NORTH DAKOTA MEDICAID

PROVIDER BULLETIN

Issue 60 • December 2006

MEDICAID MANAGED CARE PROGRAM

Medicaid Managed Care Organization

The Medicaid Managed Care Organization (MCO), referred to as *AltruCare*, has terminated their contract with the North Dakota Department of Human Services (Department) effective November 1, 2006. The Department had a contract with Blue Cross Blue Shield of North Dakota (BCBSND) to operate the MCO through Altru Health Systems.

The Department is working with Medicaid recipients who were enrolled in the MCO to transition them to the Medicaid Program's *Primary Care Case Management (PCCM) Program* (known as the *Primary Care Provider [PCP] Program*). MCO enrollees will not lose access to health care services while this transition takes place.

Primary Care Case Management (PCCM)

Currently, the Medicaid Managed Care Program consists of one program called the *Primary Care Case Management (PCCM) Program* (or the *Primary Care Provider [PCP] Program*). Medicaid-eligible families and pregnant women are required to participate in managed care; aged and disabled Medicaid recipients are not.

To provide PCCM, Medicaid enters into contracts with physicians (internists, family practitioners, general practitioners, obstetricians/gynecologists, pediatricians, and osteopaths), Rural Health Centers (RHCs), Federally Qualified Health Centers (FQHCs) and Indian Health Service (IHS) facilities, to serve as Primary Care Providers (PCPs) to provide primary health care and case management (which includes the location, coordination and monitoring of primary health care services) to managed care enrollees.

Physicians and health care facilities enrolled with Medicaid are automatically included as PCP selections for managed care enrollees, unless they notify Medicaid that they do not want to act in this capacity.

PCPs are paid $2 per enrollee per month while RHCs, FQHCs and IHS facilities receive a case management fee as part of their rate.

Physicians with temporary licenses are not eligible to provide PCP services until they are enrolled with Medicaid under a permanent license.

For general information about the PCCM/PCP Program, please refer to the *Guide to North Dakota Medicaid Primary Care Provider Program* at the following link: http://www.nd.gov/humanservices/info/pubs/docs/dn-913-primary-care-booklet-0604.pdf

MEDICAL SERVICES DIVISION
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MAGGIE D. ANDERSON, DIRECTOR

OPTOMETRIC & DENTAL MANUALS

The North Dakota Medicaid Optometric and Dental manuals have been updated and posted to the website. Please view and/or print the manuals at www.nd.gov/humanservices.

WELLPOINT
(FACILITATED ENROLLMENT PROCESS FOR MEDICARE PART D)

POINT OF SERVICE (POS) FACILITATED ENROLLMENT PROCESS IN 4 STEPS FOR PHARMACISTS

1. **Request Customer's Part D plan ID card.** Alternatively, individuals may have a plan enrollment "acknowledgement letter" that should contain the BIN, PCN, GROUP, and Member ID information. In addition, even if the individual has no proof of enrollment, their plan's billing information may be available through the new E1 query. If none of these sources of information are available, and the customer is dually eligible for Medicare and Medicaid, the POS Facilitated Enrollment process will still allow you to fill the prescription.
2. **Submit an E1 transaction to the TrOOP Facilitator.** This ensures that the member has not already been assigned to a (Prescription Drug Plan) PDP. If you are not sure how to submit an E1-transaction, please contact your software vendor. If the E1 transaction returns a valid BIN/PCN, indicating the member has been enrolled with a PDP, you may NOT submit the claim under the POS Facilitated Enrollment. (If the E1 returns only a helpdesk phone number, this means that the beneficiary has been enrolled in a plan, but that the billing data is still in process.)
3. **Identify a "Dual Eligible" Member.** Request the member's Medicare and Medicaid Identification cards. If the member cannot provide clear evidence of enrollment in both programs, the claim should NOT be processed under the POS Facilitated Enrollment process. Please see below options available to verify a member's dual eligibility.

   *To verify **Medicaid** eligibility:* You can use the following as verification of Medicaid eligibility:

   - Medicaid ID Card
   - Recent history of Medicaid billing in the pharmacy patient profile.
   - Copy of current Medicaid award letter.

   *To verify **Medicare** eligibility:*

   - Submit an expanded E1 query to determine Part A and/or B eligibility
   - Request to see a Medicare card; or
   - Request to see a Medicare Summary Notice (MSN); or
   - Call the dedicated Medicare pharmacy eligibility line at 1-866-835-7595.
4. **Bill the POS Contractor.** Please note that there is no need to call WellPoint to confirm enrollment, as no enrollment preexists the claim submission. Please also note that there are no edits for Non-Formulary Drugs, or for Prior Authorization or Step Therapy. However, drugs excluded from Medicare Part D coverage will be denied. Make sure you have first submitted an E1 query and ruled out evidence of enrollment in a Part D plan, then enter the claim into your claims system in accordance with the WellPoint (Anthem) payer sheet available at:http://www.anthem.com/jsp/atiphona/apm/nav/ilink_pop_native.do?content_id=PW_A08108 It is important that you carefully review the payer sheet and submit claims in the required format. Please work directly with your software vendor in setting this program up in your system. Please note, it is critical that Wellpoint receives both the Medicaid ID number and Medicare Health Insurance Claim Number (HICN) ID number to validate the members "dual eligible" status. Submission of claims without both the Medicaid and the Medicare ID numbers will be considered invalid.

   Member Coverage:

   - Days Supply: Limited to 14 days (This will allow for an appropriate opportunity for members to be enrolled with a PDP)

For Further Assistance: Call (800) MEDICARE or go to http://www.cms.hhs.gov/pharmacy

STERILIZATION CLAIMS

The ND Medicaid program processes and pays inpatient hospital claims using a Diagnostic Related Group (DRG) reimbursement system.

Using this payment methodology, the entire inpatient hospital claim is bundled into one line and paid at one fee determined using the DRG system.

Because of this reimbursement process, if sterilization is performed in conjunction with delivery but without the proper consent form, the coding and charges for sterilization may be omitted from the claim for inpatient hospital claims.

The codes and charges for the delivery alone may be billed on the claim.

BILLING

- Outpatient hospital billings and inpatient billings for services not paid by DRG must be billed separately for each calendar month of service.
- Newborn and mother's charges must be billed on separate claims for each patient.
- Charges should reflect the usual and customary charge of the hospital. Only the patient due amount will be paid by Medicaid. Other insurance coverage must be in Block (55) on the UB-92 claim form. The prior payment amounts in Block (54) must be the difference of total charges and patient amount due.

The following blocks on the UB 92 are required by Medicaid:

Revenue Code 001 - total charges.

Block (1) Name of entity as enrolled in North Dakota Medicaid.

Block (4) Type of bill - Only 111, 112, 113, and 114 are accepted for inpatient
Only 131, 132, 133, 134, and 141 are accepted for outpatient
Only 831 is accepted for ambulatory surgical procedures

Block (6) Statement covers period - must be actual dates of service and cannot exceed one calendar month, unless DRG inpatient.

Block (7) Covered days - required for inpatient, must equal Block (6) minus Block (8)

Block (8) Non-covered days

Block (12) Patient name - Last name, first name, middle initial

Block (14) Birth date - month, day, year

Block (17) Admission date - month, day, year

Block (19) Admission type - 1 - emergency
2 - urgent
3 - elective
4 - newborn

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The following blocks on the UB 92 (Cont.)

Block (20)	Admission source - see UB 92 manual
Block (22)	Discharge status - must be present for inpatient
Block (42)	Revenue code - list each separate revenue code on separate lines; combine like lab codes on same line
Block (44)	HCPC codes (required for outpatient services)
Block (45)	Service date - list if block 6 covers more than one day
Block (46)	Service units
Block (47)	Total charges for that revenue code line
Block (48)	Non-covered charges if applicable (not covered by Medicaid)
Block (50)	Payer - other insurance carrier
Block (51)	Provider number - the 4-digit number assigned by Medicaid
Block (54)	Prior payments - the insurance covered amount by other payers must equal the difference of total charges minus patient due and non-covered
Block (55)	Estimated amount due - patient liability
Block (60)	Medicaid ID number - the patient's ID number
Block (63)	Treatment authorization codes - assigned by PRO and/or Medicaid (see Covered Hospital Services)
Block (67)	Principal diagnosis - must be on all claims
Block (68-77)	Other diagnosis codes as applicable
Block (80)	Principal procedure codes and dates (refer to ICD-9-CM - volume 3 for codes)
Block (81)	Any other procedure codes and dates
Block (82)	Attending physician/PCP (REQUIRED)
Block (83)	Other physician/PCP

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

Please route to:
- ☐ Billing clerks
- ☐ Insurance Processors
- ☐ Schedulers
- ☐ Other Appropriate Medical Personnel

Please make copies as needed.

FAXING PRIOR AUTHORIZATIONS

Attention Providers who submit Prior Authorization (PA) via fax. When faxing a PA, do not refax the PA unless you have not received your PA number within three weeks of the original fax date. Receipt of multiple PA's causes confusion and lengthens the authorization process.