



PROVIDER BULLETIN

THE REIMBURSEMENT NEWS SOURCE

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MEDICAL SERVICES DIVISION

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NEW EDUCATION REQUIREMENTS FOR PROVIDER EMPLOYEES

The Deficit Reduction Act of 2005 (enacted in 2006) mandates that any provider or provider entity that receives payments in any federal fiscal year (October – September), of at least \$5,000,000 from any state Medicaid program must have written policies for all employees, including management, and for all employees of any contractor or agent.

The written policies must provide detailed information about the following:

- The Federal False Claims Act under title 31 of the United State Code; sections 3729 through 3733;
- Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;
- Any State laws pertaining to civil or criminal penalties for false claims and statements;
- Whistleblower protections under state laws; and
- The provider or provider entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

The policies may be written or electronic form, but must be disseminated and readily available to all employees and to all employees of any contractor, or agent, and must be included in any provider employee handbook of the provider or provider entity.

Based on this new federal requirement, North Dakota Medicaid is requiring each provider or provider entity that meets the \$5,000,000 threshold to annually certify to the Department that the entity is complying with the education requirements. The required certification form, will be available on the website at <http://www.nd.gov/eforms/>

THIRD PARTY LIABILITY

Medicaid recipients must report all third party resources when applying for or updating their Medicaid eligibility. These resources must be used prior to billing Medicaid.

Medicaid's Verify System has all eligibility, third party, and other information a provider needs to determine who and when to bill for services rendered.

Medicaid is to be billed for any balances due after other third parties have been billed and the benefit is received.

If the Medicaid patient is a pregnant woman, child under six, or is eligible for Indian Health Services, the third party does not have to be billed prior to billing Medicaid.

The Medicaid eligible patient is required to use the third party benefits to the fullest extent of the coverage. The patient and provider must follow all third party required policies and procedures to maximize available benefits, i.e. prior authoriza-

tion, limits, network providers etc. Failure to follow third party policies and procedures could result in denial of any claims billed to Medicaid.

If a provider bills, and is paid, by Medicaid and later receives a payment from an unknown third party payer, within one full business cycle, Medicaid must be refunded totally or up to the extent of the third party payment.

If you bill Medicaid not knowing a third party resource, Medicaid will deny payment and return the claim with Third Party Billing Information. The Verify System can be used to determine if there are third party resources available to the patient. The telephone number to access that system is 1-800-428-4140 or 328-2891.

More in depth information can be obtained in the General Information for Providers Manual, which can be viewed at: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/gen-info-providers.pdf>

NEW CMS 1500 FORMS

Effective June 1, 2007, paper claims for services provided after March 31, 2007 must be submitted on the new CMS 1500 claim forms. Claims must be completed using the instructions per NUCC at <http://www.nucc.org/>. Please note, Medicare does not require completion of field 33b, however, this field is required for Medicaid claims. Field 33b must contain the provider's 5 digit Medicaid Number preceded by "1D." Claims without a Medicaid number preceded by 1D will not be processed. Claims not completed per the instructions or submitted on old forms will not be processed and will be returned to the provider.

ESSURE® PROCEDURE

North Dakota Medicaid (NDMA) **DOES NOT** 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.)

Please inform NDMA recipients inquiring about tubal ligation methods, that NDMA will not allow payment for this procedure.

If you have any questions or concerns regarding sterilizations or hysterectomies under NDMA please call 701-328-4046.

COORDINATED SERVICES PROGRAM

The Coordinated Services Program (CSP) is a managed care program in which the physician is the key to accessing and providing medical care. For Medicaid recipients assigned to the CSP, the primary physician is responsible for managing a patient's medical needs and coordinating specialty services and treatment plans to avoid duplication of services, adverse interactions of medications and the unnecessary use of services.

The CSP patient is expected to be evaluated, in person, by the primary physician to determine the medical problem and, when medically necessary, referred to a specialist.

A physician who is practicing primary care (Family Practice or Internal Medicine) may be selected as a primary physician by the CSP patient. The patient is then allowed to see only their selected primary physician.

For the CSP clients, the following rules must be followed when making referrals to assure that there will be no denial or delays in payment to the provider of the services.

1. No retroactive referrals are accepted. The primary physician must make a referral before the services are provided. The referral should be made on a Medicaid supplied referral form, unless time is a factor, then a verbal referral can be made. The referral can be sent US Mail or FAX (701-328-1544) Emergency services may be provided in the ER or other facility without a referral from the primary physician, however, the medical need for the emergency services is, subject to review by Medicaid Surveillance and Utilization Review (S/UR) staff.
2. In the absence of the primary physician for more than two days, a blanket referral can be made to the covering physician to provide urgent or immediate care when medically necessary. Otherwise, the CSP patient should make an appointment with the primary physician upon his/her return. Services should not be provided for the convenience of the patient or provider. S/UR must be advised in order for Medicaid to pay claims for the covering physician.
3. The Medicaid Verify System (**328-2891 or 1-800-428-4140**) should be checked to verify if a patient is on the CSP. The system will tell you who the primary physician is and if a referral is needed.
4. All providers who have provided care to a CSP patient in the past are notified when the patient is referred to the CSP. The notice will advise whom the primary physician is or if the patient is on emergency only status. Providers of service should develop a flagging system to identify CSP Medicaid patients before services are provided to assure that the patient is accessing services with, or through, the primary physician.
5. Emergency only status is for Medicaid CSP patients who have not selected a primary care provider within an allotted time frame. Medicaid will pay for emergency or urgent care only until the patient chooses a primary physician. The services will be reviewed and must be determined not to be routine medical care. "Urgent care" is defined as services that are not an emergency, but the nature of the medical need requires that treatment be provided in a timely manner to prevent further injury or long-term effects. Urgent Care services are normally provided after hours when the primary physician is not available. The provider of the service must use discretion when providing services outside the Medicaid requirements. If the services are provided within normal working hours, the S/UR unit may be contacted for prior authorization by calling **328-2321** or toll free at **1-800-755-2604**.

Medicaid patients who do not follow Medicaid requirements for accessing medical services (not using their primary physician or a referral, not reporting eligibility or third party resources, not accessing services in the appropriate setting, or accessing non-covered services) are considered private pay and are seeking services outside the system. The provider may treat them as any other private pay patient for access and billing.

OUT-OF-STATE REFERRALS

- Out-of-state services at sites more than fifty statute miles from the North Dakota border must be prior authorized. Out-of-country services are never covered, regardless of distance.
- A minimum of two weeks before scheduling an appointment, Medicaid must receive from the recipient's Primary Care Physician in North Dakota a written request to the Medicaid program for authorization for out-of-state services.

Requests must include:

- 1) Recipient's name, Medicaid ID number, and date of birth
- 2) Diagnosis
- 3) Medical information supporting the need for out-of-state services
- 4) A written second opinion from an appropriate in-state board certified specialist, following a current (within three months) examination, which substantiates the medical need for out-of-state care
- 5) The physician and facility being referred to
- 6) Assurance that the service is not available in North Dakota

- Medicaid staff determines if the referral meets state requirements and approves or denies the request in writing. A copy of the determination is sent to the primary physician, out-of-state provider(s), recipient, and county social service office.
- Transfers for emergency out-of-state services may be done at the discretion of the in-state physician, but are subject to Medicaid review. The transferring facility must notify ND Medicaid within 48 hours of the transfer. Documentation must include: destination and date of transfer, mode of transportation and discharge summary. If transported by air ambulance and the trip was less than 50 miles, the facility must document why air ambulance, rather than ground ambulance was used.
- Claims from out-of-state providers will not be paid without written prior authorization.
- If the out-of state services are approved, the recipient's County Social Service Office is responsible for assisting the recipient with arrangements for travel, lodging, and meals.
- Failure to comply with out-of-state procedures will result in denied claims.

TRANSPORTATION PROVIDERS: EMERGENT & NON-EMERGENT

NDMA is currently revising the transportation policies and procedures for transportation services.

Please be aware that upon completion, new procedures, information, and fee schedules will be distributed.

One of the changes to be made will be a change in the code, to ensure code compliance and to assist in utilization auditing.

Current policies and procedures will be followed until further notice.

MMIS SYSTEM REPLACEMENT UPDATE

The Department is in the process of updating the existing Medicaid Management Information System (MMIS). You may already be familiar with the MMIS as this is the system that adjudicates and pays medical claims. What you may not be aware of is that there are actually six main components to the system. Those components are the Recipient Subsystem, Provider Subsystem, Claims Processing Subsystem, Reference File Subsystem, Surveillance and Utilization Review Subsystem, and the Management and Administrative Reporting Subsystem. In addition to replacing the MMIS, the Department is also acquiring an updated Decision Support System (DSS) to help analyze the additional information that will be available from the new MMIS.

For each of the six main components within the MMIS, the Department will be both enhancing and adding to our existing capabilities. One of these capabilities includes allowing individuals to locate a participating Medicaid provider using a web search tool. Just one of the many search criteria will be by distance to a given location. This should assist the individual in easily finding a provider who is both enrolled in Medicaid and is close to their location. Individuals who are enrolled in our Primary Care Case Management (PCCM) program will have the capability to select their own Primary Care Physician (PCP) using a similar web based tool.

Providers will also be able to leverage this online environment for things such as:

- Enrollment
- Submission of claims
- Submission of eligibility requests
- Submission of prior authorization requests
- Checking the status of a previously submitted claim
- Correcting select suspended claims
- Checking the remaining balance on an individual's service limit

We will also be providing claim templates for ease in submittal of online claims. These templates have the capability to be saved online and can be configured to allow for a minimal amount of data entry in order to submit a new claim.

The different vendors enlisted to help with the replacement of the system will include a vendor responsible for the development of the MMIS. In addition to designing, building, testing, and implementing the new MMIS, they will also serve as the systems integrator making sure the other vendor products are able to work with the new MMIS. A second vendor that will be involved is the Decision Support System vendor. This vendor will help with the design and implement our updated DSS. Finally, to help insure a quality system we will enlist the services of an Independent Auditor and an Independent Verification and Validation vendor.

Throughout the project there will be several phases including: planning, requirements, detail design, construction, data conversion, testing, training, and then implementation. Currently, the project is two-thirds of the way through the requirements phase. The next phase of the project will be the detail design phase, followed shortly thereafter by the construction and data conversion phases. Additional information will be required in the new system; therefore, provider re-enrollment will occur approximately six months before the full system go-live date. The tentative full system go-live date is scheduled for July of 2009.



BILLING USUAL AND CUSTOMARY CHARGES

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

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

The submission of the bill by the provider serves as affirmation that the fee submitted is the usual and customary fee of the provider for the services rendered. North Dakota Medicaid can require documentation from the provider establishing that the fee under question is the provider's usual and customary fee charged to the general public.

For providers that have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Providers should not use the North Dakota Medicaid calculated allowable fee schedule amount for the billed charge for the following reasons:

- When North Dakota Medicaid increases the rates, any providers not aware of the increase who are billing the North Dakota Medicaid allowable as their billed charge will only receive the billed charges, and not the increased rate.
- North Dakota Medicaid often draws on provider historical data to formulate possible rate increases. If a provider's billed charge is the same as the North Dakota Medicaid allowable, it will not support the need for a rate increase.
- Submission of usual and customary fees provides important information for the North Dakota Medicaid budgeting process and reporting to the State legislature.

CHECK-WRITE DATES

Typically, check-write for 2007, occurs every Monday evening; however, there will be the following exceptions:

No Check-Write	Rescheduled Date
May 28	May 29
July 30	August 6
September 3	September 4
November 12	November 13
December 24	December 26

NEW FACES & PLACES IN MEDICAL SERVICES

- ☺ **Karen Tescher** – Assistant Director, Long-Term Care Continuum
- ☺ **Barb Fischer** – Assistant Director, Budget & Operations
- ☺ **Larry Stockham** – S/UR Analyst
- ☺ **Jodi Hulm** – Administrator, ND Health Tracks & Healthy Steps
- ☺ **Sandra Kuntz** – Administrator, Medicaid Policy & Eligibility
- ☺ **Nancy Nikolas** – Administrator, HCBS
- ☺ **Amanda M.** – Claims Processing Auditor
- ☺ **Laura Olson** – Administrator, Medicaid Payment & Reimbursement Services

GARDASIL-HPV VACCINE CODING

GARDASIL (Quadrivalent Human Papillomavirus [Types 6, 11, 16, 18] Recombinant Vaccine)

CPT CODE: 90649

Human Papilloma virus (HPV) vaccine,
Types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use

INDICATIONS FOR USE:

Indicated in girls and women 9-26* years of age for the prevention of the following diseases caused by Human Papillomavirus (HPV) types 6, 11, 16, 18:

- Cervical cancer
- Genital warts (condyloma acuminata) and the following precancerous or dysplastic lesions:
- Cervical adenocarcinoma *in situ* (AIS)
- Cervical intraepithelial neoplasia (CIN) grade 2 and grade 3
- Vulvar intraepithelial neoplasia (VIN) grade 2 and grade 3
- Vaginal intraepithelial neoplasia (VaIN) grade 2 and grade 3
- Cervical intraepithelial neoplasia (CIN) grade 1

CRITERIA:

The HPV vaccine should be administered intramuscularly as 3 separate 0.5-ml doses with the first dose given at elected date, second dose given 2 months after the first dose and the third dose given 6 months after the first dose.

- ND Medicaid will reimburse for the HPV vaccine and the immunization administration for date of service 9/26/06 and after, for women 19-20* years of age at the current rate.
- ND Medicaid will reimburse for the HPV vaccine and the immunization administration for date of service 9/26/06 and after, for girls/women 9-18 years of age ONLY if no VFC vaccine is available.**

* ND Medicaid will only allow/reimburse for Gardasil (HPV) vaccine (non-VFC qualified) for women age 19 and 20 years of age. ND Medicaid will NOT allow/reimburse Gardasil for women 21 years of age and older.

** The claim must be submitted on a CMS 1500 (paper) and note in Box 19 stating, "No VFC vaccine available."

COVERED DIAGNOSIS:

V04.89 - Need for prophylactic vaccination and inoculation against, other viral diseases

CODING/BILLING:

90649 (Human Papilloma virus - HPV) vaccine - \$127.50 (ND Medicaid allowed amount) for each of three (3) doses for women 19-20* years of age. (See CRITERIA for clarification)

OR

90649-SL (Human Papilloma virus - HPV) vaccine –SL (state supplied) – \$0.00 must be submitted for girls/women 9-18 years of age who qualify and receive VFC vaccine.

AND

90471 or 90472 - The appropriate Immunization administration code and charge must be billed with each HPV vaccine (90649).

ND DEPT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
600 E BOULEVARD AVE DEPT 325
BISMARCK ND 58505-0250

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Please route to

- Billing clerks
- Insurance Processors
- Schedulers
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Medical Personnel

Please make copies as
needed.

NPI

Don't Delay! Your National Provider Identifier (NPI) will be required on all electronic claims after May 23, 2007. You are responsible for informing NDMA of your NPI. If you have questions regarding the steps to obtain or register your NPI number, please contact Medical Services via email dhsnpi_helpdesk@nd.gov.

DME FEE SCHEDULE

When referring to the fee schedules on the department website for DME supplies and/or equipment, be sure to use the fee schedule for Durable Medical Equipment, which can be found at: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider-durable.html>, not the Medicaid Basic Fee Schedule.

We're on the Web! See us at:

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