



PROVIDER BULLETIN

ISSUE 58 ~ APRIL 2006

PROVIDER INFORMATION

Checkwrite Exception Dates

There are several dates for the remainder of calendar year 2006 where the regular checkwrite dates will be postponed. Typically, check write occurs every Monday evening; with the following exceptions:

No Checkwrite	Rescheduled Date
May 29	May 30
July 31	August 1
September 4	September 5
December 25	December 26

Dentures

The Department has limits on the frequency of dentures and partial dentures. Replacement will be limited to once every five years for both dentures and partial dentures. Complete initial placement dentures do not require a Prior Treatment Authorization Request (PTAR). Complete replacement dentures do require PTAR. ALL claims for replacement dentures must indicate in blocks 33 and 34 the age of the denture and the reason for replacement. ALL partial dentures require PTAR and the teeth included in the partial denture must be indicated on the PTAR. If the partial denture is a replacement partial denture, then blocks 33 and 34 must be completed. Both dentures and partials **MUST** be billed on the date of placement.

If you have questions or concerns that you would like us to address in future newsletters, please call the state Medicaid office at 1-800-755-2604.

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MEDICAL SERVICES DIVISION

MAGGIE D. ANDERSON, DIRECTOR

Electronic Claim 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 claims payment system 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 take 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 greatly enhanced.

Risperdal Consta

Effective for date of service (DOS) January 1, 2005 and after NDMA allows/reimburses Risperdal Consta (long acting, 0.5 mg) for the treatment of schizophrenia.

Risperdal Constar (risperidone, long acting, 0.5 mg).

COVERED DIAGNOSIS: 295.00-295.65; 295.80-295.95

CODING/BILLING:

Pharmacy claim:

Risperdal Consta (risperidone, long acting, 0.5 mg) must be billed by the pharmacy (on a pharmacy claim with NDC number).

EXCEPTION: When ND Medicaid is the secondary payer, the provider may bill Medicaid for the drug (J2794) and reimbursement will be up to our current allowed amount. No administration fee will be allowed.

HCFA/CMS 1500 claim:

90772* (administration fee) - .10 RVU (ND Medicaid allowed amount when billed with J2794)

J2794 (risperdone, long acting, 0.5 mg) - \$0.00 (This line must appear on the claim form in order for the administration fee to be paid.) (The pharmacy is to bill ND Medicaid for the drug.)

*90772 Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (2006 CPT®)

Drug Administration CPT Codes

Effective for dates of service on or after January 1, 2006, North Dakota Medicaid will not accept the billing of "C" codes (C8950-C8957) when Medicaid is the primary payer. The provider must continue to use the valid CPT codes when billing IV infusion for therapy/diagnosis and/or

chemotherapy administration.

EXCEPTION: ONLY when Medicare is the primary payer and Medicaid is secondary, will NDMA allow/reimburse claims submitted with C8950-C8957.

Look for this button at our provider website:

**UPDATES
FOR PROVIDERS**

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider.html>. This will link you to provider information that is updated on a regular basis.

Home Health Agencies

Joan Ehrhardt, RN, is now performing prior authorization determinations for Home Health Services. Joan's other responsibilities include pre-admission screenings for long-term care and certificate-of-need for individuals under 21 receiving inpatient care in psychiatric hospitals and programs.

Prior authorization of Home Health Services is required if services are anticipated to exceed \$3,000 or if services are anticipated to last longer than 2 months. Short-term, low-cost services do not require prior authorization.

The prior authorization form SFN 15 is available at www.state.nd.us/eforms.

Joan can be contacted by telephone at 701-328-4864 or email: soehrj@state.nd.us

Audiologist

- It has come to the attention of the Department that some providers are not following their Medicaid contractual agreement. It is the provider's responsibility to inform a client or client's parents, that if Medicaid is the secondary payer, providers are required, by their agreement to prior authorize and bill the Department as usual for hearing aids. Furthermore, payment received from the Department is payment in full. This notification will also be placed in the recipient newsletter to remind clients of the process.

The information that we have received involved recipients who had other primary insurance that did not completely cover the usual and customary price of a hearing aid. In these instances, the providers attempted to bill the recipient rather than prior authorizing and billing the hearing aid through Medicaid.

- As of March 1 2006: Hearing Aide requests, which do not delineate which ear, will be returned. Hearing aid repair must use the RP modifier or the claims will be denied.
- For claims, or prior authorization approval status, call 701-328-4030 or 701-328-4043. If Provider Relations is unable to answer your questions, they will forward the call to the appropriate individual.

PHARMACY & DURABLE MEDICAL EQUIPMENT

Prescription Drug Coverage Ended December 2005 for Dual Eligible Clients

As of January 1, 2006, Medicaid no longer covers prescription drugs for individuals who are also eligible for Medicare. Medicare Part D started to cover the prescription drugs for these individuals. However, Medicaid may pay for benzodiazepines, barbiturates, and certain over-the-counter drugs for these individuals—

depending on which Medicare Prescription Drug Plan they choose.

What does that mean to you?

**If you are a physician or clinic, you may be asked by your patients to request exception*

Continued on Page 4

Prescription Drug Coverage – cont.

waivers (also known as Prior Authorizations or medical exception), if medically required and there is nothing else available in that class. Or, you may be asked to prescribe a generic equivalent or another medication the patient's plan will cover. Your patients may ask you to assist them in choosing a plan.

**If you are a pharmacy, you may be asked by your patients for their drug purchase histories. You also may be asked to assist your patient in choosing a plan.*

If you want more information, please contact:
1-800-Medicare (1-800-633-4273)

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp - bene>

DME Suppliers

- All DME inquiries should be directed to Provider Relations at 701-328-4030. If they are unable to assist with a specific question or request, your call will be transferred to the appropriate administrative staff person.
- K0462 code is not to be used on a claim or prior authorization form, because the provider must submit specific HCPCS code (appended with modifier RP) that identifies the item or equipment being temporarily replaced.
- As some of you may be aware, a new DME provider manual and fee schedule will be available on the Department web site in June 2006. Part of the revisions will include:
 - a. Establishing set fees for some items that are not currently priced,
 - b. Adding information on Certificate of Medical Necessities,
 - c. Establishing a process to address requests for covering a currently non-covered code.
- Establishing a currently appropriate HCPC code is the DME Company's responsibility. If there is a code established in the HCPC Coding Book, it must be used. If during the review of prior authorizations, the administrator finds that appropriate codes are not being used, the prior authorization will be returned to the provider.

Pharmacy Providers that Supply Durable Medical Equipment

Since the August 2005 system change due to HIPAA, pharmacies started billing DME like all other providers. Listed below are areas of clarification.

- 1) It is essential that pharmacy providers obtain a current HCPC Coding Book to assist them in determining the appropriate code to use for each item. The Department cannot provide anyone with a HCPC Code. If a pharmacy is unable to find a HCPC code for a specific item, they should work with the company supplying the item to determine the appropriate HCPC. The code determines how a product is paid, be that in units, as a single item, or as a pair. Brand names are not a consideration. Calls concerning approvals/ denials should all be directed to Provider Relations at 701-328-4030 or 701-328-4043.
- 2) The Department's website (<http://www.nd.gov/humanservices/services/medicalsev/medicaid/provider.html>) lists the HCPC codes covered and the assigned fees.
- 3) In June 2006, the Department will publish a new Manual and update the fee schedule.
- 4) Some products always require a prior authorization, such as nutritional supplies, incontinence products, rental items, labor or repair charges over \$500, equipment or supplies at or above \$500, items purchased on a monthly basis that exceeds \$500. Please review the DME manual to see if there are any particular rules and guidelines that apply to the product that you are providing.
- 5) Claims must be submitted on a CMS/1500 form to be processed by Medicaid. Questions on how to bill a CMS/1500, why a claim did not go through, etc. should be directed to Provider Relations. If Provider Relations cannot answer the question, it will be forwarded to the appropriate administrative staff person.
- 6) If pharmacies have questions concerning billing or how to fill out the CMS/1500 form, call Provider Relations at 701-328-4030.

CODING & BILLING

Credit Balance Accounts

Medicaid rules require that providers, who receive third-party payments after Medicaid pays, must reimburse the Medicaid Agency within one billing cycle. We have defined a billing cycle as a full 30-day period from the time a provider bills patients and the end of the cycle when the providers pay their bills. Usually the bills are collected or paid at the beginning of the month and the end of the month. Example: if the third-party payment is received on June 24, the provider would have until the end of July to reimburse the Department. There is a full business cycle from the 1st to the 31st of July. The provider can reimburse by check, electronic transfer, or adjustment.

Nursing Facilities

We continue to experience problems with nursing facilities not submitting claims or resubmitting denied claims in a timely manner. This causes many problems in the system, especially for those recipients who have recipient liability. Because the nursing facility claim normally uses all the resident's recipient liability, our system waits for those claims before applying recipient liability to other claims.

Facilities must submit a claim for every month a resident is in your facility, even if insurance or Medicare pays for the charges. **The claim should be submitted immediately after the month is over. If a claim has been denied, please correct and resubmit it.**

Health Tracks Pediatric Assessment (EPSDT)

Billing

Use a CMS 1500 claim form (UB-92 when services are rendered in Rural Health Clinic or Federally Qualified Health Center)

Use procedure code S0302 (Revenue code 521 or 951 if RHC or FQHC) to identify the visit as a completed Health Tracks Screening service.

Documentation

You must use the MCH/Health Tracks Pediatric Assessment Form. (SFN 1819). This form is available on the North Dakota State Website: <http://www.state.nd.us/eforms/Doc/sfn01819.pdf> or order a supply from the state office at 1-800-755-2604. This form completed in it's entirety will meet the requirements to support the Health Tracks Pediatric Assessment documentation.

NOTE: You may use an internal form that contains ALL of the same information as the state form.

A completed Health Tracks Pediatric Assessment includes:

- Comprehensive health and developmental history
- Health education/ anticipatory guidance
- Comprehensive unclothed physical

examination to include screening for emotional health, vision, hearing, and oral health

- Appropriate immunizations
- Laboratory tests including hemoglobin, urinalysis, and screening for blood lead level. Children ages 12 months and 24 months of age **MUST** have a capillary (finger) stick for blood lead (use the collection tube or filter paper method). Blood lead screening is completed for children ages six months to six years of age using a questionnaire (see attached).
- The following may be billed separately using the appropriate CPT code: immunizations and administration, laboratory tests and other necessary health care diagnosis and treatment services.

NOTE: The following required tests are considered included in the Health Tracks Pediatric Assessment and are NOT paid separately: vision, hearing and dental screenings.

Contact: Camille Eisenmann, Administrator, Health Tracks -- 701-328-2323 or 1-800-755-2604
600 --E. Blvd. Ave., Dept. 325 -- Bismarck, North Dakota 58505-0250

Payment Error Rate Measurement (PERM) Program

North Dakota is one of 17 states randomly selected by the Centers for Medicare and Medicaid Services (CMS) for the PERM initiative for Federal Fiscal Year (FFY) 2006 (October 1, 2005 - September 30, 2006). PERM is required by CMS pursuant to the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). Under this plan, a state will be selected for error rate measurement once every three years for each program (Medicaid and State Children's Health Insurance Program.)

For FFY 2006, CMS will only measure Medicaid fee-for-service (FFS) claim payments and premium payments made on behalf of beneficiaries for accuracy. CMS is using national contractors to measure improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP). These national contractors are:

The Lewin Group - Statistical contractor – will provide statistical support by obtaining the necessary sampling unit data and producing sample of claims to be reviewed. Will calculate North Dakota's error rates based on the findings of the review contractor.

Livanta LLC - Documentation/database contractor – will provide the documentation/database support by collecting medical policies from the State and by collecting medical records from providers.

To Be Determined - Medical Review contractor - will use the policies and medical records obtained by Livanta LLC to perform the medical and data processing reviews, provide findings to the Lewin Group, and jointly write the final report with the Lewin Group and submit the report to CMS.

Livanta LLC will begin contacting providers beginning in April 2006. If a claim is selected for a service that you rendered as part of the sample, Livanta LLC will contact you to request a copy of your medical records to support the medical review of the claim. Medical records are needed to support medical reviews on claims to determine if the claims were correctly paid. It is critical that providers supply information on sampled claims in a complete and timely matter. Non-compliance will result in a claim adjustment against the provider's claim with the monies being recovered by ND Medicaid. Failure to submit the requested medical information could also result in State errors.

We recognize providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and provide CMS (through Livanta) with information about any payments claimed by the provider for rendering services. Providing information includes medical records. Also, the collection and review of protected health information contained in individual-level medical records for payment review purposes is allowed by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164. This permits the collection and review of protected health information to meet the CMS PERM requirements. The records do not need to be de-identified.

Results of the study will be published upon its completion.

Nursing Homes – Influenza & Pneumococcal Disease

According to a final rule published in the *Federal Register* in November 2005, nursing homes serving Medicare and Medicaid patients must provide immunizations against influenza and pneumococcal disease to all residents. Nursing homes are also required to educate the resident and/or the resident's family about the advantages and possible disadvantages of receiving the vaccines.

Nutritional DME Suppliers

As of April 1, 2006, Medicaid will no longer allow any type of gastrostomy/jejunostomy tube to be submitted under the code B9998. Gastrostomy tubes of any type are to be billed only under B4086.

Emergency Out-Of-State Transfer

Reminder to Hospitals and Physicians:

North Dakota Medicaid requires notification of all emergency transfers to out-of-state facilities within 48 hours of the transfer. The information may be telephoned to Dan L. Johnson at 701-328-4027 or faxed to NDMA at 701-328-1544. This information must include the following:

- Destination and date of transfer,
- Mode of transportation, and
- Discharge summary from the transferring hospital.

In addition, ND Administrative Code (NDAC),

§75-02-02-13 (3)(a) states, in part, that:

“A referral for emergency care, including related travel expenses, to an out-of-state provider may be made by the primary physician. A determination that the emergency requires out-of-state care may be made at the primary physician’s discretion, but is subject to review by the department.”

All emergency medical claims, including emergency transportation claims, are subject to post Medicaid review and will be denied if a medical emergency (as defined in NDAC §75-02-02-12 of the North Dakota Administrative Code) is not demonstrated.

Requirements for Sterilization Claims

The federal government has STRICT REQUIREMENTS for the completion of the sterilization 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 follow the guidelines, or they will be denied.

A revised copy of the Federal Sterilization Consent Form and instructions for billing are included as an insert with this mailing and are also available on the State E-Forms website: <http://www.state.nd.us/eforms/Doc/sfn00989.pdf>

DISCARD OLD FORMS AND USE ONLY THE REVISED COPY. 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 mentally competent and at least 21 years old when the consent form is signed.
- The Statement of 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 31st day to the 179th day. The only exception is for premature birth or emergency abdominal surgery that occurs at least 72 hours after the consent is signed.

- Under the Physician’s Statement, 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.
- If you have any questions regarding sterilizations, please contact our office at 701 328-4046.

Anodyne® Therapy

Important Anodyne® Therapy information is available at:

UPDATES
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<http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider.html>.

North Dakota Screening Rules For Long Term Care

CSR - Continued Stay Review
SB - Swingbed
LOC - Level of Care
MI - Mental Illness

Client Status	Level of Care Screen (Document)	Level I
NF Applicant (Medicaid/Medicaid Applicant) <i>including ND Medicaid moving to Minnesota NF</i>	YES	YES
NF Applicant (Non-Medicaid)	Only if Level I identifies suspected or known MI or MR/RC	YES
NF Resident (Medicaid or Medicaid Applicant)	Only if: ✓ CSR (potential for improvement) ✓ LOC is questionable or no longer met ✓ Level II Status Change ✓ Time limited stay has ended & continued stay is desired	Only if: ✓ Resident with MI or MR/RC experiences change in status ✓ Resident with newly identified MI or MR/RC ✓ Resident with MI or MR/RC Short term approval ends
NF Resident (Non-Medicaid)	Only if: ✓ Resident with MI or MR/RC ✓ Medicaid Applicant	Only if: ✓ Resident with MI or MR/RC experiences change in status ✓ Resident with newly identified MI or MR/RC ✓ Resident with MI or MR/RC Short term approval ends
NF Resident transferring (Medicaid or Medicaid Applicant) (from NF to NF or NF-Hosp-NF)	Only if: ✓ No LOC approval within 90 days ✓ LOC changed - possibly no longer meets LOC for NF/SB.	Only if: ✓ Resident with MI or MR/RC & change in status ✓ Resident with newly identified MI or MR/RC
NF/SB Resident transferring (Non-Medicaid) (from NF/SB to NF/SB or NF/SB-Hosp-NF/SB)	Only if: ✓ Resident has MI or MR/RC ✓ Resident is a Medicaid Applicant	Only if: ✓ Resident with MI or MR/RC and change in status ✓ Resident with newly identified MI or MR/RC
Swingbed Applicant (Medicaid)	YES	NO
Swingbed Resident (Medicaid) (from SB to SB or SB -Hosp-SB)	Only if ✓ CSR (potential for improvement); ✓ LOC is questionable or no longer met.	NO
Swingbed Applicant or Resident (non-Medicaid)	NO	NO
Swingbed Transfer (Medicaid)	Only if: ✓ Not approved for SB LOC within 90 days	NO
Basic Care Beds/Facilities (applicants)	NO	NO
HCBS Applicant	YES	NO
HCBS Recipient	YES ✓ 2 months prior to end date ✓ As a termination review	NO
<i>Administrative -</i> Expired/discharged resident (Medicaid status unknown at death discharge)	YES (as requested)	NO
TBI Applicant	YES	NO
TBI Recipient	YES ✓ 2 months prior to end date ✓ As a termination review	NO

NF - Nursing Facility
HCBS - Home & Community Based Services
TBI - Traumatic Brain Injury
MR/RC - Mental Retardation/Related Condition

In-State & Out-of-State Nursing Homes Codes

FL7 (Covered Days):

Enter the number of covered days. Covered days must include discharge date, hospice election date, or date of death if applicable. The number should equal the statement covers period (FL 6). ND Medicaid will automatically calculate and disallow any non-covered days by using the Revenue Code field and Discharge Code field.

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 FL 47. DO NOT subtract Medicare payments from FL 47. DO NOT enter prior North Dakota Medical Assistance payments or Recipient Liability amounts.

FL22 (Nursing Home Discharge Status Code):

Whenever a recipient is discharged from the in-state or out-of-state LTC nursing facility to the hospital and the LTC nursing facility is holding the bed, with the anticipation of the recipient returning to the LTC nursing facility, the discharge status is STILL A PATIENT (30).

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. Unless there is no entry in Prior Payments (FL54), it is required that the total charges entered in FL47 also be entered in Estimated Amount Due (FL55).

FL6 (Statement Covers Period):

Enter the first date of service and 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 must include the actual discharge date, hospice election date, or date of death, if applicable. ND Medicaid will automatically calculate and disallow any noncovered days by using the Revenue Code field and Discharge Code field.

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.

COPAYMENT, COPAY EXEMPTION & SERVICE LIMITS

CoPayments and Persons & Services Exempt from CoPayments

CoPayments:

- ♦ \$1 for spinal manipulation received during a chiropractic appointment
- ♦ \$1 for each outpatient speech therapy visit
- ♦ \$2 for each office visit (includes all Medical Doctors, Nurse Practitioners, and Physician Assistant Certified)
- ♦ \$2 for each dental clinic appointment
- ♦ \$2 for each outpatient physical therapy visit
- ♦ \$2 for each outpatient occupational therapy visit

- ♦ \$2 for each optometry appointment
- ♦ \$2 for each outpatient psychological appointment
- ♦ \$2 for each outpatient hearing test visit
- ♦ \$3 for each hearing aid supplied
- ♦ \$3 for each clinic appointment to a Rural Health Clinic or Federally Qualified Health Center
- ♦ \$3 for each podiatry office appointment
- ♦ \$3 prescription drugs - brand name drugs
- ♦ \$6 for each emergency room visit that is not an emergency
- ♦ \$75 for each inpatient hospital stay

Persons & Services Exempt from CoPayments:

- ♦ Individuals under age 21
- ♦ Individuals who are pregnant
- ♦ Service is for a true emergency
- ♦ Service is for Family Planning purposes
- ♦ Individuals residing in:
 - Nursing Home/Long Term Care
 - Swing Bed/Long Term Care
 - Intermediate Care Facility/MR
 - State Hospital
 - State Hospital<21/JCAHO Facility

Service Limits & Current 2006 CPT Codes

Chiropractic manipulation - 12 visits per year	98940, 98941,98942
Chiropractic E/M office -New patient *1visit every 3 years	99201, 99202 or 99203
Chiropractic x-rays - 2 per year	72010-72120
Occupational therapy evaluation - 1 per year	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.)	97010, 97022, 97032, 97035, 97110, 97112, 97113, 97116, 97530, 97761, G0152
Speech evaluation - one per year	92506
Speech therapy - 30 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.)	92507, 92508 or G0153
Physical therapy evaluation - 1 per year	97001 or 97002
Physical therapy - 15 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.)	97010, 97022, 97032, 97035, 97110, 97112, 97113, 97116, 97530, 97761 or G0151
Psychological Evaluation - 1 per year	90801 or 90802
Psychological therapy - 40 visits per year	90804-90815; 90846-90857; 90875, 90876, 90877 or 90899
Psychological testing - four units/hours per year (<i>units-not time based codes</i>)	96101, 96102, 96103(1unit), 96105, 96110(1unit), 96111(1unit), 96116, 96118, 96119 or 96120(1unit)
Bio-feedback - 6 visits per year	90901 or 90911
Vision testing and prescriptions for glasses; under 21 years of age - 1 exam & 1 set of glasses per year; 21 and older - 1 exam & 1set of glasses every 3 years.	

* *New patient is one who has not received professional (face-to-face) services from the chiropractor or another chiropractor of the same group practice, within the past three years*

Authorizations in excess of the above limits may be granted by the Medicaid Service Utilization staff when medically necessary.

Medicare Crossover Adjustments

As you may be aware, the Deficit Reduction Act of 2005 was enacted on February 8, 2006. This updates the 2006 conversion factor for services paid under the *Medicare* Physician Fee Schedule. The Deficit Reduction Act replaces the previously announced 4.4 percent reduction in Part B physician payment with a zero percent increase for services paid under the Medicare Physician Fee Schedule. This change is effective retroactive for services provided on or after January 1, 2006. Medicare will reprocess claims reimbursed with the 4.4 percent rate reduction using the new rates.

North Dakota Medicaid's policy regarding processing third party liability claims, including Medicare, is that North Dakota Medicaid will pay

the difference between the Medicaid allowed amount for the service and the amount paid by Medicare up to the patient's deductible or co-insurance responsibility. If the amount paid by Medicare exceeds the Medicaid allowed amount, no Medicaid payment will be made.

Therefore, we will not accept adjustments for the Medicare claims affected by this adjustment if the Medicare payment is greater than what the Medicaid allowed amount is. In the majority of cases, this will be the circumstance. We envision minimal impact to the reimbursement payable from Medicaid due to this change. If the reimbursed amounts on the adjusted claims from Medicare are less than the Medicaid allowed, please submit an adjustment form to our office.

RECIPIENT LIABILITY

What is Recipient Liability (RL)

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

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

Providers should submit all claims for an individual with a recipient liability in the usual manner. As claims are received and processed, they are applied to the recipient liability amount.

The recipient is obligated to pay the provider directly for any amount applied to the recipient liability. The provider will be informed of any applicable RL on the remittance advice, once the claim has been processed. The recipient is also notified of the requirement to make payment to the provider.

Taking RL At The Time of Service

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

Here is an example of why the RL cannot be collected "up front." A recipient goes to the dentist, and the dentist collects the RL. At the end of the dental appointment, the recipient is given a prescription to fill. The recipient proceeds to the pharmacy to have the prescription filled, and the pharmacy (point of sale) system shows the recipient to have RL, which the pharmacy may collect at the time of service. The recipient has already paid the RL at the dentist, but the point of sale system does not reflect this and the pharmacist insists on collecting the RL. The recipient is unable to pay the RL to the pharmacist and cannot have the prescription filled.

PROGRAMS

Primary Care Provider Program (PCP) Information

The Medicaid Primary Care Provider (PCP) Program is based on the primary care case management model; a managed fee-for-service arrangement utilizing a primary care physician to serve as the “medical home” for Medicaid recipients.

A key component of the program is the PCP referral for specialty care. The referral process minimizes health care services that are not medically necessary and facilitates more efficient delivery of health care.

(A) Guidance for PCPs in Making Referrals for Specialty Care

1. Utilize a standard referral form to document the referral process. A “model” referral form template is included as an insert to this newsletter. Facilities are encouraged to use this model template for standardization of referral processes from facility to facility.

In case of an audit, the health care facility must have documentation of the referral. If a referral form is not used, a note in the medical record is acceptable.

It is NOT necessary to send a copy of the referral form to the Medicaid office EXCEPT when submitting an adjustment for a claim being denied for a PCP referral reason.

2. Sign or initial and date the referral form. The PCP must sign or initial the referral form to assure the referral process was initiated by the PCP. The referral form must also include the date of referral.

The PCP can designate a staff member to complete the referral form for signature. It is also acceptable for the PCP to designate a staff member to sign the referral form on the PCP’s behalf. However, the designee should indicate they are signing on behalf of the PCP; for example, “Ann Smith, RN for Dr. Bob Jones.”

(B) Exceptions to Standard Referral Processes

1. Recipients do not need a referral from their PCP for some services including emergency care, dental care, prescription medication, mental health services, and family planning services (when provided by an OB/GYN).

2. For emergency medical care, the requirement for a PCP referral is waived for the first 24 hours to allow for emergency medical providers to determine the specialty care required to stabilize the medical condition. After 24 hours, a referral from the PCP is necessary.

(C) Policy Change Regarding PCP Designation for Newborns

Effective February 3, 2006, parents of a newborn have one week (7 days) from the child’s date of birth to designate a PCP for the child. Prior policy required PCP designation two days after birth. Expanding the time frame for PCP designation for a newborn allows for birth costs to be paid and for adequate time for the parent(s) to identify a PCP for the newborn.

(D) For additional information about the PCP program, please use the following resources:

1. The electronic policy manual for the PCP program. This e-manual can be found on the North Dakota Department of Human Services (DHS) website at <http://www.nd.gov/humanservices/policymanuals/home/financialhelp.htm> and then select “Primary Care Provider”.

2. The Primary Care Provider Program booklet for recipients. This booklet can be found at the DHS website: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/managedcare.html>.

Coordinated Service Program (CSP)

The Coordinated Services Program (CSP) is an educational program designed to correct abuse and misuse of medical services. A coordinated effort between practitioners and the Medicaid program is necessary to achieve quality care for Coordinated Services recipients.

The Surveillance and Utilization Review (S/UR) staff sends the Coordinated Services Program physician a CSP referral form to use when making a referral to specialists. The form is self-explanatory and should be used when referring patients to assure Medicaid payment to the referred specialist and for medications prescribed by the referred physician. This form can be copied for your use. The form must be sent immediately to the S/UR Unit by mail or FAX: 701 328-1544. Same day referrals may be made by telephone at 1-800-255-2604 or 701-328-2321 or by FAX.

All referrals must:

- Have a start date
- Indicate end date or that the referral is ongoing
- Indicate the full name of referred physician (not the clinic name)

If the Coordinated Services physician is going to be out of the office for an extended period of time, contact the S/UR Unit staff and inform them who will be providing care for the recipient during their absence. You may also use the referral form to report the information. Likewise, when a Coordinated Services physician relocates or retires, please notify the S/UR staff so arrangements can be made for a new physician for the recipient. This can be done by telephone

or letter; if the recipient is advised by letter, a copy to S/UR staff is sufficient.

Medicaid pays for services provided through appropriate referrals but does not pay for referrals that have been initiated retroactively to satisfy patient demands. All referrals must be made by the Coordinated Services physician, not the referred physician, prior to providing the service. Referrals are required for all physicians even if they are located within the same clinic.

The patient should only be referred to another specialist when medically indicated. Retroactive referrals are not accepted. Referrals should not be made on demand by the patient. The Coordinated Services physician should make a referral to a standby physician if the Coordinated Services physician is going to be gone for an extended period of time. The standby physician should only be providing urgent or emergency services in the absence of the Coordinated Services physician. Routine and on demand services should be referred back to the Coordinated Services physician upon his/her return.

Medicaid will pay for tests, therapies, and prescribed medications by the referred physician. Emergency room visits must meet the criteria for a true emergency as determined by the department's review team and are not handled through the referral process.

When filing a claim, enter the referring physician in block 17 and 17A on the HCFA form and block 25 on electronic claims. This procedure should be followed only when the Coordinated Services physician has made and submitted the referral to our office.

Surveillance and Utilization Review

Sharing Confidential Information: Federal regulations require the North Dakota Medicaid Agency, to conduct provider and recipient reviews periodically. Currently, Medicaid conducts a set number of reviews each quarter. The reviews are conducted to assure the integrity of the program and monitor delivery of services

to assure quality and necessary care for the eligible Medicaid recipients.

During the review, Medicaid staff will periodically request documentation for specific dates of service and specific patients.

Recently we have experienced a number of providers with a reluctance to submit the

requested information, due to HIPAA confidential requirements. Under HIPAA, medical providers, insurance companies and other entities involved with utilization review and payment are allowed to share confidential information, to the extent that it is necessary for payment purposes or utilization review activities. Only information necessary to accomplish the above purposes meets the shared information requirement.

Providers are required to make application for provider status and sign an agreement that outlines the principle requirements for being a Medicaid provider. One of the articles in the agreement requires that the provider provide information periodically as requested by the

Medicaid Agency administrating the Medicaid program. Under HIPAA, this agreement is referred to a Business Partner Agreement and provides the tool in which the Medicaid Program can share confidential information with the provider and visa versa.

We ask that the request for information during the provider or recipient reviews be processed in a timely manner; 30 days is considered ample time to submit the requested information. If there appears to be an extra-ordinary volume of records requested or other circumstances that would make it difficult to produce the information in 30 days, the provider should contact the Medicaid staff for a time frame extension.

NEW PEOPLE & PEOPLE IN NEW PLACES

MEDICAL SERVICES DIVISION

Erik Elkins

Erik was selected as the Assistant Director of Program and Policy in November 2005. Erik has a Bachelor of Science in Business Administration from Minot State University. Prior to his new position, Erik was the Claims Processing Administrator since 2001, and more recently the Business Lead on the Medicaid Systems Project.

Mary Helmers

Mary joined us on November 21, 2005, as the Administrator of Quality of Care and Disabilities. She has a BSN in nursing and is OCN certified. Her nursing background includes Public Health, pediatric and adult oncology.

She is responsible for the following programs: State Review Team/Disability, Incapacity/TANF, Aid to the Blind, Workers with Disabilities, JOBS Good Cause, and Durable Medical Equipment.

Susan Burkhardtsmeier

Susan joined us in June 2005 as a claims processor. Prior work had been as an office and parent aide in the Dickinson area. Susan has worked for the State of North Dakota for 14 years.

Karalee Adam

Karalee joined us in November 2005 as the Assistant Director of Budget and Operations. Karalee has a Bachelor of Science Degree in Computer Information Systems and a Business minor. Karalee also has a Masters Degree in Management, all from the University of Mary. Prior to joining Medical Services, Karalee worked for the Department in the Division of Information Technology as the Deputy Director and the Program Director for the Medicaid Systems Project. Karalee has worked for the State of North Dakota for 14 years.

Karin Mongeon

Karin joined us on June 13, 2005 as the Administrator for Medicaid Managed Care. She has a Bachelor of Science Degree in nursing from the University of Mary. Prior to joining the Department, Karin was employed with the North Dakota Department of Health first as an epidemiologist then as the manager of the HIV/AIDS and TB programs. Karin also has prior work experience as an oncology nurse with MedCenter One Health Systems.

Sue Dunbar

Sue joined us on June 20, 2005. She currently processes Health Care Coverage applications to determine eligibility for Medicaid, Healthy Steps, and the Caring for Children program. Sue was previously employed with Burleigh County Social Services for 7 1/2 years processing applications for the Food Stamp, Medicaid, TANF, Child Care Assistance, and the JOBS programs.

Mary Lou Thompson

Mary Lou came on board in October 2004. As the new Office Manager, she supports the Director, the two Assistant Directors, and several Program Administrators. Mary Lou has over 15 years experience in office administration, and received her diploma in computer programming with a minor in accounting.

Marella Krein

Marella has recently moved from the Medicaid Policy & Eligibility Unit to the Home and Community Based Services Unit. Her duties include enrolling new individuals as Qualified Service Providers and traveling the state auditing these providers to ensure they are providing recipients with quality care.

Deb Masad

Deb joined the division in March 2005 as Medicaid Eligibility Policy Administrator. She was initially assigned to Medicare Part D; involved in general eligibility policy activities. Deb was a county eligibility worker from 1992 to 1999 and then was a regional representative for Economic Assistance Policy from 1999 March 2005.

Jacqueline Edison

Jacqueline joined the Healthy Steps staff in August of 2005, as the 1-877-KIDS NOW help-line specialist. Her duties include screening callers to identify health care coverage needs and providing information on other coverage programs available throughout the state.

Alice Duchscherer

Alice joined us in October 2005. She has an Associate in Applied Sciences, Administrative Assistant degree from Bismarck State College. Prior to joining the Medical Services Division, Alice worked in the medical field for over 15 years in various positions. Alice now supports several program administrators. She is also one of the friendly voice that answers the telephone.

Melissa E.

Melissa joined us in June 2004. She is responsible for reviewing Recipient Liability and consent forms for sterilizations and hysterectomies; and processing Vocational Rehab and Special Education claims. Before employment here, Melissa worked as a Provider Support Specialist with a Bismarck insurance company, and was also previously employed as a temporary Claims Specialist with the Department. Melissa graduated from Minot State University with a Bachelors Degree in Education and a Minor in Special Education.

Jeff R.

Jeff joined us in May 2005 as a Claims Specialist. He was previously employed with Coventry Health Care for 3 years, as an Integrated Claims Specialist. Jeff works with providers and members to resolve claim issues, and audits medical claims specializing in Coordination of Benefit claims and Medical Review. He does public speaking and seminars for organizations in the area. Jeff looks forward to serving the providers with his claims auditing experience.

Jeremy Fleckenstein

Jeremy joined the Departments Provider Audit Unit in June of 2000 as an Auditor II. Since then he has also worked as an Accounting/Budget Specialist II and an Accounting/Budget Specialist III. In January of 2006, Jeremy started in Medical Services as a Human Service Program Administrator. Jeremy serves as the Business lead on the Medicaid Systems Project He has an Associate in Arts degree from Bismarck State College, a Bachelors degree in Accounting from University of Mary and a Masters Degree in Management from University of Mary College of Professional Studies.

We're on the Web! See us at:
www.state.nd.us/humanservices/services/medicalserv/medicaid

ND DEPT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
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BISMARCK ND 58505-0250

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RETURN SERVICES REQUESTED

Please route to

- Billing clerks
- Insurance Processors
- Schedulers
- Other Appropriate
Medical Personnel

Please make
copies as needed.

ATTENTION PROVIDER/DME SUPPLIER

Prior Approval for service(s) by the North Dakota Department of Human Services does not guarantee eligibility nor ensure payment for the services(s). Eligibility is established by the appropriate county social service office on a monthly basis, and payment is contingent upon the eligibility of an individual at the time the services approved are rendered. Eligibility for dates of service may be verified by calling 1-800-428-4140 or 701-328-2891.

All providers are responsible for submitting prior authorizations and claims with the appropriate CPT/HCPC codes. Non-covered codes will be reviewed on an ongoing basis and may be paid if added to the fee schedule or allowed as an exception. Please do not

resubmit another request if the original was sent in the past three weeks. North Dakota Medicaid will not fax or resend approval notices. It is the provider's responsibility to work with their organization to secure the originally sent authorization or approval

The website for guidelines, provider bulletins, manuals and fee schedule is located at

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/>

Any applicable third parties must be billed prior to billing Medicaid and all third party requirements must be followed. The recipient may be responsible for any recipient liability before payment is made by the Department.



STERILIZATION CONSENT FORM
 ND DEPARTMENT OF HUMAN SERVICES
 MEDICAL SERVICES DIVISION
 SFN 889 (Rev. 10/2005)

Clear Fields

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as TANF or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ month / day / year

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature Date

You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):

- American Indian or Alaska Native
- Black (not of Hispanic origin)
- Asian or Pacific Islander
- Hispanic
- White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

(Name of individual to be sterilized) on _____
(Date of sterilization operation)

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
- Emergency abdominal surgery:
(describe circumstances): _____

Physician Date

(Instructions on Reverse)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
MEDICAID RULES FOR STERILIZATIONS

- 1) Once the consent form is received by the Medical Services Division, Department of Human Services, it is considered an original.
- 2) Consent forms must be attached to a paper claim form corresponding to the sterilization procedure. Tubal ligation, hysterectomies and vasectomies cannot be billed electronically.
- 3) Complete all blanks.
- 4) Patient must be mentally competent.
- 5) Patient must be 21 years old when the consent form is signed.
- 6) Patient must wait at least 30 days to have the operation after the consent form is signed except in instances of premature delivery or emergency abdominal surgery that takes place at least 72 hours after the consent is obtained. If premature delivery or emergency abdominal surgery, please check the appropriate box in the Physician's Statement Section.
- 7) Date signed by patient and the date of surgery cannot exceed 180 days.
NOTE: THIS SECTION MUST BE SIGNED AND DATED CORRECTLY OR PAYMENT FOR THE STERILIZATION WILL BE DENIED. THE FEDERAL GOVERNMENT DOES NOT ALLOW ANY CHANGES OR ADDITIONS TO THIS SECTION.
- 8) Statement of Person Obtaining Consent - date must be on or after the date patient signed and dated Consent for Sterilization but prior to the day of surgery.
NOTE: THIS SECTION MUST BE SIGNED AND DATED CORRECTLY OR PAYMENT FOR THE STERILIZATION WILL BE DENIED. THE FEDERAL GOVERNMENT DOES NOT ALLOW ANY CHANGES OR ADDITIONS TO THIS SECTION.
- 9) Physician's Statement Section - date of operation must be the same as the date of surgery.
- 10) Date the Physician Signs the consent must be on or after the date of surgery.

[Please place this referral form information on your agency's letterhead.]

**NORTH DAKOTA MEDICAID
Primary Care Provider (PCP) Program
Referral Form**

Today's Date: ____/____/____

Name of Patient: _____

This patient is being referred to: _____
Specialty Physician and/or Facility

Date of scheduled referral service: ____/____/____ through ____/____/____ or limited
to _____ visits. (The length of the referral cannot exceed 12 months.)

Diagnosis and reason for referral: _____

Referring Physician: _____
Printed

Referring Physician: _____
Signature

Date of Physician's Signature: ____/____/____

Referring Physician's UPIN: _____