaid allowable amount, ND Medicaid will pay the difference up to the ND Medicaid allowable amount.

If the AMOUNT PAID amount is greater than the ND Medicaid allowable amount, ND Medicaid makes no payment.
