GENERAL INFORMATION

FOR PROVIDERS

MEDICAID AND OTHER

MEDICAL ASSISTANCE PROGRAMS

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human services

Medical Services
(701) 328-2321
Toll Free 1-800-755-2604
Fax (701) 328-1544
TTY (701) 328-3480
Provider Relations (701) 328-4030

John Hoeven, Governor
Carol K. Olson, Executive Director

Dear Medicaid Provider:

This manual was designed to provide information that will assist you in understanding coverage and payment policies for the various services of the North Dakota Medicaid program.

The manual will be updated on an ongoing basis, and will be posted to our web page at http://www.nd.gov/humanservices/.

For other updates, please check out the Updates for Providers feature at http://www.nd.gov/humanservices/services/medicalserv/medicaid/provider.html.

If you have any questions relating to the information contained in this manual, please contact our provider relations staff at 800-755-2604. If you have suggestions for additions to the manual, please submit those to the Medical Services Division at the following email address: dhsmed@nd.gov.

Thank you for your continued participation in the North Dakota Medicaid program. Many of the recipients have chronic conditions that require ongoing care to assist them to achieve positive health outcomes. Your willingness to provide care to these individuals is greatly appreciated.

Sincerely,

Maggie D. Anderson

Maggie D. Anderson, Director
Division of Medical Services

TABLE OF CONTENTS

KEY CONTACTS **1**

PROVIDER REQUIREMENTS **4**

PROVIDER ENROLLMENT ELIGIBILITY 4
PROVIDER ENROLLMENT 4
OUT-OF-STATE PROVIDERS 5
ENROLLED PROVIDERS 5
CHANGES IN ENROLLMENT 6
CHANGE IN OWNERSHIP 6
ELECTRONIC CLAIMS SUBMISSION 6
TERMINATING MEDICAID ENROLLMENT 7
PROVIDER REQUIREMENTS 7
PAYMENT FOR SERVICES 8
MEDICAID PAYMENT IS PAYMENT IN FULL 8
PAYMENT RETURN 9
DISCLOSURE 9
CLIENT SERVICES 10
CONFIDENTIALITY 10
COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, AND POLICIES 10
PROVIDER SANCTIONS 11
AUTOMATED DIRECT DEPOSITS OF PAYMENT 11
INTERNAL REVENUE SERVICE FORM W-9 “REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION” 11

MEDICAID COVERED SERVICES **17**

ABORTION SERVICES **23**

DEPARTMENTAL APPROVAL FOR ABORTION SERVICES 23
DOCUMENTATION REQUIREMENTS 23

NORTH DAKOTA STATUTES CONCERNING RAPE AND INCEST **25**

ALLERGY IMMUNOTHERAPY – ALLERGY TESTING **27**

COVERED SERVICES 27
EXCLUDED SERVICES 27
COVERED LIMITATIONS 27

BILLING REQUIREMENT: Services must be billed on the HCFA 1500 Claim Form. 28
PROVISIONS OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY 29

AMBULATORY SURGICAL SERVICES 30

AMBULATORY SURGICAL SERVICES 30
SEPARATELY COVERED SERVICES IN THE AMBULATORY SURGERY CENTER/OUTPATIENT HOSPITAL SURGERY 31
BILLING REQUIREMENTS 32

ANESTHESIOLOGY SERVICES 33

WHO MAY PROVIDE ANESTHESIOLOGY 33
PAYMENT ISSUES 33
DOCUMENTATION REQUIREMENTS FOR BILLING 34
OTHER ANESTHESIA SERVICES 34
BILLING REQUIREMENTS 35

BILLING PROCEDURES 36

CLAIM FORMS 36
CODING 36
SUBMITTING A CLAIM 38
CLAIM INQUIRIES 40
WHEN RECIPIENTS HAVE OTHER INSURANCE 40
WHEN CAN I BILL A MEDICAID RECIPIENT DIRECTLY? 41
RECIPIENT CO-PAYMENTS 41
THE MOST COMMON BILLING ERRORS AND HOW TO AVOID THEM 43

CARDIAC REHABILITATION 45

PROVIDERS 45
COVERED SERVICES 45
NON-COVERED CARDIAC REHABILITATION SERVICES 47
PHYSICIAN PROFESSIONAL SERVICES 47

CERTIFIED NURSE PRACTITIONERS 48

WHAT IS A NURSE PRACTITIONER 48
BILLING REQUIREMENTS 48

CHIROPRACTIC SERVICES 49

WHAT IS CHIROPRACTIC CARE 49
COVERED SERVICES 49
NON-COVERED SERVICES 49
PAYMENT LIMITATIONS AND BILLING PROCEDURES 50

COORDINATED SERVICES PROGRAM 51

WHAT IS THE COORDINATED SERVICES PROGRAM (CSP)? 51
WHO IS A CANDIDATE FOR CSP? 51
PROGRAM REQUIREMENTS 51

HOW DOES THE PROCESS WORK? 52
HOW DOES AN APPEAL REQUEST WORK? 52
WHAT IF THE CSP RECIPIENT WANTS TO CHANGE PROVIDERS? 53
WHAT IF THE CSP RECIPIENT OBTAINS SERVICES FROM A NON-DESIGNATED PROVIDER? 53
WHAT IF THE RECIPEINT NEEDS TO SEE A SPECIALIST? 53

FAMILY PLANNING SERVICES 54

FAMILY PLANNING 54
PROVIDERS 54
PAYMENT ISSUES 54
FILING CLAIMS FOR SERVICES 55

HOME HEALTH PRIVATE DUTY NURSING 56

WHAT IS HOME HEALTH CARE/PRIVATE DUTY NURSING 56
WHO PROVIDES HOME HEALTH CARE 56
WHO MAY QUALIFY FOR HOME HEALTH SERVICES 57
PLAN OF CARE FOR SERVICES 57
TYPES OF HOME HEALTH SERVICES 58
NON-COVERED SERVICES 59
HOW TO REQUEST HOME HEALTH SERVICES 60
UTILIZATION CONTROL PROCESSES 61
PAYMENT FOR SERVICES 61
HOW TO FILE A CLAIM 61

HOSPITAL SERVICES 63

COVERED HOSPITAL SERVICES 63
QUALIFIED PROVIDERS 64
SUBMITTAL OF CLAIMS 64
PAYMENT TO OUT OF STATE HOSPITALS 65
AMBULATORY SURGICAL SERVICES 65
KIDNEY DIALYSIS SERVICES 66
NON-COVERED HOSPITAL SERVICES 66
BILLING MEDICAID 66
UB 92 CLAIM FORM - MEDICAID REQUIREMENTS 67
GENERAL INFORMATION 69

HUMAN SERVICE CENTER SERVICES 70

WHAT IS A HUMAN SERVICE CENTER 70
TYPE OF SERVICES PROVIDED 70

HYSTERECTOMY 73

WRITTEN CONSENT FOR HYSTERECTOMY 73
INSTRUCTIONS FOR COMPLETING THE PHYSICIAN CERTIFICATION FOR HYSTERECTOMY AND RECIPIENT ACKNOWLEDGEMENT OF STERILITY FORM 73

IMMUNIZATIONS **75**

COVERED SERVICES 75
COVERAGE LIMITATIONS 75
BILLING REQUIREMENTS 76
BILLING REQUIREMENTS FOR NORTH DAKOTA DEPARTMENT OF HEALTH SUPPLIED VACCINE THROUGH THE VACCINES FOR CHILDREN (VCF) PROGRAM 76
PAYMENT RATES 76

INDIAN HEALTH SERVICES (I.H.S.) **77**

GENERAL INFORMATION 77
BILLING INFORMATION 77

INDIVIDUAL EDUCATION PLAN RELATED SERVICES (IEPRS) **79**

WHO MAY BILL FOR SERVICES? 79
COVERED SERVICES 80
NON-COVERED SERVICES 80
RECIPIENT ELIGIBILITY 81
GENERAL BILLING PROCEDURES 81

LAB, RADIOLOGICAL, AND DIAGNOSTIC SERVICES **82**

PROVIDERS 82
INDEPENDENT LABORATORIES, MEDICARE CERTIFIED 82
COMPONENTS OF AND BILLING FOR RADIOLOGIC SERVICES 82
LABORATORY SERVICES IN A PHYSICIAN'S OFFICE 83
CT SCAN / MRI 83

MEDICAID ELIGIBILITY OF RECIPIENT **84**

THE PURPOSE OF MEDICAID 84
WHERE TO APPLY FOR MEDICAID BENEFITS 84
WHO IS ELIGIBLE FOR MEDICAID 84
MEDICAID IDENTIFICATION (ID) NUMBER AND CARD 86

MEDICARE COVERAGE **88**

WHEN RECIPIENTS ALSO HAVE OTHER COVERAGE 88
MANDATORY ASSIGNMENT OF CLAIMS FOR PHYSICIAN SERVICES 89

NON-COVERED MEDICAID SERVICES **91**

NORTH DAKOTA ACCESS AND CARE PROGRAM **94**

GENERAL INFORMATION 94
PARTICIPATING POPULATIONS 95
EXCLUDED POPULATIONS 95
VERIFICATION 95
SERVICE AREA 96
PRIMARY CARE PROVIDER PROGRAM 97

PROVIDER AND PRIMARY CARE PROVIDER ENROLLMENT 97
DUTIES OF PRIMARY CARE PROVIDER..... 98
CASE MANAGEMENT FEE 98
COORDINATION OF BENEFITS WITH OTHER MANAGED CARE PROGRAMS OR INSURANCE POLICIES 98
PAYMENT OF SERVICES 99
COVERED AND NON-COVERED SERVICES 99
EMERGENT AND URGENT SERVICES..... 104
COPAYMENTS..... 104
REFERRALS AND PRIOR AUTHORIZATIONS..... 105
OUT-OF-STATE REFERRALS..... 106
EDUCATION AND ENROLLMENT OF MEDICAL ASSISTANCE ENROLLEES..... 106
REQUESTING A CHANGE IN PCP 107
VOLUNTARY DISENROLLMENT / TRANSFER BY THE ENROLLEE 107
ENROLLEE RIGHTS AND PROTECTIONS..... 108
INFORMATION REQUIREMENTS..... 108
ADDITIONAL RULES FOR PCPS..... 108
PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES 109
SANCTIONS..... 110
MANAGED CARE ORGANIZATION 111
COVERED AND NON-COVERED SERVICES 111
EMERGENT AND URGENT SERVICES..... 113
COPAYMENTS..... 114
REFERRALS AND PRIOR AUTHORIZATION 114
EDUCATION AND ENROLLMENT FOR MCOS 114
RECIPIENTS WHO ARE IN THE HOSPITAL WHEN COVERAGE CHANGES..... 115
COMPLAINTS 115
ENROLLED RECIPIENT RIGHTS..... 115
GRIEVANCES AND APPEALS 116

NORTH DAKOTA HEALTH TRACKS EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) 117

WHAT IS EPSDT..... 117
OVERVIEW 117
HEALTH TRACKS SERVICE REQUIREMENTS..... 118
PERIODICITY SCHEUDULE..... 119
DIAGNOSIS..... 119
TREATMENT..... 119
DOCUMENTATION REQUIREMENTS 119
BILLING REQUIREMENTS 120

NURSE-MIDWIFE SERVICES 121

WHAT IS THE INTENT OF NURSE-MIDWIFE SERVICES 121
HOW TO RECEIVE PAYMENT FOR NURSE-MIDWIFE SERVICES 121

NUTRITIONAL SERVICES 122

PAYMENT AND LIMITATIONS 122
SERVICES PROVIDED BY DIABETIC EDUCATION CENTERS 123

OCCUPATIONAL THERAPY 124

GENERAL INFORMATION 124
COVERED SERVICES 125
PRIOR AUTHORIZATION PROCESS 127
NON-COVERED SERVICES 127

PHYSICAL THERAPY 129

GENERAL INFORMATION 129
COVERED SERVICES 129
PRIOR AUTHORIZATION PROCESS 131
NON-COVERED SERVICES 132

PHYSICIAN SERVICES 133

SERVICES 133
PREVENTATIVE HEALTH SERVICES 134
TELEPHONE CALLS 134
INCIDENTAL SURGICAL PROCEDURES *(added July 2005)* 135
ADDITIONAL SURGICAL PROCEDURES 135
CONCURRENT CARE 135
NON-COVERED SERVICES FOR CONCURRENT CARE 136
BILLING REQUIRMENTS FOR CONCURRENT CARE 136
CRITICAL CARE 136
PROLONGED CARE 137
CARE PLAN OVERSIGHT SERVICES 137
TELEMEDICINE SERVICE 137
MEDICAL SUPPLIES PROVIDED BY A PHYSICIAN'S OFFICE 138
ONCOLOGY DRUG TRIALS 138
OTHER COVERED PHYSICIAN SERVICES 138

PRIOR AUTHORIZATION FOR OUT-OF-STATE SERVICES 140

WHAT IS AN OUT-OF-STATE PROVIDER 140
MEDICAID COVERED SERVICES FOR OUT-OF-STATE CARE 140
REQUESTING OUT OF STATE MEDICAL SERVICES 140
ADOPTION AND FOSTER CARE 141
OUT-OF-STATE EMERGENCY SERVICES 142
TRAUMATIC BRAIN INJURY (TBI) PROGRAM 142
OUT-OF-STATE PSYCHIATRIC SERVICES FOR CHILDREN UNDER 21 142
EMERGENCY SERVICES FOR RECIPIENT'S TEMPORARILY OUT OF THE STATE/COUNTRY 143

PUBLIC HEALTH CLINICS 144

BACKGROUND 144
COVERED SERVICES 144
BILLING PROCEDURES 145

REBILLING AND ADJUSTMENTS 146

HOW LONG DO I HAVE TO REBILL OR ADJUST A CLAIM 146
WHEN TO REBILL 146
HOW TO REBILL 147
ADJUSTMENTS 147
WHEN TO REQUEST AN ADJUSTMENT 147
HOW TO REQUEST AN ADJUSTMENT 147
COMPLETING AN ADJUSTMENT REQUEST FORM 148
MASS ADJUSTMENTS 149
ELECTRONIC FUNDS TRANSFER 149

RECIPIENT LIABILITY 150

WHAT IS RECIPIENT LIABILITY 150
TAKING RECIPIENT LIABILITY (RL) AT THE TIME OF SERVICE 150

REMITTANCE ADVICE 152

REMITTANCE ADVICE DESCRIPTION 152
EXAMPLE OF MEDICAL, DENTAL OR PHARMACY REMIT ADVICE 152
(KEY FIELDS ON THE REMITTANCE ADVICE) 152
MEDICAL, DENTAL OR PHARMACY REMITTANCE ADVICE EXAMPLE 154
EXAMPLE OF INPATIENT HOSPITAL REMITTANCE ADVICE 155
INPATIENT HOSPITAL REMITTANCE ADVICE EXAMPLE 157
FINANCIAL TRANSACTIONS 158

REVIEW BY NORTH DAKOTA HEALTHCARE REVIEW 159

OVERVIEW 159
PREAUTHORIZATION PROCESS 159
PROCEDURES REQUIRING PREAUTHORIZATION 161

RURAL HEALTH CLINICS (RHC) and FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) 163

PROVIDER ENROLLMENT 163
COVERED SERVICES 163
BILLING PROCEDURES 163
PRIMARY CARE PROVIDER (PCP) DESIGNATION 164

SPEECH-LANGUAGE PATHOLOGY 165

GENERAL INFORMATION 165
COVERED SERVICES 165
PRIOR AUTHORIZATION PROCESS 166
NON-COVERED SERVICES 167

STERILIZATION 168

CONSENT FOR STERILIZATION 168
WRITTEN CONSENT FORM 168
FILING OF CLAIMS 169

STANDARDS FOR RETROACTIVE ELIGIBILITY 169

SURVEILLANCE UTILIZATION (SURS) REVIEW 171

WHAT IS THE FUNCTION OF SURS 171
DESK AUDITS 171
KEY POINTS 172
BILLING TIPS 173

THIRD-PARTY LIABILITY 175

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS 175
RECIPIENT COOPERATION WITH TPL BILLING 177

TRANSPORTATION SERVICES 178

GENERAL REQUIREMENTS 178
TRANSPORTATION BETWEEN PROVIDERS 179
PAYMENT LIMITATIONS 179
PAYMENT LIMITATION FOR TRANSPORT OF DECEASED PERSON 179
PAYMENT LIMITATION FOR AMBULANCE TRANSPORTATION 180
HANDICAP-ACCESSIBLE TRANSPORTATION 181
USUAL AND CUSTOMARY CHARGES FOR HANDICAP-ACCESSIBLE TRANSPORTATION 181
AIR AMBULANCE 181
OUT-OF-STATE TRANSPORTATION 182
EXCLUDED SERVICES 182
TRANSPORTATION BY PRIVATE VEHICLE 183
TAXI TRANSPORTATION 184

WOMEN'S WAY 185

KEY CONTACTS

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Central Time).

Provider Enrollment

(800) 755-2604
(701) 328-4033

Send written inquiries to:

Provider Enrollment
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Or e-mail inquiries to:

dhsenrollment@state.nd.us

Managed Care Program

(701) 328-1884
(800) 755-2604

E-mail: dhsmed@state.nd.us

Claims

Send paper claims to:

Claims Processing
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Provider Relations

For questions about recipient eligibility, payments, denials or general claims questions:

(800) 755-2604
(701) 328-4030

Send written inquiries to:

Provider Relations
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Coordinated Services Program

Inquiries regarding coordinated services program recipients:

(800) 755-2604
(701) 328-2334
(701) 328-4010

Client Eligibility

To verify recipient eligibility call:

(701) 328-2891
(800) 428-4140

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 755-2604
(701) 328-3507

Send written inquiries to:

Third Party Liability Unit
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Surveillance/Utilization Review

To report suspected Medicaid provider fraud and abuse:

(701) 328-4024
(800) 755-2604

E-mail: dhsmed@state.nd.us

Send written inquiries to:

Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

Prior Authorization Contacts

Ambulatory Behavior Health Care	(701) 328-4027
Durable Medical Equipment	(701) 328-4027
Emergency/Ambulance Services	(701) 328-1966
LTC UR/UC and Inpatient Psychiatric Services for Children Under 21	(701) 328-4864
Out-of-State Medical Care	(701) 328-4027
Pharmacy	(701) 328-4023
Services Limits	(701) 328-4893
North Dakota Health Care Review	(701) 852-4231
Dual Diagnosis Management (Long Term Care and Inpatient Psyche Services for Children Under 21)	(877) 431-1388

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PROVIDER REQUIREMENTS

PROVIDER ENROLLMENT ELIGIBILITY

To be eligible for enrollment, a provider must:

- Provide services to at least one Medicaid eligible recipient.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.
- Be a provider carrying current license, certification, accreditation or registration according to North Dakota state laws and regulations.

PROVIDER ENROLLMENT

Providers must complete the *North Dakota Medicaid Provider Enrollment Packet.* This is a contract between the provider and North Dakota Medicaid. The enrollment packet consists of an enrollment questionnaire, a W-9 form, and provider agreement. All forms need to be completed, signed, dated and submitted with a copy of all applicable licenses.

Medicaid payment is made only to enrolled providers.

Each provider is assigned a North Dakota Medicaid provider number, which should be used in all correspondence with Medicaid. All claim forms require the North Dakota Medicaid provider number for payment reimbursements.

Providers must apply for a Medicaid Provider Number for each type of service to be provided. For example, a pharmacy that also sells durable medical equipment (DME) must apply for a Medicaid Provider Number for the pharmacy and another Medicaid Provider Number for DME. If a hospital is billing for hospital charges on a UB-92 and would like to bill for professional fees on a CMS-1500, this would also require two enrollments. For all enrollment-related business, contact Provider Enrollment (see Key Contacts).

OUT-OF-STATE PROVIDERS

For purposes of this section, an "out-of-state provider" means a provider who provides a health service to a North Dakota Medicaid recipient at a site located in a state other than North Dakota. All out-of-state services require prior authorization (except in the local trade area within 50 miles of the North Dakota border or services provided in response to an emergency).

An out-of-state provider may apply for retroactive enrollment as a provider effective on the date of service to a North Dakota Medicaid recipient. However, North Dakota Medicaid has a one-year timely filing limit. This means you have one year from the date of service to become enrolled and bill for your services.

To participate in the North Dakota Medicaid program, an out-of-state provider must:

- Complete the North Dakota Medicaid Enrollment Packet;
- Comply with the requirements of the rules and regulations, which govern the Medicaid Assistance program;
- Comply with the licensing and certification requirements of the state where the provider is located;
- Obtain North Dakota Medicaid approval.

North Dakota Medicaid does not separately enroll out-of-state physicians practicing at a facility; North Dakota Medicaid enrolls the facility and requires the attending physician's license. North Dakota Medicaid does enroll out-of-state physicians separately if they practice independently.

To obtain the forms to enroll as a provider with North Dakota Medicaid, contact Provider Enrollment at 701-328-4033 or write to:

Provider Enrollment
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250
E-mail: dhsenrollment@state.nd.us

ENROLLED PROVIDERS

Each newly enrolled provider will receive by mail their provider number and corresponding manuals along with any pertinent billing information.

Many Medicaid-related forms are available in the provider manuals; others are available through Provider Enrollment. The Request for Forms sheet located in Appendix D may also be faxed or mailed. Forms are also

Provider enrollment does not guarantee payment.

available on our website at http://www.state.nd.us/eforms/. North Dakota Medicaid does not provide CMS-1500, UB-92, or dental claim forms.

CHANGES IN ENROLLMENT

A new provider enrollment must be completed for changes in ownership, IRS reporting number or legal status. Changes in address, telephone number or licensure may be submitted in writing or by fax and do not necessitate a new provider enrollment. Any name changes without change to IRS reporting number will require the submission of a new W-9 form.

To avoid payment delays, notify Provider Enrollment of an address change in advance.

CHANGE IN OWNERSHIP

When ownership changes, the new owner must apply for a new North Dakota Medicaid number. For income tax reporting purposes, it is necessary to notify Provider Enrollment at least 30 days in advance about any changes that cause a change in your tax identification number. Early notification helps avoid payment delays and claim denials.

ELECTRONIC CLAIMS SUBMISSION

Health Insurance Portability and Accountability Act (HIPAA) Claims

Medicaid claims that are submitted electronically experience fewer errors and quicker payment. Electronic claims submitted for Medicaid services must be in a HIPAA compliant format.

In order to submit HIPAA compliant claims electronically, providers must have software that creates HIPAA transactions. In addition, the following forms must be completed and submitted to Medical Services:

Trading Partner Agreement (TPA)
Electronic Data Interchange (EDI)
Electronic Funds Transfer (EFT)

The above forms are located on the web:
http://www.state.nd.us/humanservices/services/medicalserv/medicaid/edi.html

After the above forms are received in our office, our staff will schedule a time to test your HIPAA claims files.

Non-HIPAA Claims

Providers submitting claims for non-medical services are exempt from submitting HIPAA compliant claims. These providers include: Basic Care, Personal Care, and Developmental Disability (non-ICF/MR services). Exempt providers must complete and submit the *Web File Transfer Registration Form.*

** **Both HIPAA and non-HIPAA compliant electronic claims sent directly to Medical Services will be submitted via the *Web File Transfer system.***

TERMINATING MEDICAID ENROLLMENT

Medicaid enrollment may be terminated at any time by writing to the Provider Enrollment Unit. Include your provider number and the termination date in the letter. North Dakota Medicaid may also terminate your enrollment under the following circumstances:

- Breaches of the provider agreement
- Demonstrated inability to perform under the terms of the provider agreement
- Failure to abide by applicable North Dakota and U.S. laws
- Failure to abide by the regulations and policies of the North Dakota Department of Human Services or the North Dakota Medicaid program.

PROVIDER REQUIREMENTS

By signing the application to enroll in North Dakota Medicaid, providers agree to abide by the conditions of participation addressed on the provider agreement. This form is available at www.state.nd.us/eforms. This section includes:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- Clients enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- When a provider arranges ancillary services for their Medicaid client through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective.
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.

- Once a client has been accepted as a Medicaid client, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

PAYMENT FOR SERVICES

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid.
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law.
- Client must be enrolled in Medicaid and non-restricted.
- Service must be medically necessary. North Dakota Medicaid may review medical necessity at any time before or after payment.
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational.
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the *Billing Procedures* chapter or manual, the most current Medicaid Bulletin and manual replacement pages.
- Charges must be usual and customary.
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at $0.
- Claims must meet timely filing requirements. Timely requirement is defined as billing within one year of the date of service.
- Prior authorization requirements must be met where applicable.

MEDICAID PAYMENT IS PAYMENT IN FULL

Providers must accept Medicaid payment as payment in full for any covered service, except applicable co-payments or recipient liability that should be charged to the client.

PAYMENT RETURN

If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

DISCLOSURE

- Providers are required to fully disclose ownership and control information when requested by North Dakota Medicaid.

- Providers are required to make all medical records for Medicaid recipients available to North Dakota Medicaid. Such records may include but are not limited to the following:

  - Original prescriptions

  - Certification of medical necessity

  - Treatment plans

  - Medical records and service reports including (but not limited to):

    - Patient's name and date of birth
    - Date and time of service
    - Name and title of person performing the service, if other than the billing practitioner
    - Chief complaint or reason for each visit
    - Pertinent medical history
    - Pertinent findings on examination
    - Medication, equipment, and/or supplies prescribed or provided
    - Description and length of treatment
    - Recommendations for additional treatments, procedures, or consultations
    - X-rays, tests, and results
    - Dental photographs/teeth models
    - Plan of treatment and/or care, and outcome
    - Specific claims and payments received for services
    - Each medical record entry must be signed and dated by the person ordering or providing the service.

  - Prior authorization information

  - Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid clients.

- Records and original invoices for items that are prescribed, ordered, or furnished.
- Any other related medical or financial data

CLIENT SERVICES

- All services must be made a part of the medical record.
- Providers must treat Medicaid clients and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by regulations).

CONFIDENTIALITY

All Medicaid client and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of health care information subject to applicable laws.

COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, AND POLICIES

All providers must follow all applicable rules of North Dakota Medicaid and all applicable state and federal laws, regulations, and policies including but not limited to:

- United States Code governing the Medicaid program
- Code of Federal Regulations (CFR)
- Administrative rules of North Dakota
- Federal Department of Health and Human Services policies governing the Medicaid program
- Written Department policies
- All state laws and rules governing provider licensure and certification, as well as with the standards and ethics of their business or profession.

Providers are responsible for keeping informed about applicable laws, regulations, and policies

PROVIDER SANCTIONS

North Dakota Medicaid may withhold a provider's payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies.

AUTOMATED DIRECT DEPOSITS OF PAYMENT

North Dakota Medicaid has the capability of automatic direct deposit of payments.

Direct deposit will result in the provider receiving payments sooner because it will eliminate mail time. Payments made will be deposited directly into a savings or checking account at your bank. The form required to set up direct deposit is the Electronic Funds Transfer Form. (Appendix C)

See Appendix C

Once you have been enrolled for electronic transfer of funds you will not receive a check with the Remittance Advice (R/A). The acronym "ACH" (automated clearing house) will appear in place of the check number in the upper left hand corner of the R/A indicating an automatic check deposit.

INTERNAL REVENUE SERVICE FORM W-9 "REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION"

This form must be completed for each provider agreement, following the instructions included with the W-9 form. Please ensure that the social security number/employer identification number is correct and the name field is completed exactly as the name the Internal Revenue Service has on file for the Taxpayer Identification Number in Part I of the W-9.

APPENDIX A

Forms that need to be completed by the providers and mailed to Provider Enrollment.

Professional

DN 622 Provider Enrollment Package (see Appendix B for copy)
SFN 973 Enrollment Questionnaire ***
W-9 Form located on IRS web site at
http://www.irs.ustreas.gov/formspubs/index.html
SFN 615 Medicaid Program Provider Agreement ***

Pharmacy

DN 622 Provider Enrollment Package (see Appendix B for copy)
SFN 973 Enrollment Questionnaire ***
W-9 Form located on IRS web site at
http://www.irs.ustreas.gov/formspubs/index.html
SFN 1169 Pharmacy Agreement ***

Non-Medical

DN 622 Provider Enrollment Package (see Appendix B for copy)
SFN 620 Non-Medical Provider ***
W-9 Form located on IRS web site at
http://www.irs.ustreas.gov/formspubs/index.html
SFN 615 Medicaid Program Provider Agreement ***
Transportation cover letter (see Appendix B for copy)

Out-of-State Providers

DN 622 Provider Enrollment Package (see Appendix B for copy)
SFN 973 Enrollment Questionnaire ***
W-9 Form located on IRS web site at http://www.irs.gov/pub/irs-fill/fw9.pdf
SFN 615 Medicaid Program Provider Agreement ***
SFN 509 Out of State Enrollment Clarification Form ***

***Form available on the web: www.state.nd.us/eforms/

APPENDIX B

PROVIDER ENROLLMENT PACKAGE

ND DEPARTMENT OF HUMAN SERVICES/MEDICAL
DN 622 (Rev. 04-01)

Before you can be reimbursed for services rendered to recipients covered by the North Dakota Medicaid Program, it is mandatory that you obtain a provider number. The only way your claims can be processed is through the acquisition of this number.

For your convenience, we have enclosed a Provider Enrollment Package consisting of an Enrollment Questionnaire, Provider Agreement and a W-9 Form. Please complete the enclosed and return it to:

Medical Services Unit
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0261

Federal regulations require most professionals (physicians, dentists, therapists, nurses, etc.) meet your states licensing standards. We are required to verify current licensing and request you return a copy of your current license with your completed enrollment information. We require you to enter your name and identification number exactly as it appears on your Social Security or Employer Identification card and enclose a copy. Failure to do so may subject you to backup withholding on all payments.

Your prompt response to this request will facilitate the issuance of a provider number. The Provider Enrollment Unit will review your application to assure that eligibility requirements for your provider type and specialty are met. To eliminate delays in processing, please make sure that all the required information has been provided. The minimum time for processing the provider enrollment is two to three weeks. If an application is denied, you will be notified in writing as to the reason for denial. Providers are required to submit all claims within 12 months from the date of service.

The enrollment questionnaire contains a name match block. Providers must enter the first two characters of their provider name exactly as it will be submitted on the claims. Our system matches the first two positions of the provider name and if it is incorrect, your claims will suspend and may be denied. If you change your name on the claim form, you must contact provider enrollment and have your name match changed.

Along with your five-digit provider number you will receive the appropriate instructions relating to the completion of claim forms, adjustment requests and other pertinent information.

If you have any questions, feel free to contact the Provider Enrollment Unit at 701-328-4033.

Sincerely yours,

Administrator, Claims Processing
Medical Services

Enclosures

Transportation Cover Letter

We have received your request for an application for enrollment with the North Dakota Department of Human Services as a transportation provider for Medicaid eligible recipient(s).

As of September 1, 2003, no recipient's parent, spouse, friend, family member or household member may be paid as an enrolled provider for transportation for the recipient. Private vehicle mileage will not be allowed if there is free or low-cost transportation services available, including friends, family members or household members.

A policy has been implemented to assure that all transportation providers have a valid North Dakota driver's license and proof of Liability Insurance. North Dakota Medical Assistance now requires all transportation providers enrolling as a provider to include a copy of their North Dakota drivers license and Liability Insurance with their application.

If you have met all the above requirements, please complete the enrollment application enclosed and submit it to:

Provider Enrollment
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck, ND 58505-0250

Sincerely,

ND Medicaid Provider Enrollment
(701) 328-4033

APPENDIX C

SFN 661 Electronic Funds Transfer (EFT) Form ***

***Form available on the web: www.state.nd.us/eforms/

APPENDIX D

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
600 E BOULEVARD AVE – DEPT 325
BISMARCK, ND 58505-0250

FORM REQUEST

PROVIDER NAME _____ **PROVIDER NO.**_____

MAILING ADDRESS _____

_____

QUANTITY	FORM #	FORM NAME
_____	SFN 639***	PROVIDER REQUEST FOR AN ADJUSTMENT
_____	SFN 640***	PHARMACY REQUEST FOR AN ADJUSTMENT
_____	SFN 1115***	DME PRIOR APPROVAL
_____	SFN 634***	PHARMACY CLAIM
_____	SFN 1447	EYEWEAR ORDER FORM
_____		LONGTERM CARE TURNAROUND DOCUMENTS
_____		HCBS TURNAROUND DOCUMENTS
_____		BASIC CARE TURNAROUND DOCUMENTS

**** THESE FORMS ARE FILLABLE FORMS AVAILABLE ON THE WEB: WWW.STATE.ND.US/EFORMS/*

north dakota department of human services

MEDICAID COVERED SERVICES

- This table contains general information about services by provider type. For detailed information regarding prior authorization, coverage, and cost sharing information for specific services, refer to the provider-specific manual.
- Covered services are subject to change based on changes in funding, legislative action, and changes in administrative rules.

Medicaid Covered Services					
Services Provided by:	**Covered Under Medicaid**	**Requires Referral from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Ambulances	Yes	No	No	For emergency transport: providers have 48 hours following the service to notify Medical Services of transport	No
Ambulatory surgical centers	Yes	Yes	No	Some services require PA from ND Health Care Review	No
Audiologists	Yes	Yes	$2 co-pay for each hearing test visit; $3 co-pay for each hearing aid dispensing	No	No
Chiropractors	Yes	No	$1 co-pay for each manipulation; 12 visits per year; x-rays 2 per year	No	No

Medicaid Covered Services (continued)					
Services Provided by:	**Covered Under Medicaid**	**Referral Required from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Dentists	Yes	No	$2 co-pay for each visit, some services have limits	Some services require PA or have limits.	Some procedures and diagnosis codes have age restrictions
Durable medical equipment, medical supplies, prosthetic providers, hearing aids	Yes	Yes	Some limits apply - see DME manual	Some services require PA - see DME manual	Some age restrictions apply. See DME program manual.
Family planning (some services have additional requirements)	Yes	No, if Public Health; Yes, if clinic setting	No, if Public Health; Yes, if clinic setting	No	No
Federally qualified health centers (FQHC)	Yes	Yes	$3 co-pay for each visit to FQHC/RHC	No	No
Home and community based service providers (HCBS waiver) provided to qualifying clients in the client's home	Yes	No	No	Must be screened and meet level of care requirements	No
Home health care providers	Yes	Yes	Therapy co-payments apply	Yes, for over 60 days of service or $3000 paid claims	No

Medicaid Covered Services (continued)					
Services Provided by:	**Covered Under Medicaid**	**Referral Required from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Hospitals (inpatient)	Yes	Yes, except for services provided by obstetrician, psychologists or psychiatrists	$75 co-pay per hospital stay; rehab limited to 30 days for adults; psychiatric admission limited to 21 days with maximum of 45 days per calendar year	Some in-state services require PA. All out-of-state admissions, except emergencies, require PA.	No
Hospital swing bed	Yes	No	No	Yes, must be screened and meet level of care	No
Intermediate care facilities for the mentally retarded	Yes	No	No	Yes	No
Laboratory providers	Yes	Yes, except for independent labs	No	No	No
Nurse practitioners and certified nurse midwives	Yes	No, if care received in same clinic as PCP; No for nurse midwives	Yes, $2 each visit	No	No
Nursing facilities	Yes	No	No	Yes, must be screened and meet level of care	No
Nutritional services	Yes	Yes	Yes, 4 visits per year	No	No
Occupational therapists (outpatient	Yes	Yes	$2 each visit, limited to 20 visits/year, school based exempt	No (within limits) Yes (if over limits)	No

Medicaid Covered Services (continued)					
Services Provided by:	**Covered Under Medicaid**	**Referral Required from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Ophthalmologists (medical treatment of eye disease)	Yes	No	Yes, $2	No	No
Optometry services	Yes	No	$2 co-pay Some limitations apply, see optometric manual	Some services require PA	No
Orthodontist	Yes if referred by Health Tracks Program	Must be referred by Health Tracks Program	No	Yes	Up to age 21
Outpatient psych	Yes	No	No co-pay, limits Yes	Yes	No
Personal care services in a client's home	Yes	No	No	Yes	No
Pharmacies	Yes	Yes	Yes, $3 for brand; no for generic	Some services require PA	No
Physical therapists (outpatient)	Yes	Yes	$2 each visit, limit of 15 per year, school based exempt	No (within limits); Yes (if over limits)	No
Physicians	Yes	Yes	Yes, $2 co-pay	No	No
Podiatrists	Yes	No	$3 co-pay for each visit	No	No

Medicaid Covered Services (continued)					
Services Provided by:	**Covered Under Medicaid**	**Referral Required from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Private duty Nursing providers in non-institutional settings	Yes	Yes	No	Yes	No
Psychiatrists	Yes	No	$2 co-pay for each service; 40 therapy visits per year; testing 4 hours per year	No	No
Psychologists	Yes	No	$2 co-pay for each service; 40 therapy visits per year; testing 4 hours per year	No	No
Public health clinics	Yes	No	No	No	No
Radiology	Yes	Yes, unless independent providers	No	No	No
Residential treatment centers	Yes	No	No	Yes	Under 21 only
Rural health clinics (RHC)	Yes	Yes	$3 co-pay for each visit	No	No
School based services providers	Yes	No	No	No	Under 21 only
Speech therapists (outpatient)	Yes	Yes	$1 for each visit; 30 visits per year, school based exempt	No (within limits); Yes (if over limits)	No

Medicaid Covered Services (continued)					
Services Provided by:	**Covered Under Medicaid**	**Referral Required from Primary Care Provider**	**Copayment/ Limits**	**Need Prior Authorization**	**Age Restrictions**
Targeted case management providers	Yes	No	No	No	No
Transportation for medical services	Yes	No	No	Yes, administered by county social services	No
Women's Way	Yes	No	No	Yes, requires screening through local public health unit	64 and under

ABORTION SERVICES

DEPARTMENTAL APPROVAL FOR ABORTION SERVICES

All claims for abortion services must be submitted using a paper claim form (CMS-1500 or UB-92) accompanied by documentation that establishes the reason why it was necessary to perform the abortion procedure. The information provided by the physician will be reviewed by the Department's medical consultant and the Director of Medical Services to determine to the satisfaction of the Department that the abortion was necessary to save the life of the woman or was the result of an act of rape or incest. If the documentation provided meets Departmental guidelines, payment will be approved. If the documentation does not meet these guidelines, the claim will be denied for payment.

DOCUMENTATION REQUIREMENTS

ABORTIONS TO SAVE THE LIFE OF THE WOMAN - The treating physician must provide a signed written statement that, in the physician's professional judgment, the life of the woman would be endangered if the fetus were carried to term. The statement must contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term.

ABORTIONS THAT ARE A RESULT OF AN ACT OF RAPE OR INCEST - If a recipient has reported an act of rape or incest to an appropriate law enforcement agency or, in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports, the physician must provide the Department with a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made.

- If the rape or act of incest was not reported to an appropriate agency, the recipient must sign a written statement indicating that her current pregnancy resulted from either an act of rape or incest. The treating physician must provide a signed written verification that, in the physician's professional judgment, the woman's pregnancy resulted from rape or incest.

- North Dakota statutes specifically describe the crime of "incest." North Dakota statutes do not specifically describe the common law crime of "rape," which is unlawful carnal knowledge of a female without her consent. North Dakota

statutes prohibiting “gross sexual imposition,” “sexual imposition,” and “sexual abuse of a ward” all describe the common law crime of rape. Each of these statues uses the term “sexual act.” A copy of the North Dakota statute is attached. You may wish to consult an attorney for assistance if you are not certain that the sexual act that produced the pregnancy was an act of rape or incest.

Treatment for infection or other complications of the abortion are covered services.

NORTH DAKOTA STATUTES CONCERNING RAPE AND INCEST

12.1-20-02. Definitions.

. . . .

3. "Sexual act" means sexual contact between human beings consisting of contact between the penis and the vulva, the penis and the anus, the mouth and the penis, or the mouth and the vulva; or the use of an object which comes in contact with the victim's anus, vulva, or penis. For the purposes of this section, sexual contact between the penis and the vulva, or between the penis and the anus or an object and the anus, vulva, or penis of the victim, occurs upon penetration, however slight. Emission is not required.

12.1-20-03. Gross sexual imposition.

1. A person who engages in a sexual act with another, or who causes another to engage in a sexual act, is guilty of an offense if:

   a. He compels the victim to submit by force or by threat of imminent death, serious bodily injury, or kidnapping, to be inflicted on any human being;

   b. He or someone with his knowledge has substantially impaired the victim's power to appraise or control his or her conduct by administering or employing without his or her knowledge intoxicants or other means with intent to prevent resistance;

   c. He knows that the victim is unaware that a sexual act is being committed upon him or her;

   d. The victim is less than fifteen years old; or

   e. He knows or has reasonable cause to believe that the other person suffers from a mental disease or defect which renders him or her incapable of understanding the nature of his or her conduct.

. . . .

3. An offense under this section is a class A felony if in the course of the offense the actor inflicts serious bodily injury upon the victim, or if his conduct violates subdivision a or d of subsection 1. Otherwise the offense is a class B felony.

12.1-20-04. Sexual imposition.

1. A person who engages in a sexual act or sexual contact with another, or who causes another to engage in a sexual act or sexual contact, is guilty of an offense if the actor compels the other person to submit by any threat that would render a person of reasonable firmness incapable of resisting.

2. The offense is a class C felony unless the victim is a minor, fifteen years of age or older, in which case it is a class B felony.

12.1-20-06. Sexual abuse of wards. A person who engages in a sexual act with another person, or any person who causes another to engage in a sexual act is guilty of a class A misdemeanor if the other person is in official custody or detained in a hospital, prison, or other institution and the actor has supervisory or disciplinary authority over the other person.

12.1-20-11. Incest. A person who intermarries, cohabits, or engages in a sexual act with another person related to him within a degree of consanguinity within which marriages are declared incestuous and void by section 14-03-03, knowing such other person to be within said degree of relationship, is guilty of a class C felony.

14-03-03. Void marriages. The following marriages are incestuous and void:

1. Marriage between parents and children including grandparents and grandchildren of every degree.

2. Marriage between brothers and sisters of the half as well as the whole blood.

3. Marriage between uncles and nieces of the half as well as the whole blood.

4. Marriage between aunts and nephews of the half as well as the whole blood.

5. Marriage between first cousins of the half as well as the whole blood.

This section applies to illegitimate as well as legitimate children and relatives.

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department of
human services

ALLERGY IMMUNOTHERAPY – ALLERGY TESTING

COVERED SERVICES

- Professional services to administer the allergenic extract.
- Providing the injectable allergenic extract.
- Professional services to monitor the recipient's injection site and observe the recipient for an anaphylactic reaction.
- Allergy Testing.
- Provision of inhalants (an inhalant is a pharmaceutical).

EXCLUDED SERVICES

Medicaid does not cover the administration of oral preparations used to treat food allergies (e.g., food drops, etc.) or other allergy services not recognized as a community standard for the provision of allergy immunotherapy.

COVERED LIMITATIONS

Allergenic extracts may be administered with either one injection or multiple injections. Documentation in the recipient's health record must support the number of injections administered.

Only physicians who perform the refinement of raw antigens to allergenic extract may bill for the service. This service involves the sterile preparation of an allergenic extract by titration, filters, etc. and checking the integrity of the extract by cultures or other qualitative methods. Purchasing refined antigen, measuring dosages, and adding diluent is not refining raw antigens.

Adding diluent, as in any other medication administration service, is not a separately covered service. This service is an integral part of the professional services for providing an allergenic extract.

The reimbursement of the injection administration will be adjusted and will reflect the monitoring of the injection site and the observation of the recipient for anaphylactic reaction. A separate office visit charge for the provision of allergy services is not allowed unless other identifiable services are performed such as physical examinations, review of systems, obtaining a history of current symptoms or illness, laboratory services, or blood pressures. Identifiable services not included in an office visit may be billed separately.

BILLING REQUIREMENT: Services must be billed on the HCFA 1500 Claim Form.

Allergy Testing

Indicate the number of tests in the unit box for CPT codes 95004, 95010, 95015, 95024, and 95028.

Administration of Allergen Immunotherapy

95115 –	Professional services for allergen immunotherapy ***not including*** the provision of allergenic extracts; single injection
95117 –	two or more injections
95120 –	Professional services for allergen immunotherapy in prescribing physician office or institution, ***including*** the provision of allergenic extracts; single injection
95125 –	two or more injections
95130 –	single stinging insect venom
95131 –	two stinging insect venoms
95132 –	three stinging insect venoms
95133 –	four stinging insect venoms
95134 –	five stinging insect venoms

PROVISIONS OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY

95144 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single dose vials(s) (specify number of vials).

95145 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses) single stinging insect venom.

95146 – two stinging insect venoms

95147 – three stinging insect venoms

95148 – four stinging insect venoms

95149 – five stinging insect venoms

95150 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) (i.e. number of doses in a multiple dose vial).

north dakota
department of
human services

AMBULATORY SURGICAL SERVICES

An ambulatory surgical center (ASC) is a facility certified under code of Federal Regulation, Title 42 Part 416, to provide surgical procedures, which do not require overnight inpatient hospital care. These include freestanding and hospital-operated ASCs.

Since 1999, North Dakota Medicaid (NDMA) has been paying for all procedures that Medicare has identified as ambulatory surgical procedures, regardless of site of service, using a prospective payment methodology. Payment is made to the ambulatory surgical center **or** hospital providing the procedures in an outpatient setting using one of nine groups of procedures and payment rates. The current ND Medicaid ASC Payment Groups List identifying covered procedures is available at: http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider-fee-schedules.html. This list is updated at least annually.

AMBULATORY SURGICAL SERVICES

The following services and supplies are included in the ASC facility fee and may not be billed or paid separately:

- Use of facility including operating and recovery rooms, patient preparation areas, waiting rooms, and all other areas used by the patient or offered for use by persons accompanying the patient.

- Nursing and technical service including all services provided by employees of the ASC (e.g., nurses, technicians, orderlies).

- Drugs, biologicals, medical supplies and equipment, including:

    - All drugs, medical supplies, dyes, and equipment common to the ASC provided in conjunction with a surgical procedure. Drugs and biologicals are limited to those that cannot be self-administered.

    - Urinary supplies, such as collection devices, indwelling and external catheters, drainage bags – any type, leg straps, external urethral clamps,

irrigation supplies (bulbs, syringes, tubing, sterile saline or water), insertion trays and perianal fecal collection pouches.

- o Primary surgical dressings which are therapeutic and protective coverings applied directly to the skin or on openings to the skin and required as a result of a surgical procedure.

- Administrative, record keeping, and housekeeping services consisting of general administration and functions necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).

- Blood, blood plasma, and platelets.

- Anesthesia and any supplies, whether disposable or reusable, that are necessary for its administration.

SEPARATELY COVERED SERVICES IN THE AMBULATORY SURGERY CENTER/OUTPATIENT HOSPITAL SURGERY

The following items and services are **not** included in the ASC fee and may be billed separately. These services are subject to all applicable Medicaid coverage rules including medical necessity, sterilization consent, prior authorization and billing requirements.

- Physician services, including the services of anesthesiologists administering or supervising the administration of anesthesia to a patient and the patient's recovery from anesthesia.

- Second surgical opinion.

- Patient specific laboratory, x-ray or diagnostic procedures performed according to protocol.

- Prosthetic devices (arm, leg, back, braces, artificial limbs, corneal lenses, titanium screws, etc.).

- Ambulance services.

- Durable medical equipment for use in the patient's home.

- Take home supplies, medications, splints, and casts. These are separately billable if not furnished at the time of surgery.

- CRNA services.

- Pathology services.

BILLING REQUIREMENTS

Freestanding ASCs must bill on a CMS-1500 claim form using appropriate CPT procedure code and SG modifier. Hospital-operated ASCs must bill on a UB-92 claim form using the appropriate revenue code and CPT procedure code.

Separately billable supplies, noted in this chapter, must be billed with the appropriate HCPCS code.

NDMA reviews all 131 and 831 bill type claims for revenue codes 360-369 and 490-499. CPT procedure codes must be included for revenue codes 360-369 and 490-499. If the CPT procedure code is identified as an ambulatory surgical procedure, ND Medicaid pays the established ASC rate for the surgical procedure.

When two or more procedures are performed on separate body areas in the same operative session, the standard rate will be paid for the primary procedure. The second procedure will be paid at 50% of the procedure group.

Effective May 1, 2005, all 131 and 831 bill type claims that include revenue codes 360-369 and 490-499 will be denied, if the CPT procedure code(s) are not on the 2005 ND Medicaid ASC Payment Groups List. The provider may submit documentation to ND Medicaid justifying the medical necessity for a specific surgical procedure(s) performed in an ASC or outpatient hospital surgery center that is not on the 2005 ND Medicaid ASC Payment Groups List. If the surgical procedure(s) is medically necessary in an ASC or outpatient setting, payment will be made using one of the nine groups where there are similar procedures.

If the procedure is not on the ASC list and is a lesser procedure that could be done in a clinic/office, it will be denied as not medically necessary. The provider has the option of submitting information for review by Medicaid. If the information submitted supports medical necessity, and supports that the procedure is appropriate in an ASC setting, the procedure will be paid at a comparable ASC rate.

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ANESTHESIOLOGY SERVICES

WHO MAY PROVIDE ANESTHESIOLOGY

Anesthesiology is provided by a physician trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures or by a nurse anesthetist, an advanced registered nurse who is licensed as a certified registered nurse anesthetist (CRNA).

PAYMENT ISSUES

Medicaid will pay an anesthesiologist for the personal medical direction furnished to a certified registered nurse anesthetist (CRNA).

CRNAs may enroll with the Medicaid program and may directly bill for services or bill for services under a supervising physician's Medicaid provider number.

Medicaid pays for anesthesiology services personally furnished by a physician or CRNA only if the anesthesiologist or CRNA:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies;
- Provides indicated post-anesthesia care; and
- Complies with federal requirements when performing sterilization procedures.

DOCUMENTATION REQUIREMENTS FOR BILLING

Medicaid uses the specific CPT/HCPCS anesthesia codes with the appropriate modifier for anesthesia services.

The provider must:

- Submit claims for anesthesia services on the CMS-1500 claim form.

- Submit the exact number of minutes from the preparation of the patient for induction to the time when the physician or the anesthetist is no longer in personal attendance or continues to be required.

- Identify the exact nature of the services being provided with one of the following modifiers:

  AA = Anesthesia services performed personally by anesthesiologist. (This modifier should be used only when the physician is involved on a full-time basis in the administration of anesthesia to one patient, with or without the assistance of an anesthetist).

  AD = Medical supervision by a physician: more than four concurrent anesthesia procedures.

  QX = CRNA services with medical direction by a physician.

  QZ = CRNA services without medical direction by a physician.

  Use the modifiers listed above for all claims submitted.

OTHER ANESTHESIA SERVICES

Pre-anesthetic Evaluations and Post-operative Visits: Medicaid uses the CMS list of base values adopted from the relative base values established by the American Society of Anesthesiology. The base value for anesthesia services includes usual pre-operative and post-operative visits. No separate payment is allowed for the pre-anesthetic evaluation regardless of when it occurs unless the recipient is not induced with anesthesia because of a cancellation of the surgery.

Patient Controlled Analgesia (PCA) used to control a patient's pain with continuous infusion of pain medication facilitated by an infusion pump is a billable service. Placement of an intrathecal or epidural catheter is paid separately. The correct unmodified CPT surgical code must be used to bill the catheter placement.

Medically necessary pain management must be conducted face to face and is limited to one service per day. The appropriate CPT/HCPCS code must be used when billing for this service.

Epidural Analgesia for Vaginal or Cesarean Section is used to provide continuous epidural analgesia for labor and vaginal or cesarean delivery. The CPT code that describes this service includes the placement of the epidural catheter.

The number of minutes that the provider is physically present with the recipient must be recorded in the unit's box.

Conscious Sedation, used to achieve a medically controlled state of depressed consciousness, is not a billable service. Codes not covered are 99141 and 99142. The cost of conscious sedation is included in the fee for the procedure.

Special Services, such as insertion of Swanz-Ganz catheters, placement of central venous lines and arterial lines, and performed by an anesthesiologist or independent CRNA are billable services. These services must be billed as a surgical procedure with no time unit recorded using the appropriate unmodified CPT codes that describe the service.

BILLING REQUIREMENTS

Anesthesia services must be billed on CMS-1500 with the appropriate anesthesia code and modifier (if applicable).

Hospital providers must bill on UB-92 claim form using 964 revenue code.

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human services

BILLING PROCEDURES

CLAIM FORMS

All Medicaid claims must be submitted on Department approved claim forms. Many Medicaid-related forms are available in the specific provider manuals. For instructions on completing claim forms, refer to your specific provider manual. The following are approved forms:

- CMS-1500 (formerly HCFA-1500) *
- UB-92 *
- ADA Dental claim form * (1999, 2000 & 2002 versions only)
- Pharmacy claim form (SFN 634)
- Turn Around document (home and community based services)

  * Medicaid does not provide these forms.

CODING

- Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used.

- The International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

- The Health Care Financing Administration Common Procedural Coding System (HCPCS). HCPCS includes two levels of procedure codes.

  - Level I: The Physicians Current Procedural Terminology (CPT)

  - Level II: HCPCS

  Providers billing HCPCS/CPT codes must follow the instructions and guidelines set forth in the most current versions of HCPCS and CPT.

- National Drug Codes (NDC).

- Current Dental Terminology (CDT).

Always refer to the long descriptions in coding books

Provider Relations or the Department cannot suggest specific codes to be used in billing for services. The following suggestions may help reduce coding errors:

- Use current Level I - CPT, Level II - HCPCS, ICD-9-CM, and CDT coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.

- Use the current UB-92 Reference manual from the North Dakota Hospital Association (NDHA). It contains current revenue codes.

- Attend classes on coding offered by certified coding specialists.

- Use specific codes rather than miscellaneous codes. For example, 99213 is more specific (problem-focused visit) rather than 99499 (unlisted evaluation and management service).

- Bill for the appropriate level of service provided. For example, the Level I - CPT coding book contains detailed descriptions and examples of what differentiates a level 1 office visit (99201) from a level 5 office visit (99205).

- Services covered within “global periods” for certain Level I - CPT procedures are not paid separately and should not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. A modifier can indicate that a service/ procedure performed has been altered by a specific circumstance but not changed in its definition or code, or the medical supply or equipment is being rented, leased, purchased, repaired, or altered.

- Pay close attention to modifiers used with Level I - CPT and Level II - HCPCS codes on CMS-1500 bills. Modifiers are becoming more prevalent in health care billing, and they often affect payment calculations.

- Use the correct “units” measurement on CMS-1500 and UB-92 bills. In general, Medicaid follows the definitions in the Level I - CPT and Level II - HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure.

- Unlisted codes for procedures, medical equipment, supplies, etc., may be billed only when a specific code that defines the procedure, medical equipment, or medical supply is not available. When an unlisted code is used, a thorough and complete narrative defining the service/supply must be provided with the claim.

SUBMITTING A CLAIM

Electronic Claims

Electronic Data Interchange (EDI) submission is a fast and cost effective alternative to paper claim submission. Providers can use EDI to submit original claims, and resubmit denied claims.

While some providers continue to submit claims on traditional paper forms, more are taking advantage of EDI submission. The Department offers a number of methods providers can use to quickly and accurately submit claims, replacement claims, screening documents, and some prior authorizations. Claims submitted electronically:

- Provide a standardized format, which guarantees uniformity, reducing the chance for errors in data exchange and processing. It also allows submitters to exchange electronic data with multiple entities while using the same format structure.

- Reduce administrative costs for paper and postage.

EDI submissions - HIPAA compliant ANSI X12N Transactions

The Department is committed to meeting the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Transactions and Code Sets were the first standards to be finalized under the Administrative Simplification portion of HIPAA and require providers who submit electronic transactions to use applicable standards for transactions. The Department encourages providers to submit electronic transactions in order to efficiently exchange health care information. Companion guides and billing manuals are available at: http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider.html. With these formats, a provider or a billing agent may send claims to the Department via the Web File Transfer.

Getting Started

- If you are interested in electronically exchanging data utilizing HIPAA transactions, complete the following steps:

- Decide which software and hardware you will use. If you do not have software, the Department's web site provides a listing of vendors.

- Complete and sign the Trading Partner Agreement (DN 550).

- Complete and sign the EDI Registration Form (SFN 548). The Department will assign you a Provider/Clearinghouse number if you do not have one.

- Complete and sign an Electronic Funds Transfer Agreement (SFN 661) if you have not already done so.

  Please be familiar with the 997 and TA1 because these transactions will return errors on test claims. Your billing software must be setup and ready to submit HIPAA compliant claims prior to the scheduled testing appointment. Collect claim data for all specialties, lines of business, and types of bills.

- Notify the Department of the date you will be ready to test. All Trading Partners are required to notify the Department when they will be ready to test. To schedule testing with the Department, E-mail dhsenrollment@state.nd.us or call 701-328-2325. The Department will then contact the Trading Partner when a testing appointment is available. The Department will assign you a Submitter Identification Number.

- Production status will be granted after testing is satisfactory.

Paper Claims

Unless otherwise stated, all paper claims should be mailed to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250

Please follow these guidelines. This 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.

GUIDELINES FOR SUBMISSION OF PAPER CLAIMS
• Use only blue or black ink. DO NOT use RED ink to complete claims • Make sure the ink is dark enough to be picked up by the scanner. Times New Roman font is preferred • All information must be legible, typed or printed and within the boxes. • DO NOT use highlighter on claims or attachments. • Submit claims and attachments on 8½ x 11 paper. If any item is smaller or larger than this size, you will need to copy it so it is on 8½ x 11 paper. • DO NOT Staple any items. This includes two-page claims and attachments. • DO NOT submit carbon copies of claims or attachments.

- DO NOT submit two-sided documents.
- If whiteout is used for corrections, make sure it is applied thick enough to cover. Write the correct information to the side of the whiteout, NOT over it. If information does not fit in the box, use a new claim form.
- 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.
- DO NOT use dashes or slashes in the Recipient ID, Patient Account Number or other fields.
- The Revenue Code cannot be greater than three positions. DO NOT enter a leading zero.
- If there is an individual doctor's name in the provider area, the last name MUST be first.
- When submitting multiple-page claims, you MUST follow these guidelines:
  - The following fields must match on all pages of a multiple page **UB-92**:

    Patient Control Number (UB 30)
    Statement Covers Period From and through (UB 6)
    Provider ID (UB 51 – 1, 2 or 3)
    SSN (UB 60 – 1, 2 or 3)
    ** 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)
    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.

CLAIM INQUIRIES

Contact Provider Relations for questions regarding recipient eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see Key Contacts).

WHEN RECIPIENTS HAVE OTHER INSURANCE

If a Medicaid recipient is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the recipient's health care, Medicaid is the payer of last resort.

WHEN CAN I BILL A MEDICAID RECIPIENT DIRECTLY?

In most circumstances, providers may not bill recipients for services covered under Medicaid. The exception is that providers can bill recipients for co-payments and recipient liability (RL).

More specifically, providers cannot bill recipients directly:

- For the difference between charges and the amount Medicaid paid.
- For a service provided to a Medicaid enrolled recipient after it has been billed to Medicaid.
- When a third-party payer does not respond.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When services are being provided free to the recipient, Medicaid may not be billed for those services either.

If a provider bills Medicaid and the claim is denied because the recipient is not eligible, the provider may bill the recipient directly.

Providers may bill Medicaid recipients directly under the following circumstances:

- For co-payments. Providers may choose to collect recipient co-payments at the time of service or bill the recipient later.

- For recipient liability amount documented on the remittance advice. Providers (with the exception of Point of Sale Pharmacy) may not collect RL at the time of service.

- For services not covered by Medicaid, as long as the provider and recipient have agreed prior to providing services.

- If a provider chooses not to enroll as a Medicaid provider, the recipient is responsible for all charges.

RECIPIENT CO-PAYMENTS

A provider cannot deny services to a Medicaid recipient due to the recipient's inability to pay the co-payment at the time services are provided. If a provider has a policy on collecting delinquent payment from non-Medicaid recipients, that same policy may be used for Medicaid recipients whose co-payment is delinquent.

Co-payment fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. **Do not show co-payments as a credit on the claim; it is automatically deducted and shown on the remittance advice.**

CO-PAYMENTS	
Provider Type	**Amount**
Audiology	$2.00 per hearing test
Chiropractors	$1.00 per spinal manipulation
Dental	$2.00 per exam
FQHC	$3.00 per visit
Hearing aid	$3.00 per dispensing
Hospital (inpatient)	$75.00 per admission
Licensed psychiatrist	$2.00 per visit
Licensed psychologist	$2.00 per visit
Mid-level practitioner	$2.00 per visit
Non-emergent use of emergency rooms	$6.00 per occurrence
Occupational therapy (includes Home Health)	$2.00 per visit
Optometric and optician	$2.00 per exam
Physical therapy (outpatient) (includes Home Health)	$2.00 per visit
Physician Clinic Appointment	$2.00 per visit
Podiatry	$3.00 per visit
Prescription drugs (Brand Names only)	$3.00 per prescription fill
RHC	$3.00 per visit
Speech therapy (includes Home Health)	$1.00 per visit

The following Medicaid recipients are exempt from co-payments:

- Individuals under 21 years of age
- Pregnant women
- Individuals in skilled nursing facility, swing bed, intermediate care facility/mentally retarded, State Hospital, Anne Carlsen Center for Children
- Individuals receiving services in Indian Health Services (IHS) facilities

  NOTE: Dual Eligible Medicare recipients are subject to Medicaid co-payments.

THE MOST COMMON BILLING ERRORS AND HOW TO AVOID THEM

Paper claims are often returned to the provider before they can be processed, and many others are denied. To avoid returns and denials, double check each claim form to confirm the following items are included and accurate.

CLAIMS RETURNED TO PROVIDER BEFORE PROCESSING	
Reasons for Return	**How to Prevent Returned Claims**
Medicaid provider number missing or invalid	The provider number is a 5-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the billing form.
Incorrect claim form used	The claim form must be the correct form for the provider type. Refer to your specific provider manual.
Information on claim form not legible	Information on the claim form should be legible. Use dark ink and center the information in the field - information should not be obscured by lines.

DENIED CLAIMS	
Denial Reason	**How to Prevent Denial**
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the recipient: • View the recipient's ID card at each visit. Medicaid eligibility may change monthly. • Verify recipient eligibility by using the **Verify or Medifax** systems.
Duplicate claim	• Please check all remittance advices for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments*). • Please allow 60 days for the Medicare Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.

Prescription refill too soon (pharmacy claims only)	Prescription refills will be denied if refilled too soon. (See the *Pharmacy Manual* for instructions on requesting early refills).
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Refer to your specific provider manual. • Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
TPL on file and no credit amount on claim	• If the recipient has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Third Party Liability* chapter. • If the recipient's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in the *Provider Requirements* chapter. • To ensure timely processing, claims and adjustments should be mailed to Claims Processing at the address shown in *Key Contacts.*
Missing Medicare EOB/Insurance EOBs	All Medicare crossover claims on CMS-1500 forms must have an EOB attached.
Invalid type of bill (UB-92s only)	The bill type should be a 3-digit number, please refer to the UB-92 billing manual for details.
Provider is not eligible during dates of services, or provider number terminated	• If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied. • New providers cannot bill for services provided before Medicaid enrollment begins. Providers must be enrolled to receive reimbursement.
Type of service/procedures is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPS and CPT-4 billing manual.
Invalid or discontinued NDC code (pharmacy claims only)	Verify whether the NDC code has been discontinued or changed (Provider Relations may be able to determine if the code is invalid or discontinued).

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human services

CARDIAC REHABILITATION

Cardiac rehabilitation is defined as a recovery program consisting primarily of monitored cardiac exercise or therapy with recipient instruction and diagnostic testing services. Typically, the recipient undergoes a comprehensive, base line assessment to evaluate coronary risk factors and exercise capacity. Cardiac rehabilitation staff must review the assessment to outline a medically necessary, and realistic individual program with short and long-term goals. Designed to be an aftercare program, it is appropriate for recipients recovering from:

- Myocardial Infarction or,
- Coronary artery bypass surgery or,
- Coronary angioplasty with or without stent or,
- Valve replacement/repair surgery or,
- Heart and heart/lung transplant and/or have
- Stable angina pectoris or,
- Ventricular assistive device

A physician must be immediately available for an emergency at all times when an exercise program is being conducted.

PROVIDERS

An outpatient hospital or a physician-directed clinic that has a Medicare approved cardiac rehabilitation program may provide cardiac rehabilitation services to Medicaid recipients. A copy of the provider's Medicare notification of cardiac rehabilitation program approval must be provided to Medicaid's Provider Enrollment.

Services of non-physician personnel must be furnished under the direct on-site supervision of a physician.

COVERED SERVICES

Medicaid payment will be made only for cardiac rehabilitation services that are provided by a Medicare-approved cardiac rehabilitation program. The program must meet all of the requirements mandated by Medicare. Services must be considered reasonable and

necessary. Medicaid will pay for up to 36 sessions consisting typically of 3 sessions per week in a single 12-week period.

At least one of the following services must be included in a cardiac rehabilitation session:

- A limited examination for physician follow-up to adjust medication or other treatment changes, when performed by a hospital employed physician;
- ECG rhythm strip with interpretation and physician's revision of exercise therapy, when performed by a hospital-employed physician;
- Exercise therapy with continuous ECG telemetric monitoring (excludes physical therapy and occupational therapy);
- Diagnostic and therapeutic services that are reasonable and necessary to perform cardiac rehabilitation services safely and effectively;
- One new recipient comprehensive evaluation, when performed by a hospital-employed physician and if the exam has not already been performed by the recipient's attending physician or if the exam performed by the attending physician is not acceptable to the program's director. The exam should include a history, physical, and preparation of initial exercise prescription. The medical record must document the need for a repeat examination.

The following services provided based on individualized medical needs, may be billed separately:

- Mental health services.
- Laboratory services that are not performed to monitor the recipient's cardiac condition and cardiac rehabilitation program progress.
- ECG stress tests – one is usually performed at the beginning of the program and after three months or at the completion of the program. Performance of these tests more frequently requires medical record documentation demonstrating medical necessity.
- Nutritional counseling by a Licensed Registered Dietician.
- Physician services;
    - That are medically necessary to provide medical care for diagnoses or conditions that are not a part of cardiac rehabilitation;
    - To interpret and report on ECG stress testing; and

- Consisting of services provided by physicians to evaluate complications of cardiac rehabilitation, other diagnoses and conditions.

NON-COVERED CARDIAC REHABILITATION SERVICES

- Services provided by an outpatient hospital or physician clinic without Medicare approval.

- Formal lectures and counseling on health education that are normally furnished by the attending physician following a recipient's acute cardiac episode. Examples include assistance with daily living habits and sexual activity.

- Physical therapy and occupational therapy when furnished in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

PHYSICIAN PROFESSIONAL SERVICES

The following services are not separately payable when performed in conjunction with a cardiac rehabilitation program.

- A physician visit to monitor, read, or interpret ECG rhythm strips;

- A physician visit to adjust medication or the cardiac rehabilitation exercise prescription.

All separately billable physician professional services should be billed with the appropriate HCPCS code that describes the consultation, visit, or professional services involved with the interpretation of ECG stress testing. The correct procedure codes are:

- 93797 – Physician services for outpatient cardiac rehabilitation without continuous ECG monitoring (per session)

- 93798 – Physician services for outpatient cardiac rehabilitation with continuous ECG monitory (per session)

- ICD-9 DIAGNOSIS CODE
  93.36 – Cardiac Retraining

- UB-92 REVENUE CODE
  943 – Cardiac Rehabilitation

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CERTIFIED NURSE PRACTITIONERS

WHAT IS A NURSE PRACTITIONER

A nurse practitioner is a registered nurse who is currently licensed to practice in the state and is certified as a nurse practitioner by the appropriate national certifying entity.

Medicaid billable services consist of services otherwise covered as a physician service that are within the scope of practice of the nurse practitioner's license as a registered nurse.

BILLING REQUIREMENTS

Services are to be billed using CPT procedure codes, and following Medicaid requirements for covered physician services.

Services may be billed by:

- Independently enrolled certified nurse practitioners on a CMS-1500 claim using their own provider number and SA modifier, after the appropriate CPT code. When assisting at surgery the AS modifier must be used after the appropriate CPT code.

- Services of non-enrolled certified nurse practitioners can be billed by enrolled physician employers. The provider number of the physician employer must be in box 24K on the CMS-1500 claim form. Modifier SA is required.

Nurse practitioners may not perform consultations or referrals. Nurse practitioners may also not be selected by a recipient to be the primary care provider.

Nurse practitioners must always bill their usual and customary charge. Services will be paid the lower of billed charges or 75% of Medicaid's fee schedule. When assisting at surgery, Nurse Practioner services are reimbursed at 15% of the Medicaid fee schedule.

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CHIROPRACTIC SERVICES

WHAT IS CHIROPRACTIC CARE

Chiropractic care is a service provided by a doctor of chiropractic, licensed under North Dakota law and enrolled as a North Dakota Medicaid provider.

COVERED SERVICES

- Manual manipulation of the spine for treatment of subluxation (incomplete or partial dislocation) and determined to be medically necessary by generally accepted chiropractic standards of care, and
- X-rays that are needed to support a diagnosis of subluxation.

A complete list of Medicaid covered diagnoses and procedure codes are available at http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider.html

NON-COVERED SERVICES

- Examinations and consultations
- Laboratory services
- Vitamins or nutritional counseling
- Acupressure or Acupuncture
- Treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation
- Medical supplies or equipment supplied or prescribed by a chiropractor
- X-rays, other than those needed to support a diagnosis of sublaxation
- Exercise counseling, activities of daily living counseling
- Physiotherapy modalities including, but not limited to ultrasound, diathermy, electrical muscle stimulation, interferential current, russian stimulation, and application of hot/cold packs.

PAYMENT LIMITATIONS AND BILLING PROCEDURES

Payment for manual manipulations of the spine is limited to one manipulation per day and may not exceed 12 manipulations per calendar year. Effective for dates of service on or after January 1, 2005, NDMA 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.

Payment for x-rays may not exceed two (2) per year and are limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine.

Chiropractic services are billed on the CMS 1500, or electronically using the 837-P HIPAA transaction.

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COORDINATED SERVICES PROGRAM

WHAT IS THE COORDINATED SERVICES PROGRAM (CSP)?

CSP is a program utilized by ND Medicaid to:

- Improve the continuity and quality of medical care for recipients,
- Improve utilization patterns to control Medicaid expenditures, and
- Provide education on the proper access of services at the appropriate level.

WHO IS A CANDIDATE FOR CSP?

Medicaid uses a list of parameters to determine if a recipient may be a candidate for CSP. These parameters include but are not limited to:

- Usage of multiple physicians and clinics,
- Early prescription refills and usage of multiple pharmacy providers,
- Use of Emergency Room Services for other than emergent care or,
- Prescription use that is excessive or potentially threatening to the health of the recipient indicated by:
    - Multiple prescribing physicians
    - Use of multiple controlled drugs
    - Overlapping prescriptions with counterproductive therapeutic value

PROGRAM REQUIREMENTS

Recipients that are referred to the CSP must choose a primary care physician by selecting one (1) family practice, general practice or internal medicine physician of their choice. CSP recipients are restricted to one (1) pharmacy of their choice to manage their drug usage, thereby eliminating the potential dangers of multiple drug use. Based on the usage of medical services the recipient may be restricted to one (1) dentist of their choice. The recipient's selection of service providers is subject to approval by the Department.

HOW DOES THE PROCESS WORK?

The Surveillance and Utilization Review (SUR) Analyst initiates a review of services utilized by Medicaid recipients. Recommendations are referred to the medical review team consisting of a physician and pharmacist or other specialty type. The medical review team determines if a recipient could benefit from the CSP and the provider type(s) the recipient will need to select. Upon receipt of an approval from the medical review team, the following process occurs:

- A notice detailing the areas of concern, program requirements and appeal rights is sent to the recipient informing him/her of the CSP placement.
- The recipient's eligibility worker in the county social service office receives notification from the SUR Analyst to initiate CSP requirements along with a copy of the notice sent to the recipient, and a Provider Selection Form (SFN 558) to be signed by the recipient.
    - Within 10 days of receipt of the CSP notice, the county eligibility worker must arrange an appointment with the recipient to complete CSP forms and to have the recipient select a provider(s).
    - The provider selection process must be completed within 30 days of the recipient's notice of placement in the CSP. If the selection process is not completed within 30 days, the recipient is placed on emergency status only.

An initial 18-month period of CSP status is required before a follow up review is conducted. The medical review team will review and analyze the recipient's use of services during that 18-month period to determine if the CSP status should continue as well as recommendations for additional medical reviews.

If a recipient becomes ineligible for Medicaid during the CSP period, CSP status resumes at the time Medicaid eligibility is re-established. If the recipient is ineligible for Medicaid for a period of three months or less, the medical team review will be conducted on the original review date. For periods of Medicaid ineligibility that exceed three months, the medical team review will occur 18 months after the most recent date of Medicaid eligibility.

HOW DOES AN APPEAL REQUEST WORK?

The recipient has 30 days from the date of the CSP notice to request an appeal. The appeal must be in writing to: Appeals Supervisor, 600 E Boulevard Avenue, Dept. 325, Bismarck, ND 58505. If the appeal request is received within 10 days from the date of the CSP notice, the implementation of the CSP will be delayed until an appeal decision is reached. For appeals received later than 10 days from the date of the notice, the CSP process continues.

WHAT IF THE CSP RECIPIENT WANTS TO CHANGE PROVIDERS?

A CSP recipient may request a change in provider(s) by contacting the county eligibility worker of their request in writing. The request must contain reasons for the requested change(s) along with applicable supportive documentation. The county worker submits the request to the Department's SUR unit for review by the medical review team. The recipient is notified of the decision in writing with a copy to the county worker.

WHAT IF THE CSP RECIPIENT OBTAINS SERVICES FROM A NON-DESIGNATED PROVIDER?

Medicaid will not pay for services obtained from a non-designated provider, services obtained without a referral from the recipient's CSP physician or emergency services that are determined non-emergent. The CSP recipient is responsible for these incurred costs.

WHAT IF THE RECIPEINT NEEDS TO SEE A SPECIALIST?

Only the recipient's CSP physician can authorize a referral to a specialist. Referrals must be medically necessary. Medicaid will not approve retroactive referrals. Once authorized, the specialist may order medically necessary tests and treatment. If additional specialists are needed the CSP physician must initiate the referral.
If a CSP physician is going to be absent from practice for an extended period of time, the CSP physician should refer the recipient to another physician to provide necessary urgent or emergent care. The recipient should wait for the return of his/her CSP physician for services that are considered routine care.

Referral forms are available by calling the Department's Surveillance and Utilization Review unit at 701-328-4010, 701-328-2334 or 701-328-4024. A clinic's referral form is also acceptable provided the form contains the name of the CSP physician, the referred physician, the name of the recipient being referred, the duration of the referral and a dated signature of the CSP physician. The referral form must be mailed or faxed to the Department. The Department's fax number is 701-328-1544. The CSP physician may also notify the Department by telephone if the referral need is urgent.

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FAMILY PLANNING SERVICES

FAMILY PLANNING

A family planning agency provides family planning services and has a medical director who is a physician enrolled in the Medicaid program. The medical director signs the provider enrollment form acknowledging that the counseling and information on family planning provided by the agency is performed by trained personnel and in keeping with accepted community standards.

Family planning services consist of health services or family planning supplies for the voluntary planning of conception and pregnancy for individuals of childbearing age.

PROVIDERS

Physicians, clinics, outpatient hospital departments, pharmacies, nurse midwives, nurse practitioners, and family planning agencies may provide some or all of the available family planning services and family planning supplies.

Family planning agencies may provide only those services within the scope of practice of the personnel working within the agency.

PAYMENT ISSUES

Medicaid pays providers for family planning services and supplies for Medicaid eligible individuals of childbearing age, including minors eligible for Medicaid. Recipients must be free of coercion and free to choose the method of family planning they will use. The provider may not require that an unmarried minor's parent or guardian consent to family planning services for the minor.

The Department pays for family planning services only when:

- The recipient has full knowledge of the service and consents to it freely.
- The provider submits a correctly completed Consent Form with the claim for voluntary sterilization procedures (See Sterilization Chapter).

The following family planning services are covered, although all providers listed above may not directly provide all of these services.

- Birth control “shot” Depo-Provera.
- Contraceptive devices, i.e., diaphragm, intrauterine device (IUD).
- Contraceptive implants, i.e., Norplant (removal must be medically necessary if within five years of implant).
- Counseling by trained personnel regarding family planning.
- Distribution of information on family planning.
- Consultation, examination, and medical treatment.
- Genetic counseling.
- Prescriptions for the purpose of family planning.
- Distribution of family planning devices such as latex condoms, thermometers, charts.
- Laboratory examinations and tests.
- Voluntary sterilization (see Sterilization Chapter).

Medicaid does not pay for non-covered services including:

- Reversal of voluntary sterilization
- Artificial insemination or in vitro fertilization
- Hysterectomies for the purpose of sterilization

FILING CLAIMS FOR SERVICES

Use the CMS-1500 claim form to bill these services.

Pharmaceutical services must be billed through Point-of-Sale (POS).

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HOME HEALTH PRIVATE DUTY NURSING

WHAT IS HOME HEALTH CARE/PRIVATE DUTY NURSING

Home health services are skilled nursing services as defined in the Nurse Practice Act, that are provided on a part-time or intermittent basis. All services are provided based on a licensed physician's orders and a written plan of care. Other services include home health aide services, physical therapy, occupational therapy, speech pathology, and audiology services, and medical supplies, equipment and appliances suitable for use in the home.

Private duty nursing services means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse. The services must be provided by a registered nurse or a licensed practical nurse under the direction of the recipient's physician in his or her own home.

For skilled nursing needs which exceed four hours per day, the department will review for medical necessity and negotiate an hourly fee with the home health agency or a private duty nurse. Specific billing requirements will be discussed at that time.

Physician must certify need for skilled nursing services.

WHO PROVIDES HOME HEALTH CARE

Home health services are provided by a home health agency. A "Home Health Agency" means a public or private agency or organization (or part of an organization) that meets the requirements for participation in Medicare. Some of the Medicare requirements are as follows:

- The home health agency is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech therapy, or occupational therapy, and home health aide services.
- All policies must be established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services and provide for supervision of such services by a physician or registered professional nurse.
- The agency maintains clinical records on all patients.
- The agency is licensed in accordance with state or local law.

- The agency meets other conditions identified by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

WHO MAY QUALIFY FOR HOME HEALTH SERVICES

To qualify for coverage of any home health services, the recipient must meet the criteria listed in this section.

- The physician must certify that the recipient requires skilled nursing care in the home. Services must be medically necessary and the recipient service is considered the most appropriate setting consistent with meeting the recipient's medical needs.

- A recipient is not considered appropriate for home health care if he/she has the capacity to obtain health care outside the home.

- An aged person who does not often travel because of feebleness and insecurity brought on by advanced age would not qualify for home health care unless illness or injury restricts the ability to leave home.

- Services must be provided at the recipient's place of residence. A residence may be the recipient's own dwelling, an apartment, a relative's home, or temporary housing such as a motel/hotel room.

PLAN OF CARE FOR SERVICES

- The original written plan of care must be established by the licensed physician and based upon medical necessity, objective clinical evidence, and professional judgment. The medically necessary opinion is determined by the physician's personal and medical philosophy, educational background, years of clinical experience and is based upon a complete and current appraisal of the recipient's current condition. The appraisal includes a patient history, a physical examination, laboratory studies and other clinical modalities. The appraisal results in a diagnosis(es), written orders and a written plan of care. The plan of care must contain: all pertinent diagnosis; (including the recipient's mental status); the types of services ordered for care; supplies and equipment ordered; the number and the frequency of the nursing visits and an estimate of the duration that care will be needed; prognosis; rehabilitation potential; functional limitations(s); activities permitted; nutritional requirements; medications and treatments; safety measures to protect against injury; discharge plans; and any additional items the physician may choose to include.

Plan of care must be renewed every 60 days

- The orders on the plan of care must indicate the type of services to be provided to the recipient both with respect to the professional who will provide them and with respect to the nature of the individual services, Including the frequency of the services).

- The recipient's health status and medical need provide the basis for services, which must be reasonable and medically necessary. The physician must review the care plan and reorder care every 60 days. The medical necessity of home health care shall be compared to alternative care options which include but are not limited to outpatient services, clinic visits, nursing home placement and public health services.

TYPES OF HOME HEALTH SERVICES

- The recipient must <u>need</u> skilled nursing care on a part-time or intermittent basis, (at least one skilled nursing service every 60 days), or physical therapy or speech therapy or occupational therapy to qualify for home health services. To be considered skilled nursing services, the service must require the skills of a registered nurse or licensed practical nurse under the supervision of a registered nurse. The services must be reasonable and necessary to the treatment of the recipient's illness or injury and must be intermittent. To determine whether a service requires the skills of a nurse, the inherent complexity of the service, the condition of the recipient, and the accepted standards of medical and nursing practice must be considered. Observation and assessment of the recipient's condition by a registered nurse are reasonable and necessary skilled services when the likelihood of change requires professional judgment. The possible need for treatment modification or the initiation of additional treatment procedures until the recipient's condition has stabilized are nursing judgments.

  A service is not a skilled nursing service merely because it is performed by or under the direction of a registered nurse. If and when a service can be safely and effectively performed (or self-administered) by the average non medical person without the direct supervision of a registered nurse, the service cannot be regarded as a skilled nursing service. Similarly the unavailability of a competent person to provide a non-skilled service, not withstanding, the importance of the service to the recipient does not make it a skilled service when a nurse provides it.

  Psychiatric evaluation and intensive short term therapy needed by a recipient that recently has been treated as an inpatient and who is suffering from a DSMIII classified psychiatric disorder may be covered as a skilled nursing service under home health. The nurse must be a certified psychiatric nurse. The services provided must be coordinated between the psychiatric nurse and psychiatrist.

The documented evidence available to support the plan of care must be reviewed by the nurse and psychiatrist every 30 days.

- Home health aide services are covered when the recipient meets the conditions to qualify for home health services and the services are provided under the direction of a registered nurse. The services must be part-time or intermittent and be reasonable and necessary to the treatment of the recipient's illness or injury. The reason for the service must be to provide hands on care which is needed to maintain the recipient's health or to facilitate treatment. The physician's order must indicate the frequency of the services and the care must be in accordance with the physician's plan of treatment.

- Physical therapy, occupational therapy, and speech therapy are covered as optional services under home health services.

  All skilled therapy services must be provided by licensed therapists and be reasonable and necessary to the treatment of the client's illness or injury within the context of the unique medical condition. The services must be provided with the expectation that the client's condition will improve in a reasonable and predictable period of time. Services involving activities for the general welfare of the client like exercises to promote overall fitness or flexibility or activities that provide diversion or motivation do not constitute skilled therapy. Those services can be performed by non-skilled individuals without the supervision of a therapist. Documentation must reflect the medical necessity of the therapy and that the skills of a therapist are required to treat the illness or injury and evidence that the service cannot be carried out by non-skilled personnel.

NON-COVERED SERVICES

- Individual procedures which are not covered under the North Dakota Medicaid Program as skilled nursing services are as follows: 1) eye drops or ointment instillations; 2) routine glucose monitoring and insulin administration; 3) routine foot care; 4) stasis ulcer maintenance care; 5) pediatric maintenance care; 6) routine medication setup; and 7) other services that become self-care activities after the recipient or family members or others have been taught how to do the procedure(s) in a reasonable amount of time. If the recipient or caregiver will not or is not able to learn the procedures, other options should be explored. Observation and assessment by a skilled nurse is not reasonable and necessary to the treatment of the illness or injury when indications are that it is a long standing pattern of the recipient's condition and no clinical progress is demonstrated.

- Personal care services not directly related to the need for skilled nursing care are not covered. For example, a recipient requiring ongoing assistance with acts of daily living not related to a current illness or injury is not appropriate for home

health care. Incidental services that do not meet the definition of home health aide services are not covered. They include but are not limited to light housekeeping, transportation, meal preparation, laundry, trash removal, shopping, taking children to school, child care, and respite care.

- Social services provided by social workers are not covered.
- Respiratory therapy services (as a separate category of services) are not covered. R.N.'s may provide respiratory therapy as a nursing service.
- Supplies are included in the rate and are not covered separately.

HOW TO REQUEST HOME HEALTH SERVICES

Prior authorization is required for all recipients except recipients for whom services are anticipated to not exceed $3,000 in paid services and/or for whom required services are anticipated to last less than sixty days. Prior authorization is required at the time services exceed $3,000 in paid services and/or the duration of services exceeds two months. Prior authorization is required for Medicare/Medicaid eligible recipients.

The written prior approval request, SFN 15, must contain a legible copy of the Home Health Certification and Plan of Treatment Form HCFA 485 or certified plan of treatment and a copy of the original physician's order. SFN 15 is located at: http://www.state.nd.us/eforms/Doc/sfn00015.pdf

Any other information which would be pertinent to evaluate the recipient's medically necessary home care needs should be submitted to the program with the prior authorization request. The home health agency must submit the request as early as possible to assure service coverage.

Facsimile copies will be accepted and response given in the same manner. Return FAX numbers must accompany the request. Telephone approvals will be accepted only for emergencies.

Prior authorization will be granted for up to sixty days. If the same level of care or a more intense level of care is necessary beyond the original sixty-day approval, a new treatment plan is required. The home health agency must submit the plan of treatment and the Medical Update and Patient Information Form HCFA 486 and the Addendum to the Plan of Treatment/Medical Update Form HCFA 487 for approval by the agency.

The home health agency must keep a copy on file of all documents submitted to the Medicaid office. Approved prior authorizations are dependent on the recipient's eligibility during the approved prior authorization period. If a recipient requires additional services in an approved period, the home health agency is responsible for requesting prior authorization in writing of the expanded services.

UTILIZATION CONTROL PROCESSES

Utilization control measures safeguard against unnecessary or inappropriate use of Medicaid services and the prevention of excess payments.

The Department monitors home health services statewide and takes all necessary corrective action to ensure the effectiveness of the program. In unusual or complex cases the home health agency must provide professional expertise on an ongoing basis to assist the Department in its utilization control process.

Home health cases that have received services exceeding $3,000 in paid services and/or exceed sixty days must be reviewed by the Department for prior authorization. Additional information may be requested when the medical necessity of services is questioned.

The Department will reduce or deny the claims for payment if it concludes that medical necessity for home health care cannot be demonstrated. If the recipient believes the decision is incorrect, they may request an appeal. The appeal must be requested within 30 days from the date of the notice.

PAYMENT FOR SERVICES

Services provided by Home Health Agencies will be paid by the Department as follows:

- Skilled Nursing Visits: A visit is defined as a continuous period of time not to exceed a two hour period in which the nurse remains at the residence of a recipient for the purpose of providing ongoing skilled nursing services.

- Home Health Aide Visits: A visit is defined as a continuous period of time not to exceed a two hour period in which the aide remains at the residence of the recipient for the purpose of providing necessary ongoing home health aide services.

- Therapy Services: All therapy services will be paid per visit.

HOW TO FILE A CLAIM

Medicaid requires all home health agencies to meet Medicare certification requirements. Home health agencies must enroll in the North Dakota Medicaid program before payment can be made. Home health agencies interested in enrolling may refer to the Provider Enrollment chapter.

Providers can submit electronic claims through the Department's Web File Transfer or through the Blue Cross Blue Shield of North Dakota PC-Ace program, or on a paper

UB-92 claim form. Providers are encouraged to file claims using the PC-Ace or Web Based File Transfer. See website for additional information on these: http://www.state.nd.us/humanservices/services/medicalserv/medicaid/edi.html. Paper claims are only required if additional information is requested or submitted with the claim. Providers using PC-Ace should refer to the UB-92 Instruction Manual published by Blue Cross Blue Shield of North Dakota for specific instructions.

Claims will be monitored for prior approval as appropriate. Non-priored claims or claims that exceed the authorized period will be denied for payment. Providers must enter the day home health services started in the admit date block of the claim.

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.

HOSPITAL SERVICES

COVERED HOSPITAL SERVICES

Covered hospital services are subject to the following requirements:

- The service must be provided by a qualified provider.
- The service must be determined as medically necessary.
- Prior authorization must be obtained from North Dakota Health Care Review, Inc. (PRO) for, but not limited to: gastrectomy, cosmetic or reconstructive surgery involving facial, ear, nose or breast, and admission to a long-term hospital. Prior authorization number must be included in Block (63) of the UB 92 claim form.
- Abortion and abortion-related services are covered only when medically necessary to prevent the death of the pregnant individual or when the pregnancy is the result of incest or rape.
- Hysterectomies and voluntary sterilization are subject to informed consent requirements.
- All non-diagnostic outpatient services related to an inpatient admission and all diagnostic services provided within 3 days of a hospital admission as an inpatient, are not covered as separate services. Such services must be included on the inpatient claim along with other related services.
- Outpatient services provided on the day of discharge may not be separately billed and must be included on the inpatient claim.
- Ambulance services are not payable to hospitals on UB 92 form and must be billed on CMS 1500 claim form using a 5-digit ambulance provider number.
- Partial hospitalization services must be preauthorized by the Department.
- Observation days are not limited and may be billed as outpatient services if an inpatient admission does not occur within three days of last day of observation stay.

- Observation stay must be included with an inpatient stay if inpatient admission occurs within three days of the last day of an observation stay and the observation days are considered part of the inpatient stay.

- Inpatient rehabilitation and psychiatric stays are subject to day limits for patients 21 years of age and older.

Rehabilitation - 30-day limit per calendar year
Psychiatric - 21-day limit per episode, not to exceed 45 days per calendar year.

QUALIFIED PROVIDERS

To be qualified for coverage of inpatient hospital services, a facility must:

- Be certified to participate in Medicare and be licensed under North Dakota statutes; or

- If located outside of North Dakota, provide inpatient hospital services and be licensed under the requirements of the state in which it is located; or

- Be designated by the federal government to provide acute care if providing services through Indian Health Services.

SUBMITTAL OF CLAIMS

Payment to instate hospitals, excluding long-term care, psychiatric, and rehabilitation hospitals or distinct part units, is based on Diagnostic Related Groups (DRG) for inpatient services. Payment to psychiatric and rehabilitation hospitals or distinct part units is based on a per diem payment. Inpatient services provided by a long-term care hospital and all outpatient services are paid based on a percentage of charges.

Hospital billings for services that will be paid by DRG cannot be submitted until the patient is discharged. For inpatient and outpatient services that are not paid by DRG, the hospital must bill each calendar month.

Separate payments will be made for the mother and newborns.

Separate claims are required to be submitted when a patient is transferred between acute care and a distinct part unit within the same hospital. The distinct part unit provider number must be on the claim for services provided within the distinct part unit.

Medicare claims should be billed as follows:

- If patient has Part A Medicare, charges for a DRG hospital billing must be billed entirely on a UB 92 claim form.

- If the patient has only Part B and incurs charges during an inpatient stay billed as a DRG claim, the Part B charges must first be submitted to Medicare and then submitted to Medicaid on a UB 92 claim form, which includes all charges for the inpatient stay. The UB 92 claim must include the Part B payment from Medicare in the insurance block.

- If the patient receives Medicare Part B services on an outpatient basis, all charges must be billed on a UB 92 claim form.

- If the patient receives Medicare Part B services in an inpatient setting where services are not paid by DRG, the Part B charges may not be submitted to Medicaid.

As always, bill Medicare and any other third party insurance before submitting to Medicaid.

Medicaid is payer of last resort. Therefore, all third party liability must be utilized before Medicaid can be billed.

PAYMENT TO OUT OF STATE HOSPITALS

Payment to out of state hospitals is based on a percentage of charges and is payable if the patient has obtained prior approval from North Dakota for out of state referral. Prior authorization is not required for true emergencies or for United States hospitals within 50 miles of the North Dakota border.

AMBULATORY SURGICAL SERVICES

Ambulatory surgery service is a surgical procedure that does not require overnight inpatient hospital care and meets the definition as stated in ambulatory surgical services section of this manual. The ambulatory surgical center (ASC) must be an enrolled provider and must bill on a UB 92 claim form using bill type 131 and CPT procedure code only.

Outpatient surgeries performed in hospitals that meet the definition of an ambulatory surgical service are subject to the ASC requirements and payments.

KIDNEY DIALYSIS SERVICES

Kidney dialysis units (KDU) must be enrolled separate from a hospital and are assigned a specific provider number. KDU must bill with bill type 131 and may use only revenue codes 821 and 634.

NON-COVERED HOSPITAL SERVICES

The following is a list of non-covered services that must be identified as non-covered if billed on the UB 92 claim form.

Admission kits
Anesthetic acupuncture
Ambulance charges effective 10-1-97
Barber/beauty
Biofeedback
Books/tapes
Circumcision - routine outpatient
Drugs - experimental
Guest tray
Late discharge
Leave of absence room
Lifeline
Linen
Non-patient room rent
Nursing - outpatient
Patient convenience items
Physician charges - bill on CMS 1500
Postage
Private room
Social services
Take home drugs - bill on pharmacy claim
Take home supplies - bill on pharmacy claim or CMS 1500 claim
Tax
Technical support charges
Telemetry in ICU
TV, telephone, radio

BILLING MEDICAID

Inpatient hospital billings for services paid by DRG under Medicaid may not be submitted until the patient is discharged.

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. In case of other insurance coverage, that amount must be in Block (55) on claim form. The prior payment amounts in Block (54) must be the difference of total charges and patient amount due.

UB 92 CLAIM FORM - MEDICAID REQUIREMENTS

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) Noncovered days

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

Block (14) Birthdate - month, day, year

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

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

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 payors must equal the difference of total charges minus patient due and non-covered

Block (55) Estimated amount due - what patient is liable for

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

GENERAL INFORMATION

- Only 44 lines can be accepted on paper claim.
- Up to 999 lines may be billed through HIPAA 837 (I) Transaction.
- HIPAA transactions will be processed faster than paper claims.
- Zero billed charges will delay claim processing as will non-covered revenue codes.
- Revenue code 001 must be on all claims.
- Insurance must be processed before billing Medicaid.
- Denied claims must be corrected and resubmitted.
- Bill summarized claim forms.
- Claim should not be submitted until all charges can be included. Submission of additional charges on separate claim could result in delay or denial of payment.
- Sterilization claims must be billed on paper claims and must have consent form attached.
- All outpatient services or visits occurring on same day for a client must be billed on one claim.
- Family planning charges must be billed on separate claim form from other charges.
- Nutritional education must be billed using revenue code 982 using appropriate CPT codes.
- Miscellaneous lab codes need description and report.
- Diabetic education is payable only once in a recipient's lifetime. Use revenue code 942. Prior authorization code must be on claim in Block (63).
- PCP numbers must be in Block (82) or (83) or claim will be denied.

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human services

HUMAN SERVICE CENTER SERVICES

WHAT IS A HUMAN SERVICE CENTER

A human service center (HSC) is a clinic setting that provides health services by or under the supervision of a physician. To operate as a human service center the agency must:

- Have non-profit status;
- Have tax-exempt status as provided for in the Internal Revenue Code;
- Be established to provide health services to low income population groups; and
- Have written clinic policies.

To be eligible to participate as a human service center, the agency must establish:

- A written description of health services provided by the human service center,
- Written policies concerning the medical management of health problems including health conditions which require referral to physicians and provision of emergency health services, and
- Written policies concerning the maintenance and review of health records by the physician.

TYPE OF SERVICES PROVIDED

Clinical services are provided in a human service center or a satellite location. A satellite location includes offices outside the central location. Services include the following:

- Individual, group, family or marital/couple therapy;
- Medication management;
- Psychological, psychiatric, addiction, or other clinical evaluation; and
- Chemical dependency outpatient treatment programs.

Before services are provided, the HSC must obtain an order for these services from an affiliated physician or psychiatrist. The physician or psychiatrist must perform an initial face-to-face interview with the recipient, a treatment plan for the recipient must be developed, reviewed and updated annually, and the physician or psychiatrist must sign off on the treatment plan.

Rehabilitation mental health services consist of medically necessary or remedial services provided to recipients for treatment of a DSM-IV (diagnostic and statistical manual of mental disorders) diagnosis relating to a mental, emotional or behavioral condition. A physician, psychiatrist or psychologist must order treatment for services. A treatment plan must be developed and updated at least annually. The treatment plan must focus on service deliverables that will assist the recipient in attaining and maintaining his/her highest level of functioning. Physician, psychiatrist, or psychologist sign off on the treatment plan is required. All rehabilitation services must be supervised by a physician, psychiatric nurse, a licensed addiction counselor, or a licensed certified social worker practicing within the scope of their license.

Rehabilitation services provided by or under contract with the Department of Human Services include:

- Residential therapeutic services;
- Intensive-in-home;
- Crisis intervention and behavioral intervention; and
- SMI (seriously mentally ill) day treatment

SMI case management service must be provided by staff with the following qualifications: bachelor's degree in social work, psychology, nursing, occupational therapy, or a master's degree in counseling; or a bachelor's degree in vocational rehabilitation, physical therapy, child development, and family science, communication disorders, severely multi-handicapped, special education, or sociology with at least two courses in mental illness; or registered nurses, licensed psychologist, licensed social workers, and licensed addiction counselors.

There must be a written comprehensive assessment of a person's abilities, deficits, and needs. Service gaps and unmet needs should be documented. The individual treatment plan must include specific goals, objectives, services to be provided, responsible person, projected time lines, and criterion for attainment. To the extent possible, the development of the treatment plan is a collaborative process involving the recipient, the family or other support system, the case management provider, and other service providers, if applicable.

Waiver Services: MR/DD (mental retardation/developmentally disabled) case management is the only **waiver service** provided by all Human Service Centers. Other

MR/DD waiver services provided by some, but not all Human Service Centers, include day supports at Southeast Human Service Center; infant development at Northwest, Northeast, Southeast and South Central Human Service Centers; and supported employment extended services at Northwest and Badlands Human Services Centers. For Waiver services to be reimbursed, the recipient must be eligible to receive MR/DD case management services pursuant to North Dakota Administrative Code Chapter 75-04-06, authorized to receive the service, Title XIX eligible and have a current screening for HCBS ICF/MR.

The units of MR-DD case management services reported on the direct log must be documented.

HYSTERECTOMY

WRITTEN CONSENT FOR HYSTERECTOMY

Medicaid payment is available for a hysterectomy unless it is performed for the purpose of making the recipient sterile. The recipient and her representative, if applicable, must sign an acknowledgment of receipt of both oral and written information that the hysterectomy would make the recipient permanently incapable of reproducing. The Physician Certification for Hysterectomy and Recipient Acknowledgment of Sterility SFN 614 form (consent form) must accompany the paper claims submitted by the physician, anesthesiologist, and hospital. A sample form of SFN 614 Physician Certification for Hysterectomy and Recipient Acknowledgement of Sterility is available on http://www.state.nd.us/eforms/Doc/sfn00614.pdf. Do not use the Sterilization consent form for tubal ligations.

The consent form when signed by the recipient or her representative indicates that the provider informed the recipient (and her guardian if applicable), that the procedure would cause sterility.

The recipient or recipient's guardian may sign the consent form before or after the hysterectomy. Guardians must sign the consent form for mentally incompetent recipients. A recipient residing in an institution may sign the acknowledgment for herself unless she has been found incompetent by a court.

INSTRUCTIONS FOR COMPLETING THE PHYSICIAN CERTIFICATION FOR HYSTERECTOMY AND RECIPIENT ACKNOWLEDGEMENT OF STERILITY FORM

Section a and b. Prior to surgery, recipient was advised both orally and in writing that the surgical procedure known as a hysterectomy would cause permanent sterility. Both the physician and recipient must certify this acknowledgment with written signatures.

Section c. A hysterectomy performed on a recipient who was sterile before the surgery is subject to the written acknowledgment statement. The claims submitted by the physician who performed the hysterectomy, the anesthesiologist, and the hospital must be accompanied by written physician certification of the recipient's sterility and the cause of her sterility.

Section d. The written acknowledgment statement does apply when a recipient needs a hysterectomy because of a life-threatening emergency situation in which a physician determines that prior acknowledgement is not possible. A written physician certification that prior acknowledgment was not possible, and a description of the nature of the emergency must accompany all claims for services associated with the hysterectomy.

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IMMUNIZATIONS

COVERED SERVICES

North Dakota Medicaid pays for immunizations that are medically necessary and approved by the Federal Drug Administration (FDA). The population includes both children and adults. A listing of Medicaid covered immunizations includes:

- Vaccines for Children (VFC) – a current listing of recommended vaccines is available at www.cdc.gov/nip. VFCs are exempt from the PCP program.

- Hepatitis B – administration is medically appropriate for individuals with multiple sexual partners, individuals exposed to hepatitis B, sanitary engineers, and individuals employed in a nursing facility or medical facility.

- Influenza vaccine – typically recommended for individuals at risk including children age 6 to 24 months, individuals age 65 and over, individuals age 2 to 64 with underlying chronic medical conditions, residents of long term care facilities, health care workers providing direct patient care, out-of-home caregivers and contacts with infants age 6 months and less, out-of-home caregivers and household contacts of individuals in high risk groups and individuals age 50 to 64 years. Recommendations for influenza vaccination are available at www.cdc.gov/flu.

- Synagis – recommended for infants at high risk of Respiratory Synctial Virus (RSV), must be medically necessary and must meet American Academy of Pediatrics (AAP) guidelines. For billing information refer to Medicaid Coding Guidelines at www.state.nd.us/humanservices/services/medicalserv/medicaid/cpt.html.

COVERAGE LIMITATIONS

Vaccinations required for out-of-country travel are not billable to Medicaid as the travel is not considered medically necessary.

BILLING REQUIREMENTS

All providers, except pharmacy providers who may choose to bill with NDC, must bill for immunizations using valid vaccine/toxoid CPT codes. In addition to the vaccine/toxoid codes (90476-90749) the provider must bill the appropriate immunization administration code(s) (90465, 90466, 90471, 90472).

BILLING REQUIREMENTS FOR NORTH DAKOTA DEPARTMENT OF HEALTH SUPPLIED VACCINE THROUGH THE VACCINES FOR CHILDREN (VCF) PROGRAM

Providers must bill according to the following instructions when administering vaccines supplied at no cost by the North Dakota Department of Health (NDHD).

When the vaccine/toxoid (90476-90749) is a state supplied vaccine, the vaccine/toxoid CPT code with modifier–SL must be appended. In addition to the state supplied vaccine/toxoid the provider must bill the appropriate immunization administration code(s) (90465, 90466, 90471, 90472).

PAYMENT RATES

Payment to providers for non-state supplied (non-VFC) vaccine/toxoid product must meet NDMA medical necessity guidelines. When medical necessity requirements are met, the payment is based on the Medicare allowed amount. Additional payment will be made for the vaccine/toxoid administration codes.

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INDIAN HEALTH SERVICES (I.H.S.)

GENERAL INFORMATION

CFR §431.110 Participation by Indian Health Service facilities.

(a) *Basis.* This section is based on section 1902(a)(4) of the Act, proper and efficient administration; 1902(a)(23), free choice of provider; and 1911, reimbursement of Indian Health Service facilities.

(b) *State plan requirements*. A state plan must provide that an Indian Health Service facility meeting State requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider. However, when State licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, a Medicaid agency or State licensing authority may not take into account an absence of licensure of any staff member of the facility.

Indian Health Service facilities are paid with a per diem (encounter) rate published annually in the Federal Register by the Office of the Federal Register, National Archives and Records Administration (NARA). The IHS encounter rate is paid for any North Dakota Medicaid covered service when provided in an IHS clinic or hospital.

BILLING INFORMATION

Indian Health Services are billed on a UB-92 form using the following Revenue Codes (with CPT codes when appropriate).

	Bill Types	Revenue Codes	CPT Code Required
Inpatient	111	100	
Outpatient	131	500	

Pharmacy	131	250	
Vision	131	510	
ASC	831	490	Yes*
Dental	131	512	
Mental Health (Psychiatrist/Psychologist)	131	513	
EPSDT	131	519	
Telemedicine (clinic/physician)	131	509	
Telemedicine (mental health)	131	961	
Physician Inpatient Services	131	987	Yes*

* Revenue codes 490 and 987 require CPT codes in Form Locator 44. Payment is based on Medicaid fee schedule. We will only accept the following CPT codes for revenue code 987: 99221-99239; 99251-99263; 99291-99297; and 99431-99440.

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INDIVIDUAL EDUCATION PLAN RELATED SERVICES (IEPRS)

Individual Education Plan (IEP) Related Services (IEPRS) are:

- Medically necessary health services. “Medically necessary” or “medical necessity” means a health service that is consistent with the recipient’s diagnosis or condition and is recognized as the prevailing standard or current practice by the provider’s peer group.

- Determined through the school’s planning and placement team and outlined within an Individualized Education Plan.

- Prescribed by a physician as part of the written plan of care. The Individual Educational Plan can be used as the initial plan of care when certified by the recipient’s attending physician.

- Provided by eligible licensed/certified providers.

- Billed by an enrolled provider.

WHO MAY BILL FOR SERVICES?

Medicaid pays public school districts for providing health related services that are described in the Individual Education Plan (IEP). To receive Medicaid payment, the services must be part of a local public school district special education program. The public school district must use qualified personnel to provide services that will be billed to Medicaid. Medicaid will not directly pay private schools, but can make payments to the public school district for IEP-related services for children in that district who are attending private educational facilities.

School districts also may contract for billing functions with a billing agent. The public school district, when seeking direct payment for IEP-related services is accountable for all services provided and claims submitted to Medicaid.

Services that are similar to services provided by a school district as part of an IEP may be provided to the recipient separate from the educational setting for other reasons of medical necessity. These services may be provided concurrently with IEP-related

services provided by the school district and would be billed by the entity providing the service.

COVERED SERVICES

- Physical Therapy and Occupational Therapy
- Speech-Language Pathology
- Audiology
- Psychologist or Psychiatrist
- Medical Consultation
- Transportation to and from school to receive IEP-related services
- Durable medical equipment and supplies

NON-COVERED SERVICES

- Services provided without physician order or authorization.
- Services authorized by a physician but not documented in the recipient's clinical record.
- Services that are not provided directly to the recipient. Indirect services such as attendance of staff meetings, staff supervision, recipient screening, development and use of instructional text and treatment materials, are non-covered services.
- Communications between the provider and recipient that are not face-to-face.
- Concurrent services for the same recipient involving similar services or procedures.
- Follow-up visits upon completion of treatment services without physician orders/authorization.
- When maximum benefits of treatment programs are reached, services will no longer be covered.
- Transportation to and from home to school.

RECIPIENT ELIGIBILITY

It is the responsibility of the provider to verify the recipient's eligibility status before providing the services. Medicaid pays only services provided on a day in which the child is eligible for Medicaid coverage. Verification of a valid eligibility card is recommended. Providers may call the Eligibility Verification System at 1-800-428-4140 or (701) 328-2891.

GENERAL BILLING PROCEDURES

General billing procedures, usual and customary charges, claim submission guidelines, claims format, direct billing by provider and/or his/her agents, and provider responsibilities are found in the Billing Chapter.

- **Contract Services:** School districts may contract for services with a qualified provider or billing agent. However, all services provided to a recipient as part of their IEP must be billed to Medicaid using the school district's provider number. When school districts bill, the school district is accountable to Medicaid for all services rendered and all bills submitted.

- **Concurrent IEP and Non-IEP Services:** Medicaid will pay all eligible providers delivering medically necessary services to Medicaid recipients. A school district may bill Medicaid for IEP-related health services provided to a recipient who also receives non-IEP related rehabilitative services from a non-school district provider type, such as a rehab agency or outpatient hospital. IEP-related services and non-IEP related services provided on the same day may be billed. Documentation by each provider must reflect medical necessity for concurrent care by both providers.

- **Third-party Payer:** Medicaid is the payer of last resort. All enrolled providers must bill any third party payers prior to billing Medicaid. If Medicaid receives a claim for services provided to a recipient with additional coverage, the claim will be rejected. Payment will not be provided without proof that the primary payer source has denied payment. Coverage by any private or third party payer (HMO, PPO, Medicare, Insurance Carrier) must be accessed according to the specifics of the insured's health care plan.

- **Recipient Liability:** Is the amount the client is responsible to pay toward monthly medical costs. This must be met before claims will be paid.

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LAB, RADIOLOGICAL, AND DIAGNOSTIC SERVICES

PROVIDERS

To be eligible for participation as a provider of (independent) laboratory services, (independent) x-ray services, or portable x-ray services, a vendor must be certified by Medicare.

INDEPENDENT LABORATORIES, MEDICARE CERTIFIED

The Centers for Medicare and Medicaid Services (CMS) directives require Medicaid to identify the independent laboratory and check certification for procedures they are authorized to perform. Medically necessary services provided by certified independent laboratories are covered by Medicaid if those services fall within the range of Medicare certified specialties and subspecialties for that laboratory. Hospital laboratory services also must be certified by Medicare for Medicaid coverage. Services that are not certified will not be covered.

COMPONENTS OF AND BILLING FOR RADIOLOGIC SERVICES

Both professional and technical components may be billed to Medicaid. The professional component is applicable in any duration in which the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities. To bill for the professional component, use the applicable procedure code and enter “26” in the modifier box on the claim. When more than one provider is involved with providing and billing the procedure the providers should establish a written agreement as to which component each provider will be billing. Duplicate billing is considered fraudulent.

For example, a physician may bill for the professional component for a service they provided, while the hospital may bill for only the technical component. Or, the hospital may bill for the total component (professional and technical), and the second provider (physician or hospital) may not bill for either component.

When a physician or physician clinic is billing for services performed, and the equipment used is owned by the physician or clinic, the service should not be separated into a

technical and professional component. Bill the appropriate CPT code but do not modify the code.

The professional component represents the professional services of the physician. The professional component includes: examination of patient when indicated, performance or supervision of the procedure, interpretation, and written report of the examination.

The technical component includes the charges for personnel, materials, including usual contrast media and drugs, film or xerograph, space, equipment and other facilities but excludes the cost of radioisotopes. (Technical components may be billed by providers owning the equipment). To identify a charge for the technical component, enter the 5-digit procedure code and indicate “TC” in the modifier box.

LABORATORY SERVICES IN A PHYSICIAN’S OFFICE

Providers eligible for reimbursement of laboratory services in a physician’s office are physicians or physician extenders under the direct supervision of the physician.

Physicians also may send laboratory specimens to independent or outpatient hospital laboratories. However, claim submission must be done by the independent or outpatient hospital laboratory.

CT SCAN / MRI

North Dakota Medicaid will cover medically necessary MRI and CT scans. MRI and CT scans can be used for the diagnosis of many medical conditions.

Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis.

Medicaid does not cover CT or MI scans that are not medically necessary.

north dakota
department of
human services

MEDICAID ELIGIBILITY OF RECIPIENT

THE PURPOSE OF MEDICAID

Medicaid is a program designed to assist individuals and families who do not have enough income to obtain health care. Medicaid is authorized under Title XIX, a 1965 amendment to the federal Social Security Act.

WHERE TO APPLY FOR MEDICAID BENEFITS

Applications for Medicaid can be obtained at all county social service offices. The initial contact may occur through the mail, by telephone, or in person. The local county agency will inform the individual or their representative of the eligibility requirements and the procedure for completing a written application.

The application process consists of:

- A written application filed with the local county service agency;
- The local county social service agency verification of information provided by the applicant; and
- An eligibility determination by the local county social service agency.

Eligibility determination on applications is made within forty-five days for families and children and the aged, or within ninety days in disability cases, except in unusual circumstances.

Eligibility for Medicaid may be retroactive up to three months prior to the month a signed application is received by the local county social service office.

WHO IS ELIGIBLE FOR MEDICAID

Medicaid provides coverage to the following individuals and families who meet the eligibility requirements:

- Recipients of Financial Assistance: Persons receiving financial assistance under the state program of Temporary Assistance for Needy Families (TANF) or who

are eligible for federal Supplemental Security Income (SSI) benefits are usually eligible for Medicaid.

- Families Whose Financial Assistance Terminates: Families whose Temporary Assistance for Needy Families (TANF) case closes because of increased child support, increased earned income or loss of income disregards may be eligible for continued Medicaid from 4 to 12 months.

- Aged, Blind, and Disabled Individuals with Low Income: Aged (65 years of age or over), blind or disabled individuals who have sufficient income to meet their basic maintenance needs, as defined by the state, may be totally or partially eligible for Medicaid.

- Families with Low Income Families with children who have sufficient income to meet their basic maintenance needs, but not enough to meet their medical needs as defined by the state may be eligible for Medicaid.

- Elderly Persons in Mental Institutions: Persons 65 years of age or over with low income and assets who are receiving treatment in the State Hospital at Jamestown and do not have the money to pay for their care may be eligible for Medicaid.

- Individuals Under Age 21 in the State Mental Institution: Individuals under 21 years of age receiving an active program of treatment in the State Hospital at Jamestown may qualify for Medicaid.

- Individuals Under Age 21 in Foster Homes: Individuals under 21 years of age residing in licensed foster homes may be eligible for Medicaid if the income available to them does not exceed standards established by the state.

- Certain Adoptive Children: Adoptive children under age 21 may be eligible for medical services as defined under the state's "subsidized adoption law."

- Other Individuals Under Age 21: Individuals under age 21 who, based on state standards, do not have sufficient income to meet their medical expenses may be eligible for Medicaid.

- Pregnant Women and Children Under Age Six: Pregnant women and children under age six, who meet income standards based on the poverty level, may be eligible for Medicaid.

- Children, Age Six to Nineteen: Children who have income within the poverty level may be eligible for Medicaid.

- Qualified Medicare Beneficiaries (QMB): Aged, blind or disabled individuals who meet the established asset and poverty level standards, may be eligible for coverage of their Medicare premium, Medicare co-insurance and/or deductibles.

- Qualified Disabled and Working Individuals (QDWI): Individuals entitled to enroll in Medicare Part A, who meet established asset and poverty level standards and who are not eligible for Medicaid under any other provisions, may be eligible for coverage of their Medicare Part A Premium.

- Special Low Income Medicare Beneficiaries (SLMB): Aged, blind or disabled individuals who meet the established asset and poverty level standards, may be eligible for coverage of their Medicare Part B Premium.

- Qualifying Individuals (QI-1 and QI-2): Aged, blind or disabled individuals who meet established asset and poverty level standards and who are not eligible for Medicaid under any other provisions, may be eligible for coverage of all or part of their Medicare Part B Premium.

MEDICAID IDENTIFICATION (ID) NUMBER AND CARD

When an individual applies for benefits, a unique 9-digit Medicaid Identification Number is assigned. Once a recipient's Medicaid ID number is assigned, it does not change, and follows the recipient through any changes in eligibility or programs.

Once the recipient is determined to be eligible for Medicaid benefits, a Medicaid ID Card is issued to the recipient, usually by the 15th of the month following the month eligibility is determined. Regardless of program eligibility, all Medicaid ID cards are issued in the same format. One Medicaid ID card is issued for the lifetime of a person no matter if their eligibility ends or if their case reopens.

THE INFORMATION ON THE FACE OF THE MEDICAID ID CARD IS LIMITED; THEREFORE, IT IS THE PROVIDER'S RESPONSIBILITY TO VERIFY ELIGIBILITY ON THE DAY SERVICES ARE PROVIDED. The provider must call the Verify system at (701) 328-2891 or 1-800-428-2891, to verify eligibility.

north dakota department of human services

MEDICARE COVERAGE

WHEN RECIPIENTS ALSO HAVE OTHER COVERAGE

Recipients with Medicare

Medicaid recipients enrolled in the federally administered Medicare program are referred to as dual eligible. Medicare currently consists of two parts. Medicare Part A includes service coverage for inpatient hospital care and skilled nursing care; and Medicare Part B includes coverage for outpatient hospital care and physician care.

Medicare is the primary insurer for all dual eligibles. Medicaid may be required to pay some or all of the client's Medicare premium, deductible and coinsurance costs, depending on the following type of eligibility:

- **Qualified Medicare Beneficiaries (QMB)**

  For QMB's, Medicaid pays the Medicare premiums and some or all of the Medicare coinsurance and deductibles. QMB recipients may or may not also be eligible for Medicaid benefits.

  - **QMB Only.** Medicaid will make payments only toward Medicare coinsurance and deductibles.

  - **QMB/Medicaid.** The list of covered services is the same as for other Medicaid clients. If a service is covered by Medicare but not by Medicaid, Medicaid may pay all or part of the Medicare deductible and coinsurance. If a service is covered by Medicaid but not by Medicare, then Medicaid will be the primary payer.

- **Special Low-Income Medicare Beneficiaries (SLMB)**

  For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

- **Qualified Individuals (QI)**

  For these individuals, Medicaid pays the Medicare Part A premium only. These individuals cannot be eligible for Medicaid.

MEDICAID BENEFITS FOR DUALLY ELIGIBLE CLIENTS		
Type of Dual Eligible	Medicare Premium Paid By	Medicare Coinsurance & Deductible Paid By
QMB only	Medicaid	Medicaid
QMB/Medicaid	Medicaid	Medicaid
Special Low-Income Medicare Beneficiary	Medicaid	Recipient

Recipients with other sources of coverage

Medicaid recipients may also have coverage through Workforce Safety, employment-based coverage, or other insurance. Other parties may also be responsible for health care costs. Examples of these situations include child support or auto accident insurance. Under state and federal law, the Medicaid program is the payer of last resort. The provider must bill other health care coverage prior to billing Medicaid.

Cost Effective Health Insurance Program

Medicaid may pay the health insurance premiums for some Medicaid eligible recipients if it is determined to be cost effective based on their current medical needs and how much their insurance pays on those expenses.

Indian Health Service

The Indian Health Service (IHS) provides federal health services to American Indians and Alaska Natives. IHS is a secondary payer to Medicaid.

MANDATORY ASSIGNMENT OF CLAIMS FOR PHYSICIAN SERVICES

The Omnibus Reconciliation Act of 1989 provides for the mandatory assignment of claims for physician services furnished to individuals who are eligible for Medicaid, including those eligible as Qualified Medicare Beneficiaries. This provision defines Physician services as services furnished by a medical doctor, podiatrist, osteopath, chiropractor, or dentist. This provision does not apply to providers of non-physician services.

Medicare does not require providers of non-physician services to accept assignment. Medicare defines non-physician services as services provided by non-physicians. Examples include ambulance, DME, pharmacies. If Medicare processes these claim types, they should cross over to Medicaid.
For a provider accepting assignment, the Medicare allowable rate is considered payment in full. The provider may bill Medicaid for the coinsurance and deductible cost of Medicare approved services.

For a provider that does not accept assignment, the provider may bill Medicare, but not Medicaid.

Most Medicare claims should be crossing over to Medicaid electronically. If crossover claims do not cross over and the recipient is eligible for dates billed, determine if Medicare's provider number/recipient I.D.# is cross-referenced to the Medicaid information on file.

north dakota
department of
human services

NON-COVERED MEDICAID SERVICES

This list refers to services that are not covered by the Medicaid program. This is not an all-inclusive list.

- Health services paid by the recipient or other source, unless the payment for services incurred during the recipient's retroactive eligibility period.
- Drugs that are not approved by the FDA.
- Autopsies.
- Missed appointments (providers may bill Medicaid clients for missed appointments, if this is the normal practice for all patients).
- Health services for which required authorizations were not obtained prior to service delivery (refer to the Prior Authorization chapter).
- Health services that do not comply with guidelines and limitations contained in this manual.
- Health services, other than emergency health services, provided without the full knowledge and consent of the recipient or the recipient's legal guardian.
- Health services for which a physician's order is required but not obtained.
- Health services not in the recipient's plan of care.
- Health services not documented in the recipient's health/medical record.
- Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers. (Providers of services, which are determined to be of low quality, must bear the cost of these services.)
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services.

- More than one office, hospital, long-term care facility, or home visit by the same provider, per recipient per day, except for an emergency.

- More than one consultation by a provider, per recipient per day except for an emergency. For purposes of this item, “consultation” means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis and therapy.

- When a consulting physician assumes responsibility for the continuing care of the patient,(i.e. writes orders) the service ceases to be a consultation.

- Non-CLIA certified lab services.

- Abortions (except in cases of rape or incest, to save the live of the mother or in line threatening situations).

- Artificial insemination.

- Reversal of sterilization.

- Surgery primarily for cosmetic purposes.

- Services for detoxification unless medically necessary to treat an emergency.

- Body piercing (tattoo or tattoo removal).

- Services performed outside of the practitioner’s scope of practice as defined by state laws.

- Alcoholic beverages.

- Acupuncture.

- Experimental services and procedures.

- Massage therapy.

- Workforce Safety and Insurance Commission.

- Services that are not medically necessary.

- Psychiatric services for ages 21-64 in an IMD (Institution for Mental Disease).

- Services to lock-in recipients that are not referred by the lock-in provider, except for emergency services.

- Services to a Medicaid recipient to which a PCP (Primary Care Provider) referral is required but not obtained, except for emergency services.
- Out-of-state services that were not prior approved, except for emergency services.
- Services that were denied by responsible third party payer because third party requirements were not followed.
- Hypnotherapy.
- Interpreter services.
- Chiropractic services, with the exception of spinal manipulations, limited to 12 per calendar year and x-rays to the spine limited to 2 per calendar year.
- Weight loss programs and exercise programs.
- Annual routine physical examination with no clinical indications, except ICF/MR individuals.
- Services provided by a non-Medicaid provider.
- Alcoholics Anonymous.
- Transportation for non-medical appointments.
- Routine circumcisions.
- Patient convenience (example: moving patient to facility closer to home).
- Home modifications to accommodate mobility (example: wheelchair ramp, etc.).
- Infertility Testing (treatments or diagnostics related to infertility).
- Equine therapy.
- Music therapy.
- Drug testing.
- Paternity testing.
- Telephone Consultation.

NORTH DAKOTA ACCESS AND CARE PROGRAM
(Primary Care Provider (PCP) and Managed Care Organization (MCO)

GENERAL INFORMATION

The Centers for Medicare & Medicaid Services approved North Dakota Department of Human Services, Medical Services Division's (Department) State Plan Amendment concerning managed care in July 2001. Management of the North Dakota Access and Care (NoDAC) program using the State Plan Amendment is authorized under section 1932(a)(1) and (2) of the Social Security Act. This State Plan Amendment permits mandatory enrollment of eligible Medicaid enrollees into managed care.

The objective of the North Dakota Access and Care Program (NoDAC) is to assure adequate access to primary care by Medicaid enrollees; improve the quality of care received by enrollees; promote coordination and continuity of health care; reduce costs; and assist enrollees to use the health care system appropriately and effectively by preventing unnecessary utilization and reducing inappropriate utilization.

The basic concept is to allow Medicaid enrollees to select a Managed Care Entity (MCE), either a Primary Care Provider (PCP) or Managed Care Organization (MCO), to provide, through an ongoing patient/physician relationship, primary care services and referrals for all necessary specialty services. The MCE is responsible for monitoring the health care and utilization of non-emergency services. Neither true emergencies nor family planning services provided by family planning clinics or OB/GYNs are restricted.

The Department contracts with an MCO to serve recipients as a way of providing quality, cost-effective, health care services. The State Plan allows the Department to require a Medicaid enrollee in a designated county to select an MCO or PCP.

The MCE assists the enrollee in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The MCE will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of enrollees.

Enrollees will be restricted to receive services included under the managed care benefit package either from the MCE or from another qualified provider to whom the participant was referred by the MCE. The state plan's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will reinforce continuity of care and efficient and effective service delivery.

PARTICIPATING POPULATIONS

The medical assistance population required to participate in the managed care programs are comprised of the following coverage groups:

- Categorically needy - Family Coverage Group (1931) and Transitional (extended)
- Medicaid
- Optionally Categorically Needy
- Medically Needy (nonexempt) - **excluded in MCO**
- Poverty Level - Pregnant women, Children to age 6, and Children ages 6 to 19

EXCLUDED POPULATIONS

The population identified below is excluded from mandatory enrollment:

- Enrollees under age 19 with special needs that are:
    - Eligible for SSI;
    - Eligible under section 1902(e)(3) of the Social Security Act; or
    - Eligible under a Maternal Child Health Services Block Grant
- All Dual Eligible Medicare enrollees
- Individuals residing in a nursing facility
- Individuals residing in an ICF/MR
- Enrollees receiving home and community based services
- Disabled enrollees
- Blind enrollees
- Aged enrollees
- Residents of the State Hospital
- Enrollees receiving foster care, IV-E and non-IV-E
- Enrollees receiving adoption assistance, IV-E and non-IV-E
- Enrollees receiving refugee assistance
- Enrollees having a retroactive eligibility period

VERIFICATION

All Medicaid enrollees receive a North Dakota Medicaid identification card confirming past or current Medicaid eligibility. It is the provider's responsibility to verify continued eligibility and the selected PCP by calling the Eligibility Verification System at (701) 328-2891 or 800-428-4140 or by using the Medifax eligibility verification system.

SERVICE AREA

PCP enrollment is mandatory statewide. In the MCO service counties, eligible enrollees must select either a provider in the PCP program or the MCO.

MCO Name	Servicing Counties	Client Population	Effective Date
AltruCare	Grand Forks	TANF, Poverty Level	11/01/97
AltruCare	Pembina, Walsh	TANF, Poverty Level	01/01/04

PRIMARY CARE PROVIDER PROGRAM

DEFINITION OF PRIMARY CARE PROVIDERS

Primary Care Provider (PCP) means:

- A physician,
- A physician group practice,
- An entity that employs or arranges with physicians to furnish primary care case management services.

PCPs are:

- General practitioners,
- Family practitioners,
- Pediatricians,
- Internists,
- Obstetricians/gynecologists,
- Other physician specialty as approved by the department in either a solo or group practice,
- Rural health clinics (RHC),
- All federally qualified health centers (FQHC) within the state, or
- All Indian Health Service facilities (IHS) within the state.

While RHC and FQHC can be designated as a PCP, these facilities cannot be used as a referring physician on claims. Referrals from these clinics must contain an authorization of the referral (signature, initials) from a physician associated with the clinic or a supervising physician of the clinic. IHS facilities have an assigned unique PCP number that is used on the claim when referring.

Primary care case management services means case management related services that include location, coordination, and monitoring of primary health care services; and are provided under a contract between the Department and a PCP.

PROVIDER AND PRIMARY CARE PROVIDER ENROLLMENT

Providers who deliver health care services to enrollees participating in the PCP program and want to be reimbursed by the Department, must be enrolled as a provider with the Department. An application needs to be completed and submitted to the Department along with an appropriate copy of a provider's license from the North Dakota Board of Medical Examiners. Applications can be received by contacting the Department's Provider Enrollment at (701) 328-4033. For more information on provider enrollment, refer to the Provider Requirement chapter.

Once a provider is enrolled with the Department, and they practice in one of the specialties defined as a Primary Care Provider, the provider automatically becomes a Primary Care Provider selection.

If a provider wants to discontinue designation as a PCP, please contact Provider Enrollment at (701) 328-4033.

If a provider relocates, the Department's Provider Enrollment must be informed as soon as possible. Provider Enrollment can be contacted by telephone at (701) 328-4033 or email at dhsenrollment@state.nd.us.

DUTIES OF PRIMARY CARE PROVIDER

The PCP requirement was implemented to improve patient care by developing a doctor patient relationship and to reduce the number of unnecessary medical services. The expected duties of the Primary Care Provider are to:

- Provide primary, preventive and routine care;
- Case manage and coordinate the enrollee's health care;
- Act as an entry point into health care system.

CASE MANAGEMENT FEE

Primary Care Providers receive a $2 case management fee per month for each enrollee selecting the provider as their Primary Care Provider. This excludes RHC, IHS, and FQHC due to the inclusion of the case management fee in the encounter fee paid to these facilities.

COORDINATION OF BENEFITS WITH OTHER MANAGED CARE PROGRAMS OR INSURANCE POLICIES

Private insurance is always the primary payer, with the PCP Medicaid program being the payer of last resort. If Medical Assistance is expected to pay all or any portion of a medical claim, the private insurance guidelines must first be complied with. If the private insurance is a managed care program or policy that requires selection and use of a PCP, the PCP selected under the private insurance must be the same PCP selected under the PCP program before Medical Assistance will consider payment.

PAYMENT OF SERVICES

Providers who deliver health care services to enrollees participating in the PCP program must bill the Department. If the PCP rules established by the Department are not followed, the provider is at risk for the cost of care.

COVERED AND NON-COVERED SERVICES

SERVICE	COVERAGE	REFERRAL
Acupuncture	Not covered by North Dakota Medicaid.	
Ambulance Services	Covered by North Dakota Medicaid for emergencies that are medically necessary	Referral not required.
Ambulatory Surgical	Covered by North Dakota Medicaid	Referral required.
Anesthesia Services	Covered by North Dakota Medicaid	Referral not required.
Chemical Dependency	Covered by North Dakota Medicaid; Counselor services only through the regional Human Service Center	Referral not required for inpatient, outpatient and detoxification services if services are provided or referred by Psychiatrists, Psychologists, or provided at the regional Human Service Center; if provided by other types of providers, referral required.
Chiropractor	Covered by North Dakota Medicaid; Spinal manipulation and x-rays of the spine are the only covered services; Spinal manipulations - 12 per calendar year maximum benefit; Radiological examinations - 2 per calendar year maximum benefit.	Referral not required.
Cosmetic Surgery	Not covered by North Dakota Medicaid.	
Dental Services, Routine	Covered by North Dakota Medicaid	Referral not required.
Durable Medical Equipment	Covered by North Dakota Medicaid. Prior authorization required if cost is greater than $300 per item.	Referral required.

SERVICE	COVERAGE	REFERRAL
Emergency Services	Covered by North Dakota Medicaid for services billed as an emergency	Referral not required.
Emergency Services - follow-up care	Covered by North Dakota Medicaid	Referral required if not provided by PCP.
Emergency Services - Inpatient admission	Covered by North Dakota Medicaid	No referral required for the first 24 hours of an emergency admission; Following the first 24 hours, a referral is required.
Experimental Services and Procedures	Not covered by North Dakota Medicaid.	
Family Planning Clinic	Covered by North Dakota Medicaid; Reproductive health exams; Patient counseling; Patient education; Lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol / triglycerides, prolactin, pregnancy tests, and diagnosis of infertility; Sterilizations as defined by Department rules; Screening, testing, treatment, and pre and post test counseling for sexually transmitted diseases and HIV; Family planning medications and supplies provided by Title X clinics; and the diagnosis but not the treatment of infertility.	Referral not required.
Health Tracks	Covered by North Dakota Medicaid; Well-baby and childhood health screening services performed by Public Health Agencies, Head Start, or PCP.	Referral not required.
Hearing (Audiology) Services	Covered by North Dakota Medicaid	Referral required.

SERVICE	COVERAGE	REFERRAL
Hearing aids	Covered by North Dakota Medicaid; Replacement every 5 years, if medically necessary; Prior authorization required.	Referral required.
Home Health Care	Covered by North Dakota Medicaid	Referral required.
Hospice	Covered by North Dakota Medicaid	Referral required.
Hospital Services		
Inpatient	Covered by North Dakota Medicaid	Referral required
Emergency admission	Covered by North Dakota Medicaid	No referral required for the first 24 hours of an emergency admission; Following the first 24 hours, a referral is required
Outpatient	Covered by North Dakota Medicaid	Referral required
Observation	Covered by North Dakota Medicaid	Referral required unless provided as emergency Service
Rehabilitation	Covered by North Dakota Medicaid; Limitation of 30 days per stay for adults 21 years of age and older	Referral required
Partial	Covered by North Dakota Medicaid; Prior authorization required	Referral required
Immunizations	Covered by North Dakota Medicaid	Referral not required for Vaccines for Children
In-vitro Fertilization and Embryo Transplantation or Implantation Fertility treatments	Not covered by North Dakota Medicaid.	

SERVICE	COVERAGE	REFERRAL
Lab, X-ray, and Radiology Services		
Independent lab and radiology	Covered by North Dakota Medicaid	Referral not required
Non-Independent lab and radiology	Covered by North Dakota Medicaid	Referral required
Massage Therapy (by an Independent therapist)	Not covered by North Dakota Medicaid	
Mental Health Services	Covered by North Dakota Medicaid	Referral not required for inpatient and outpatient services if services are provided or referred by Psychiatrists, Psychologists, or provided at the regional Human Service Center; if provided by other types of providers, referral required. Inpatient is limited to 21 days per stay for adults 21 years of age and older. Counselor services are only covered through the regional Human Service Center.
Mid-level Practitioner Services	Covered by North Dakota Medicaid; Includes family and pediatric nurse practitioners.	Referral not required if care is received in the same clinic as the PCP.
Nursing Facilities and Swing Bed Services	Covered by North Dakota Medicaid	Referral not required.
Nutritional Services	Covered by North Dakota Medicaid	Referral required.
Obstetric and Gynecologic Services	Covered by North Dakota Medicaid	Referral not required if services provided by or referred by obstetrician/gynecologist or certified nurse midwife.
Occupational Therapy	Covered by North Dakota Medicaid - limits apply	Referral required.
Ophthalmologic Services	Covered by North Dakota Medicaid	Referral not required.

SERVICE	COVERAGE	REFERRAL
Optometric Services	Covered by North Dakota Medicaid; Vision testing and prescriptions for glasses; under 21 years of age - 1 exam & 1 set of glasses per year; 21 and older - 1 exam & 1 set of glasses every 3 years.	Referral not required.
Oral Surgery	Covered by North Dakota Medicaid	Referral required; Referral can originate from orthodontist, dentist, or PCP.
Orthodontic Services	Covered by North Dakota Medicaid - restrictions apply	Referral required only through Health Tracks Program
Physical Therapy	Covered by North Dakota Medicaid - limits apply	Referral required.
Physician Services Primary Care Specialty Care	 Covered by North Dakota Medicaid Covered by North Dakota Medicaid	 Referral not required if provided by primary care physician or colleague in same specialty as PCP and in the same clinic as the PCP. Referral required.
Podiatric Services	Covered by North Dakota Medicaid	Referral not required.
Prescription Drugs	Covered by North Dakota Medicaid	Referral not required.
Private Duty Nursing Services	Covered by North Dakota Medicaid	Referral required.
Prosthetic Devices	Covered by North Dakota Medicaid	Referral not required.
Public Health Unit Services	Covered by North Dakota Medicaid	Referral not required.
Reconstructive Surgery	Covered by North Dakota Medicaid; Prior authorization required	Referral required
Reversal of Sterilization	Not covered by North Dakota Medicaid.	
Speech Therapy Services	Covered by North Dakota Medicaid - limits apply	Referral required
Transplant Services	Covered by North Dakota Medicaid	Referral required
Transportation to medical appointments	Covered by North Dakota Medicaid for non-emergency, non-ambulance transportation	Referral not required.

SERVICE	COVERAGE	REFERRAL
Urgent Care/After Hours Clinic/Convenience Clinic	Covered by North Dakota Medicaid	If provided by the primary clinic, no referral required. If not provided by the primary clinic, referral is required.
Workers Compensation Services	Not covered by North Dakota Medicaid	

EMERGENT AND URGENT SERVICES

Medical emergency means a medical condition of recent onset and severity, including severe pain that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Post-stabilization care services means covered services related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Urgent care services are necessary care for non-life-threatening conditions that cannot wait for a regular scheduled appointment. The condition has the potential to worsen without timely medical intervention. Any follow-up care after urgent care must be authorized by the patient's PCP.

COPAYMENTS

The provider may charge and collect the appropriate following co-payment to each enrollee obtaining services:

- $1 for spinal manipulation received during a chiropractic appointment
- $1 for each outpatient speech therapy visit
- $2 for each office visit. This 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

REFERRALS AND PRIOR AUTHORIZATIONS

Original Referrals

The PCP has authority to generate referrals. This includes group practices where the medical health system or network has established an internal and/or external referral management system.

Referral source documents consist of but are not limited to a formal referral form (either paper or electronic format), a statement in a patient's medical records dictated and recorded by the designated PCP. Telephone referrals can be made if the PCP considers it appropriate. The telephone authorization must be documented in the patient's medical record. In case of an audit, there must be a source document for a referral.

While RHC and FQHC can be designed as a PCP, these facilities cannot be used as a referring physician on claims. Referrals from these clinics must contain an authorization of the referral (signature, initials) from a physician associated with the clinic or a supervising physician of the clinic. IHS facilities have an assigned unique PCP number that is used on the claim when referring.

Primary care provided by a colleague of the designated PCP (same clinic and same specialty) does not require a referral from the PCP. Services that require a referral, even in the same clinic as the PCP, must have a referral from the PCP if payment is expected.

Referral Scope and Duration

The services authorized or requested by the PCP indicate the intensity and extent of the referral for specialty care. Referrals stating for example, "diagnose only" qualifies for one visit, "diagnose and treat" means to the conclusion of the treatment. While most referrals will express or imply the period of time the referral is effective, it is the judgment of the PCP as to the length of the referral period. It is the Department's policy that referrals should be effective for no more than one year.

The original referral from the PCP is also applicable for secondary and tertiary services. Again, it is dependent upon the services authorized or requested by the PCP. If further specialty care is necessary that is not included in the initial PCP referral, communication between the PCP and the specialists will facilitate any need for further care and additional referrals.

Retroactive Referrals

Retroactive referrals are not allowed for services stated in the Covered and Non-Covered Services section, with the exception of urgent care. For urgent care, the provider must have a referral before the claim is submitted for payment. A grace period of 15 working days is allowed. The grace period begins on the date of service and ends on the date the referral is authorized by the PCP.

OUT-OF-STATE REFERRALS

Except for emergency care, the following process must be used for claims to be paid by the Department:

- The patient must first be seen by their Primary Care Provider;
- The PCP must determine that it is advisable to refer the patient for care or services which they are unable to provide;
- A request for active treatment is first made to an in-state specialist;
  - The specialist concludes that the patient should be referred to an appropriate out-of-state provider because necessary care or services are unavailable in the state;
- The primary care provider or specialist submits, to the department, a written request that includes medical and other pertinent information, including a report from the specialist documenting the out-of-state referral is medically necessary;
- The department determines that necessary care and services are unavailable in the state and approves referrals on that basis.

EDUCATION AND ENROLLMENT OF MEDICAL ASSISTANCE ENROLLEES

The Department administers the education and enrollment process through each county social service agency. At the time of application for medical assistance, the applicant is informed of the need to select a PCP for each eligible member of the Medicaid unit. Enrollment is mandatory effective with the date the county eligibility worker informs the applicant they are required to select a PCP.

The applicant/enrollee should choose a provider in their county or surrounding area that can meet the medical needs of the applicant/enrollee. Assistance may be provided by the county eligibility worker in the selection of a PCP. The worker cannot influence the

applicant's/enrollee's decision on which PCP to select, but may offer information if requested. A list of providers is available to the county to assist enrollees in their selection. A booklet explaining the PCP program, its covered services and non-covered services, out-of-pocket costs, toll-free and local telephone numbers to call with questions, and complaint process is given to enrollees by the county social service staff.

REQUESTING A CHANGE IN PCP

The PCP may request disenrollment or exemption from enrollment for specific cases or persons where there is good cause. Good cause includes, but is not limited to:

- The enrollee has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees;
- The enrollee has moved outside the enrollment area;
- The enrollee has violated rules of the PCPs; or
- The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason is only permitted if demonstrated that the PCP provided the enrollee with the opportunity to select an alternative PCP, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship, and informed the enrollee that the enrollee may file a grievance on this matter.

The PCP may not request disenrollment because of a change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except where his or her continued enrollment seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees)

VOLUNTARY DISENROLLMENT / TRANSFER BY THE ENROLLEE

The enrollee may request disenrollment or may transfer from one PCP to another by submitting an oral or written request to the county social service agency. The county eligibility worker must inform each enrollee of their right to request disenrollment/transfer at the time of enrollment. Enrollees may request a change in their PCP any time during the first ninety days, every six months or if they have good cause. When a good cause request is made to change the PCP, the county eligibility worker needs to determine if good cause exists and document the reason and decision.

Voluntary disenrollment from a PCP is effective the day the request is received.

Enrollees who request a change of their PCP six times within a twelve month period will be referred to the Surveillance Utilization Review System (SURS) staff to determine if

over utilization patterns exist and could be subjected to the Coordinated Services Program

ENROLLEE RIGHTS AND PROTECTIONS

An enrollee has the following rights:

- To receive information on the PCP program
- To be treated with respect and with due consideration for his or her dignity and privacy
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand
- Participate in decisions regarding his or her health care, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

INFORMATION REQUIREMENTS

Written material:

- Must be available in the prevalent non-English languages in its particular service area.
- Must use easily understood language and format.
- Must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- All enrollees and potential enrollees must be informed that written information is available in alternative formats and how to access those formats.

The PCP must make oral interpretation services available and to make those services available free of charge to each potential enrollee and enrollee. The PCP must notify enrollees and potential enrollees, that oral interpretation is available for any language.

ADDITIONAL RULES FOR PCPS

- Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.
- Restrict enrollment to enrollees who reside sufficiently near one of the PCP's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

- Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services can be furnished to enrollees promptly and without compromise to quality of care.
- Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the enrollee's health status or need for health care services.
- Provide that enrollees have the right to disenroll from their PCP in accordance with guidelines in the Voluntary Disenrollment/Transfer by the Enrollee section.
- Provider-enrollee communications. A health care provider's ability to advise enrollees about medically necessary treatment options may not be interfered with or restricted. Any provider shall comply with any state or federal statute, rule, or regulation intended to limit or prevent restriction on, or interference with, communications between a health care provider and an enrollee concerning medically necessary treatment options.
- Marketing activities. Any marketing plan and all marketing material that is directed to enrollees in the PCP program must be submitted to the Department for prior written approval.

PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES

A PCP may not knowingly have a relationship of the type described below with the following: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an individual who is an affiliate, of a person described in the above.

The relationships described in this paragraph are as follows:

- A director, officer, or partner of a PCP.
- A person with beneficial ownership of five percent or more of the PCP's, equity.
- A person with an employment, consulting or other arrangement with the PCP for the provision of items and services that are significant and material to the PCP's, obligations under its contract with the State.

If the Department finds that a PCP is not in compliance with the above:

- The Department must notify Centers for Medicare and Medicaid Services (CMS) of the noncompliance;
- May continue an existing agreement with the PCP unless the Secretary directs otherwise.
- May not renew or otherwise extend the duration of an existing agreement with the PCP unless CMS provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

SANCTIONS

Sanctions may be imposed when the PCP acts or fails to acts as follows:

- Fails substantially to provide medically necessary services required under law or under this contract, to an enrollee.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or other health care providers.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Act and any implementing regulations.

In the event the PCP fails to perform in accordance with these requirements, and such failure shall not be cured within 60 days after written notice thereof is given by the Department to the PCP, then the Department may, at its election:

- Grant enrollees the right to terminate enrollment without cause and notify the affected enrollees of their right to disenroll.
- Suspend enrollment of new enrollees with the PCP. The suspension period may be for any length of time specified by the Department, or may be indefinite. The Department shall rescind such suspension if and when the PCP cures the default for which the suspension was imposed.
- Impose an appropriate or proportionate adjustment to payment levels if the failure to perform involves the failure to make available any records or reports. The PCP may not elect to withhold any medically necessary covered services or hold enrollees liable for payments to providers in order to receive adjusted payment levels.
- Impose civil money penalties in the following specified amounts.
  - A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees, or health care providers; or marketing violations.
  - A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statement to CMS or the Department.
  - A maximum of $15,000 for each enrollee the state determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
  - A maximum of $25,000 or double the amount of excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program.
- Grant enrollees the right to terminate enrollment without good cause.

The Department retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents the Department from exercising that authority.

MANAGED CARE ORGANIZATION

PAYMENT OF SERVICES PROVIDED TO MCO RECIPIENTS

Providers who provide health care services to enrollees participating in a MCO must seek reimbursement from the MCO for contracted covered services.

If a provider is participating in the MCO network, a referral may not be needed. However, specialty care outside the network requires a referral from the MCO. Please confirm with the MCO if the provider is participating. MCOs may refer individuals to providers outside the plan. In such cases, the MCO is responsible for payment. MCOs are responsible for the payment of emergency services and family planning services, even if the recipient seeks care out-of-plan for these services. In emergency cases, the MCO must be contacted as soon as the provider is aware of the recipient's participation in a MCO.

The provider may bill the recipient under certain circumstances, only if the recipient is notified in writing before the service is delivered that payment may be the recipient's responsibility.

Under no circumstances will the Department directly reimburse individual providers for contracted services provided to MCO recipients for services detailed in the section titled, Covered and Non-Covered Services. For more information on billing for the Department or the MCO, refer to the Billing Policy Chapter.

Recipients traveling outside of the MCO's service area are covered by their MCO for emergency care. Non-emergency services are not covered outside of the service area, unless prior authorized by the MCO.

COVERED AND NON-COVERED SERVICES

SERVICE	COVERAGE
Acupuncture	Not covered by MCO; not covered by North Dakota Medicaid
Ambulance Services	Covered by MCO for emergencies that are medically necessary
Ambulatory Surgical	Covered by MCO

Anesthesia Services	Covered by MCO
Chemical Dependency	Covered by MCO
Chiropractor	Covered by MCO
Cosmetic Surgery	Not covered by MCO; Not covered by North Dakota Medicaid.
Dental Services, Routine	Not covered by MCO; Covered by North Dakota Medicaid; Referral not required
Durable Medical Equipment	Covered by MCO
Emergency Services	Covered by MCO
Emergency Services - follow-up care	Covered by MCO
Emergency Services - Inpatient admission	Covered by MCO
Experimental Services and Procedures	Not covered by MCO; Not covered by North Dakota Medicaid.
Family Planning Clinic	Covered by MCO; Reproductive health exams; Patient counseling; Patient education; Lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol / triglycerides, prolactin, pregnancy tests, and diagnosis of infertility; Sterilizations as defined by Department rules; Screening, testing, treatment, and pre and post test counseling for sexually transmitted diseases and HIV; Family planning medications and supplies provided by Title X clinics; and the diagnosis but not the treatment of infertility.
Health Tracks	Covered by MCO
Hearing (Audiology) Services	Covered by MCO
Hearing aids	Covered by MCO
Home Health Care	Covered by MCO
Hospice	Covered by MCO
Hospital Services	Covered by MCO
Immunizations	Covered by MCO
In-vitro Fertilization and Embryo Transplantation or Implantation Fertility treatments	Not covered by MCO; Not covered by North Dakota Medicaid.
Lab, X-ray, and Radiology Services	Covered by MCO
Massage Therapy (by an Independent therapist)	Not covered by MCO; Not covered by North Dakota Medicaid.
Mental Health Services	Covered by MCO

SERVICE	COVERAGE
Mid-level Practitioner Services	Covered by MCO
Nursing Facilities and Swing Bed Services	Not covered by MCO; Covered by North Dakota Medicaid; Referral not required
Nutritional Services	Covered by MCO
Obstetric and Gynecologic Services	Covered by MCO
Occupational Therapy	Covered by MCO
Ophthalmologic Services	Covered by MCO
Optometric Services	Not Covered by MCO; Covered by North Dakota Medicaid
Oral Surgery	Not covered by MCO; Covered by North Dakota Medicaid
Orthodontic Services	Not covered by MCO; Covered by North Dakota Medicaid
Physical Therapy	Covered by MCO
Physician Services	Covered by MCO
Podiatric Services	Covered by MCO
Prescription Drugs	Not covered by MCO; Covered by North Dakota Medicaid
Private Duty Nursing Services	Not covered by MCO; Covered by North Dakota Medicaid
Prosthetic Devices	Covered by MCO
Public Health Unit Services	Covered by MCO
Reconstructive Surgery	Covered by MCO
Reversal of Sterilization	Not covered by MCO; Not covered by North Dakota Medicaid
Speech Therapy Services	Covered by MCO
Transplant Services	Covered by MCO
Transportation to medical appointments	Covered by MCO
Urgent Care/After Hours Clinic/Convenience Clinic	Covered by MCO
Workers Compensation Services	Not covered by MCO; Not covered by North Dakota Medicaid.

EMERGENT AND URGENT SERVICES

Medical emergency means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Urgent care services are necessary care for non-life-threatening conditions that cannot wait for a regularly scheduled appointment because the condition has the potential to worsen without timely medical intervention.

COPAYMENTS

MCOs contracting with the Department may not impose enrollee co-payments for contracted covered services and special programs.

REFERRALS AND PRIOR AUTHORIZATION

Providers who are participating providers of a MCO's network, a referral may not be needed. However, specialty care outside the network requires a referral from the MCO. This includes out-of-state services. Please confirm with the MCO if the provider is participating.

Providers who are participating providers of a MCO's network must follow prior authorization, preadmission certification and second surgical opinion requirements of the MCO. This includes out-of-state services. For information regarding prior authorization of services for recipients enrolled in an MCO, contact Altru Managed Care Department at 701-780-1604. For information regarding eligibility and claims, contact Noridian at 701-792-4891.

EDUCATION AND ENROLLMENT FOR MCOS

The Department administers the education and enrollment process through each county social service agency. At the time of application for medical assistance, the applicant is informed of the need to select an MCO or PCP for each eligible member of the Medicaid unit. Enrollment in the MCO begins the first of the month following the selection of the MCO.

Additional outreach and education is provided by the MCO. The MCO conducts a continuous open enrollment period during which the MCO accepts all eligible recipients without regard to the recipient's health status.

Assistance may be provided by the county eligibility worker in the selection of a PCP or MCO. The worker cannot influence the recipient's decision on which PCP or MCO to select, but can only offer information. A list of PCPs and MCOs are available to the

county to assist recipients in their selection. A booklet explaining the difference in the MCO and PCP program is available at the county social service agency. A booklet explaining the MCO is also available at the county social service agency or the MCO.

RECIPIENTS WHO ARE IN THE HOSPITAL WHEN COVERAGE CHANGES

Inpatient hospital services provided during an entire inpatient hospital stay for a recipient who enrolls or disenrolls from the MCO while hospitalized will be paid by:

- North Dakota Medicaid if the recipient is admitted for inpatient hospital services prior to an effective enrollment date in the MCO and the recipient remains in the inpatient hospital setting on or after the effective enrollment date; or

- The MCO if the recipient is enrolled in the MCO, and is admitted for inpatient hospital services prior to an effective disenrollment date from the MCO and the recipient remains in the inpatient hospital setting on or after the effective disenrollment date.

COMPLAINTS

Each MCO contracting with the Department is required to develop procedures for handling enrollees' complaints. For information contact the Altru Managed Care Department at 701-780-1604.

ENROLLED RECIPIENT RIGHTS

MCO recipients are entitled to:

- Receive information in accordance with the MCO contract.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the recipient's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected as specified in 45 CFR part 164.

GRIEVANCES AND APPEALS

A provider, acting on behalf of an MCO recipient and with the recipient's written consent, may file an appeal. A provider may file a grievance or request a Department fair hearing on behalf of a recipient.

The MCO must provide the following information to all recipients, providers and subcontractors at the time they enter into a contract:

- For state fair hearing; the right to hearing; the method for obtaining a hearing; and the rules that govern representation at the hearing.
- The right to file grievances and appeals.
- The requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process.
- The toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone.
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for Department fair hearing within the timeframes specified for filing; and the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

NORTH DAKOTA HEALTH TRACKS EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

WHAT IS EPSDT

Health Tracks is the name of North Dakota Medicaid's EPSDT program. EPSDT is a federally required program that requires states to ascertain, for individual's under age 21, the physical and mental level of wellness and to provide care, treatment and other corrective health measures as necessary.

The federal guidelines for EPSDT are available at www.cms.hhs.gov.

OVERVIEW

ND Health Tracks is a comprehensive child health program consisting of supportive, operational components to:

- Assure the availability and accessibility of required health care resources, and
- Help Medicaid recipients and their parents or guardians to effectively use services.

These components enable Health Tracks to manage a comprehensive child prevention and treatment system, to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the types of assistance available,
- Help them and their families use health resources,
- Assess the child's health needs through initial and periodic examinations, and
- Assure that health problems found are diagnosed and treated early, before they become complex and their treatment becomes more costly.

HEALTH TRACKS SERVICE REQUIREMENTS

The Health Tracks benefits include the following benefits:

- Screening services
    - A comprehensive health and developmental history including assessment of both physical and mental health development,
    - A comprehensive unclothed physical exam,
    - Appropriate immunization – (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccine.)
    - Lead Toxicity Screening – All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.
    - Laboratory tests, and
    - Health Education – Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of health lifestyles and practices.

- Vision services including diagnosis and treatment for defects in vision.

- Dental services including relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

- Hearing services including diagnosis and treatment for defects in hearing, including hearing aids.

- Other necessary health care to provide diagnosis and treatment to correct or improve defects, physical and mental illnesses and conditions discovered by the screening services.

PERIODICITY SCHEUDULE

The recommendation for frequency of Health Tracks assessments is according to the following schedule. Please consult the Bright Futures Well Child Periodicity Schedule at www.brightfutures.org for a description of visits.

1 month	2 months	4 months	6 months	9 months
1 year	15 months	18 months	2 years	3 years
4 years	5 years	6 years	7 years	8 years
9 years	10 years	11 years	12 years	13 years
14 years	15 years	16 years	17 years	18 years
19 years	20 years			

DIAGNOSIS

When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services. The referral should be made without delay and follow-up to make sure that the recipient receives a complete diagnostic evaluation.

TREATMENT

Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.

Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level.

DOCUMENTATION REQUIREMENTS

Providers are encouraged to use the MCH/Health Tracks Pediatric Assessment Form (SFN 1819) available at http://www.nd.gov/eforms/Doc/sfn01819.pdf A supply of this form can be ordered by calling 1-800-755-2604. Documentation requirements can also be met using an internal form as long as the information contains all of the components listed above in the Health Tracks Service Requirements. These documentation requirements include:

- Comprehensive health and developmental history, to include mental health screening,
- Health education/anticipatory guidance,
- Comprehensive unclothed physical examination,

- Immunizations received,
- Lead screening,
- Hearing screening,
- Vision screening,
- Dental screening, and
- Laboratory tests and results.

BILLING REQUIREMENTS

When services are provided in a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC), claims are filed on a UB-92. All other screening providers use the CMS 1500.

To identify the visit as a completed Health Tracks screening service, RHC and FQHC providers use revenue code 521 or 951. All other providers use procedure code SO302.

Vision, hearing and dental screenings are considered part of the Health Tracks assessment and cannot be billed separately. The following may be billed separately using the appropriate CPT code:

- Immunizations and administration,
- Laboratory tests, and
- Other necessary diagnostic and treatment services.

NURSE-MIDWIFE SERVICES

WHAT IS THE INTENT OF NURSE-MIDWIFE SERVICES

Nurse mid-wifery is intended to increase access to obstetric services for women eligible for Medicaid. States are required to cover nurse-midwife services to the extent that state law or regulation authorizes nurse-midwives to practice. To practice in the state of North Dakota, a nurse-midwife must be:

- Currently licensed in North Dakota as a nurse-midwife and registered nurse,
- Certified by the American College of Nurse-Midwives,
- Legally authorized under state law regulations to practice as a nurse-midwife.

HOW TO RECEIVE PAYMENT FOR NURSE-MIDWIFE SERVICES

To receive payment as an independently practicing nurse-midwife, the nurse-midwife must enroll as a Medicaid provider. The assigned nurse-midwife provider number must be submitted in box 33 on the CMS-1500 claim form when billing for services.

If the nurse-midwife provides services as part of a clinic or physician practice, the group (clinic or physician office) must submit the clinic or physician group provider number on the CMS-1500 claim form in box 33. The nurse-midwife's number must be in block 24K.

The Department pays for nurse-midwife services whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

A modifier SB is required after the CPT codes on all billings.

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NUTRITIONAL SERVICES

Nutritional services consist of counseling and supplies for individuals in relation to the nutritive and metabolic processes of the body. Nutritional counseling may be provided by Licensed Registered Dieticians or Certified Diabetes Educators according to the American Diabetes Association criteria.

A complete list of Medicaid covered diagnoses and procedure codes are available for nutritional services and diabetic education at http://www.state.nd.us/humanservices/services/medicalserv/medicaid/docs/cpt/medical-nutritional-therapy.pdf and http://www.state.nd.us/humanservices/services/medicalserv/medicaid/docs/cpt/diabetic-training.pdf

PAYMENT AND LIMITATIONS

To receive payment, a Licensed Registered Dietician must enroll as an independent Medicaid provider or be part of a clinic or physician practice. Certified Diabetes Educators may not enroll independently and must be part of a clinic or physician practice for services to be covered.

All services require a physician's order and must be billed on CMS 1500 claim form or the UB-92 claim form. Services may be billed electronically, using the 837-P or 837-I HIPAA transactions.

Nutritional services are allowed up to four (4) visits per calendar year without prior authorization. Diabetic training and counseling is limited to a maximum of 16 hours per lifetime. Medicaid does not pay for:

- Exercise classes
- Nutritional supplements for the purpose of weight reduction
- Instructional materials and books
- Diet pills with the exception of Xenical

SERVICES PROVIDED BY DIABETIC EDUCATION CENTERS

Diabetic Education Centers may provide services to individuals with Diabetes Mellitus requiring insulin therapy. Services must be ordered by a physician and will be limited to the educational centers in North Dakota approved by the American Diabetes Association.

Payment for services provided at Diabetic Education Centers consists of a limit of $200 per lifetime for all services. Providers must bill on UB92 claim form utilizing Revenue Code 942. Blocks 51 and 60 on claim must include provider number and Medicaid ID.

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OCCUPATIONAL THERAPY

GENERAL INFORMATION

An Occupational Therapist is an individual who has graduated from an approved program and is registered by the American Occupational Therapy Association as an occupational therapist, meets licensing requirements and is licensed to practice occupational therapy in the state in which the services are provided.

Occupational Therapy departments and their personnel must comply with state and federal requirements that establish the standards of Occupational Therapy.

Occupational Therapy services encompass evaluation and re-evaluation of an individual's deficits in occupational performance, consultation, motor skills, cognitive skills, sensory integrative skills, preventive skills, therapeutic adaptations, and activities of daily living.

Occupational Therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the recipient's physician.

The following must be documented in the recipient's plan of care:

- The recipient's medical diagnosis and any contraindications to treatment;
- A description of the recipient's functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the recipient's progress toward the objectives.

The recipient's physician must sign the plan of care. Recertification of the treatment plan must occur within 60-days from the date of the initial evaluation or encounter. Subsequent recertification must occur at 60-day intervals throughout the course of treatment.

COVERED SERVICES

Occupational Therapy services must be of a level of complexity and sophistication, or the condition of the recipient must be of a nature that requires the judgment, knowledge, and skills of a qualified Occupational Therapist.

Services must be directly and specifically related to an active written treatment plan prescribed by a physician. The services must be anticipated to progress toward or achieve the objectives in the individual's treatment plan within a relatively short amount of time, not likely to exceed 90 days.

Occupational Therapy provided on an ongoing basis for recipients who have a condition due to congenital abnormality, trauma, deprivation, or diseases that interrupt or delay the sequence and rate of normal growth, development, and maturation is a covered service unless it is considered maintenance. The therapy must be medically necessary to prevent the loss or digression of the recipient's functional level. The recipient must have one of the following:

- Spasticity or severe contractures that interfere with the recipient's activities of daily living or the completion of routine nursing care;
- A chronic condition that results in physiological deterioration and that requires specialized rehabilitative therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;
- An orthopedic condition that may lead to physiological deterioration and require therapy intervention by a physical or occupational therapist to maintain strength, joint mobility and cardio graphic function;
- Chronic pain that interferes with functional status and is expected by the physician to respond to therapy; or
- Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Occupational Therapy is limited to 20 visits per calendar year, and one (1) evaluation per year. Prior authorization is required for visits exceeding this limit. Procedures addressing the prior authorization are addressed in the following section.

The counts for limits for Occupational Therapy will be accrued on an encounter basis. This means that a count of 1 would be applied per date of service occurrence. For example, if CPT code 97010, 97022, & 97032 were provided on the same date of service, the count would be calculated as 1 occurrence and the total limit count for that service would increase by 1. Please see example below:

ICN	DOS	CODE	UNITS	COUNT/DOS	TOTAL CLAIM COUNT
#1	01-01-2005 01-01-2005 01-01-2005	97010 97022 97032	1 2 3	1	3
	01-02-2005	97010	2	1	
	01-03-2005 01-03-2005	97010 97022	1 1	1	

If any five (5) or more covered therapy code(s) are billed, the claim will suspend for review of documentation. (For example: 97010, 97032, 97035, 97110, 97113, date of service (DOS) is 01-03-2006) The claim will also suspend if any covered therapy code contains five (5) or more units per code.

The following is a list of Medicaid covered CPT codes for restorative and rehabilitative services:

97003	Occupational therapy evaluation	1 unit
97004	Occupational therapy re-evaluation	1 unit
97010	Application of a modality to one or more areas; hot or cold packs	1 unit
97022	Application of a modality to one or more areas; whirlpool	1 unit
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 min./1 unit
97035	Application of modality to one or more areas; ultrasound, each 15 minutes	15 min./1 unit
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 min./1 unit
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromusculare reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	15 min./1 unit
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	15 min./1 unit
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	15 min./1 unit
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 min./1 unit
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 min./1 unit
G0152	Services of occupational therapist in home health setting, each 15 minutes	15 min / 1 unit
All other services for physical therapy and rehabilitation are non-covered by ND Medicaid.		

PRIOR AUTHORIZATION PROCESS

Prior authorization is required for services exceeding the limit of 20 visits per calendar year. The provider must complete and submit, prior to the recipient's receipt of additional services, an SFN 481 Service Limits Prior Authorization Request to ND Medicaid.

Information needed is:

- Prior short-term goals
- Prior long-term goals
- Progress since previous update
- New short-term goals
- New long-term goals

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals
- Progress
- Reasonable new goals
- Maintenance care

If the services requested appear to be at the maintenance level, ND Medicaid will contact the therapist to discuss. If the services are determined necessary to sustain a level of function or the recipient's condition would digress, the services would be covered by Medicaid. The services must be medically necessary and physician ordered.

North Dakota Medicaid will not pay for services that are provided without submitting required information.

NON-COVERED SERVICES

- Occupational therapy that is provided without a prescription from a physician;

- Services for contracture that are not severe and do not interfere with the recipient's functional status;

- Ambulation of a recipient who has an established gait pattern;

- Services for conditions of chronic pain that do not interfere with the recipient's functional status and that can be maintained by routine nursing measures;

- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;

- Bowel and bladder retraining programs;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the recipient's health care record;
- Services that are not part of the recipient's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary by the recipient's attending physician;
- Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Occupational therapy services provided in a nursing facility or ICF/MR. Medicaid pays for those service through the rate established for the facility;
- Maintenance therapy.

PHYSICAL THERAPY

GENERAL INFORMATION

A Physical Therapist is an individual who has graduated from an approved School of Physical Therapy or has equivalent training and is licensed to practice physical therapy in the state in which the individual provides services.

Physical Therapy departments and their personnel must adhere to the “APTA Standards for Physical Therapy Services and Physical Therapy Practitioners”, the “North Dakota Physical Therapy Practice Act established in ND Century code 43-26 and the NDPTA Guidelines for Physical Therapists”.

Physical Therapy services consist of evaluation and re-evaluation, treatment planning, provision of treatments, instruction and consultative services.

Physical Therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the recipient’s physician.

The following must be documented in the recipient’s plan of care:

- The recipient’s medical diagnosis and any contraindications to treatment;
- A description of the recipient’s functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the recipient’s progress toward the objectives.

The recipient’s physician must sign the plan of care. Recertification of the treatment plan must occur at 60-day subsequent intervals from the date of the initial evaluation or encounter.

COVERED SERVICES

Physical Therapy services must be of a level of complexity and sophistication, or the condition of the recipient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist.

Restorative physical therapy must be medically necessary, ordered by a physician, anticipated to result in substantial improvement of the recipient within a predictable period of time, generally not exceeding 90 days.

Physical therapy considered rehabilitative is typically provided for recipients with conditions due to congenital abnormality, trauma, deprivation, or diseases that interrupt or delay the sequence and rate of normal growth, development, and maturation. Medicaid does not cover these services if they are maintenance in nature. However, if they were needed to sustain a level of function or the recipient's condition would digress, the services would be covered by Medicaid. The services must be medically necessary and physician ordered.

Physical Therapy is limited to 15 visits per calendar year. Prior authorization is required for visits exceeding this limit. Procedures addressing the prior authorization are addressed in the following section.

The counts for limits for Physical Therapy will be accrued on an encounter basis. This means that a count of 1 would be applied per date of service occurrence. For example, if CPT code 97010, 97022, & 97032 were provided on the same date of service, the count would be calculated as 1 occurrence and the total limit count for that service would increase by 1. Please see example below:

ICN	DOS	CODE	UNITS	COUNT/DOS	TOTAL CLAIM COUNT
#1	01-01-2005 01-01-2005 01-01-2005	97010 97022 97032	1 2 3	1	3
	01-02-2005	97010	2	1	
	01-03-2005 01-03-2005	97010 97022	1 1	1	

If any five (5) or more covered therapy code(s) are billed on a single date of service, the claim will suspend for review of documentation. (For example: 97010, 97032, 97035, 97110, 97113, date of service (DOS) is 01-03-2006) The claim will also suspend if any covered therapy code contains five (5) or more units per code.

The following is a list of Medicaid covered CPT codes for restorative and rehabilitative services:

97001	Physical therapy evaluation	1 unit
97002	Physical therapy re-evaluation	1 unit
97010	Application of a modality to one or more areas; hot or cold packs	1 unit
97022	Application of a modality to one or more areas; whirlpool	1 unit

97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 min./1 unit
97035	Application of modality to one or more areas; ultrasound, each 15 minutes	15 min./1 unit
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 min./1 unit
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromusculare reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	15 min./1 unit
97113	Aquatic therapy with therapeutic exercises	15 min./1 unit
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	15 min./1 unit
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 min./1 unit
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 min./1 unit
G0151	Services of physical therapist in home health setting, each 15 minutes	15 min./1 unit
All other services for physical therapy and rehabilitation are non-covered by ND Medicaid.		

PRIOR AUTHORIZATION PROCESS

The provider must complete and submit, prior to the recipient's receipt of additional services beyond the limit of 15 visits, an SFN 481 Service Limits Prior Authorization Request to ND Medicaid

Information needed is:

- Prior short-term goals
- Prior long-term goals
- Progress since previous update
- New short-term goals
- New long-term goals

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals
- Progress
- Reasonable new goals
- Maintenance care

If the services requested appear to be at the maintenance level, ND Medicaid will contact the therapist to discuss. If the services are determined necessary to sustain a

level of function or the recipient's condition would digress, the services would be covered by Medicaid. The services must be medically necessary and physician ordered.

NON-COVERED SERVICES

- Physical therapy that is provided without a prescription from a physician;
- Services for contracture that are not severe and do not interfere with the recipient's functional status;
- Ambulation of a recipient who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the recipient's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Bowel and bladder retraining programs;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the recipient's health care record;
- Services that are not part of the recipient's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary as part of a re-certification process;
- Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Physical therapy services provided in a nursing facility or ICF/MR. Medicaid pays for those service through the rate established for the facility;
- Maintenance therapy.

PHYSICIAN SERVICES

Physicians must enroll with Medicaid to receive payment for services provided to Medicaid recipients. Physicians must receive an individual provider number even if the physician is a member of a group, clinic or is employed by an outpatient hospital or other organized health care delivery system that employs physicians. For information on enrollment of out-of-state physicians, please refer to the Provider Requirements Chapter.

SERVICES

Services that may be provided by a physician are not restricted to a specific place of service unless specified by a CPT code description. Physicians may provide services in the recipient's home, a nursing home, the outpatient hospital, inpatient hospital, etc. Physicians may not bill separately for performing administrative or medical functions that are reimbursed through an institution's per diem rate.

In order to be a covered service, the health service must be medically necessary. A service that is medically necessary is a service that:

- Is recognized as the prevailing standard or current practice by the provider's peer group; and
- Is provided in response to a life threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
- Is a preventative health service.

PREVENTATIVE HEALTH SERVICES

Preventive health services are services provided to a recipient to avoid or minimize the occurrence of illness, infection, disability, or other health conditions. Preventive health services are covered when the following conditions are met:

- The service is provided to the recipient in person;
- The service affects the recipient's health condition rather than the recipient's physical environment;
- The service is not otherwise available to the recipient without cost as part of another preventive health program funded by a government or private agency;
- The service is not part of another covered service;
- The service minimizes an illness, infection, or disability that will respond to treatment;
- The service is generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness;
- The service is ordered in writing by a physician and included in the plan of care approved by the physician. Examples of covered services are sports physicals and well-baby examinations.

<u>Services that are not covered as preventive health services:</u>

- Services that are only for a vocational purpose or an educational purpose that is not health related;
- Services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health; and
- Annual exam ordered by a group home with a routine diagnosis;
- Preventive health counseling that is provided to recipients to promote health and prevent illness or injury.

TELEPHONE CALLS

Telephone calls **are not a covered service**. North Dakota Medicaid does not pay for any type of telephone consultation.

INCIDENTAL SURGICAL PROCEDURES *(ADDED JULY 2005)*

Incidental surgical procedures performed at the same time as other major surgery is not a billable item and Medicaid will not pay separately for these procedures. The removal of healthy tissue organs is not a Medicaid covered service. Organ removal from a living donor to a recipient is considered part of the transplant procedure.

ADDITIONAL SURGICAL PROCEDURES

Additional medically necessary surgical procedures performed at the time of a major medical procedure are covered at a reduced rate.

The medical reason for the surgery must be substantiated with an ICD-9-CM code supported with documentation in the recipient's medical record.

Modifier 51 is to be used when multiple procedures are performed in an operative session. The major operative procedure is reported and the secondary procedure is reported with the 51 modifier. For example:

Splenectomy
Liver Biopsy – 51

Modifier 50 is used for bilateral procedures. A bilateral procedure is one that is performed in an operative session on both sides of the body. Bilateral procedures require separate incisions and are performed on organs that are pairs or have a left/right distinction. For example:

Mastectomy
Mastectomy – 50

CONCURRENT CARE

Concurrent care services are those provided by more than one physician when the recipient's condition requires the service of another physician. If a consulting physician subsequently assumes responsibility for a portion of patient management, they provide concurrent care.

North Dakota Medicaid reimburses concurrent care when the medical condition of the recipient requires the services of more than one physician. Generally, a recipient's condition that requires physician input in more than one specialty area establishes medical necessity for concurrent care.

NON-COVERED SERVICES FOR CONCURRENT CARE

North Dakota Medicaid will not pay for concurrent care when:

- The physician makes routine calls at the request of the recipient and family or as a matter of personal interest; or
- Available information does not support the medical necessity or concurrent care.

BILLING REQUIRMENTS FOR CONCURRENT CARE

When the recipient's condition requires concurrent care, each physician providing services identifies their services by entering the CPT code and his/her Medicaid provider number on the claim form.

CRITICAL CARE

Critical care includes the care of a critically ill or injured patient in a variety of medical emergencies that requires the constant attendance of the physician (eg, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

CPT codes 99291 and 99292 are used to report critical care. These codes are designed to include all the diagnostic and therapeutic services listed and direction of care provided by the physician during the period for which this code is billed. Physician must not bill listed procedures performed during the critical care hour but may bill services performed that are not listed.

Services for a recipient who is not critically ill but happens to be in a critical care unit are reported using subsequent hospital care codes (see 99231-99233) or hospital consultation codes (see 99251-99263) as appropriate.

Medicaid follows CPT guidelines identifying the services that are included in reporting critical care when performed during the critical period by the physician providing critical care. Any services performed that are not listed as critical care should be reported separately.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill or injured patient, even if the time spent by the physician providing critical care services on that date is not continuous. Code 99291 is used to report the <u>first 30-74 minutes of critical care</u> on a given date. It must be used <u>only once per date</u> even if the time spent by the physician is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be

reported with the appropriate E/M code. Code 99292 is used to report each additional block of time, up to 30 minutes beyond the first 74 minutes.

PROLONGED CARE

Codes 99354-99357 are used for prolonged services involving direct (face-to-face) patient contact. Codes 99354-99357 are used to report the total duration of face-to-face time spent on a given date. Codes 99358 and 99359 are used when prolonged services not involving direct (face-to-face) care is provided. These service are not covered by North Dakota Medicaid. Code 99360 is used to report standby services that are requested by another physician and involves prolonged attendance without direct (face-to-face) patient contact. The only time that operative standby services would be covered is in the case of a documented existing risk or distress, such as documented fetal distress.

CARE PLAN OVERSIGHT SERVICES

Codes 99374-99380 are not covered by North Dakota Medicaid.

TELEMEDICINE SERVICE

Telemedicine Services are a covered Medicaid service provided the following criteria is met:

- The recipient must be present during the provision of the service;
- The appropriate CPT codes are used by the consulting site along with a GT modifier; and
- The originating site uses HCPC code Q3014.

Physicians at both the originating and consulting sites may bill for services. Supplies needed for any procedures performed are considered part of the procedure and are not separately billable.

Separate long distance charges required for out-of-network sites are billable to North Dakota Medicaid. Medicaid will pay for the actual cost charged by the telephone company.

MEDICAL SUPPLIES PROVIDED BY A PHYSICIAN'S OFFICE

Medical supplies provided by a physician's office are those supplies applied or used in direct relationship to a specific injury or illness.

Durable Medical Equipment (DME) applied or used in direct relationship to a specific injury or illness and supplied by a physician's office are a Medicaid covered service, separate from the physician's services. Physician and physician clinics enrolled as a North Dakota Medicaid provider may bill for these services.

Supplies or dressings sent home with the recipient are not a North Dakota Medicaid covered service.

When billing for surgical supplies, HCPC code A4550 must be reported on the same claim as the surgical procedure. When billed alone, HCPC code A4550 will be denied as included in the surgical fee.

Surgical trays are a Medicaid covered service when billed with the procedures identified in the Medicaid Coding Guideline - Sterile trays.

ONCOLOGY DRUG TRIALS

North Dakota Medicaid will pay for chemotherapy when administered via a protocol that is registered with one of the main regional oncology research organizations provided the FDA has approved each medication in the regimen. FDA approval can be for any indication. If any chemotherapeutic agent in the regimen is not FDA approved, the entire treatment will not be paid.

If the recipient has a primary payer, the primary payer must be billed before requesting payment from North Dakota Medicaid. If the primary payer denies coverage of the product because they consider the use "experimental", North Dakota Medicaid will also deny the claim.

OTHER COVERED PHYSICIAN SERVICES

Laboratory Services: Refer to the Laboratory, Radiological and Diagnostic Services chapter for specific information regarding laboratory, radiologic, diagnostic services, laboratory handling fees, and specimen collection fees.

When a physician or physician clinic is billing for services performed and the equipment used is owned by the physician or clinic, the service should not be separated into a technical and professional component. Bill the appropriate CPT code but do not modify the code.

Casting Performed in a Physician's Office: ND Medicaid pays for the application of a cast in a physician's office. The reimbursement for the CPT code for application of a cast includes the professional's time to apply the cast, the equipment necessary to apply the cast, and plaster casting materials. This service should be billed with the correct CPT code that describes the area casted. When a specialty cast is applied, the physician should bill the appropriate CPT code for the specialty casting material in addition to the office visit code.

Surgical Services: North Dakota Medicaid covers surgical services that are medically necessary. North Dakota Medicaid includes routine surgical services in a surgical package. The surgical package includes the surgery and 14 days post-operative care.

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human services

PRIOR AUTHORIZATION FOR OUT-OF-STATE SERVICES

WHAT IS AN OUT-OF-STATE PROVIDER

An out-of-state provider is a provider located outside of the state of North Dakota and the recipient's local trade area. Local trade area is defined as the geographic area surrounding a person's residence that is commonly used by local residents to obtain similar goods and services. Local trade area includes portions of states within 50 statute miles from the North Dakota border, excluding Canada.

MEDICAID COVERED SERVICES FOR OUT-OF-STATE CARE

Service provided to a North Dakota Medicaid recipient by an out-of-state provider must be medically necessary and be a billable Medicaid service. The provider of the service must enroll as a North Dakota Medicaid provider and abide by all program provisions. In addition, out-of-state providers will receive payment only under the following circumstances:

- The health service is provided in response to an emergency while a recipient is out of the state;
- The health service is provided to a NON-Title IV-E child for whom North Dakota makes adoption assistance payments through the state Adoption Subsidy Program, or state foster care payments;
- The health service is not available in North Dakota or the recipient's local trade area; or
- The health service is required because the recipient's health would be endangered if the recipient was required to return to North Dakota.

REQUESTING OUT OF STATE MEDICAL SERVICES

When the attending physician determines that it is medically necessary for a recipient to receive an out-of-state health service, the following must be done:

- The referring physician must submit a written request to North Dakota Medicaid before scheduling the appointment. Requests must include:
    - Recipient's name and Medicaid number.

- Diagnosis.
- All medical information supporting the need for out-of-state services.
- Referral facility and physician.
- Assurance that services are not available in state.
- A written second opinion and examination by an appropriate in-state board certified specialist supporting medical need for services not available in North Dakota.

Upon receipt of the above information, the Medicaid office will determine if the referral meets state requirements and denies or approves the request in writing to the primary physician, recipient, out-of-state provider(s) and county social service office. Payment for out-of-state services is dependent on an approved prior authorization. Recipients of North Dakota Managed Care Organization (MCO) are subject to prior authorization requirements of the MCO. The county social service board is responsible for assisting recipients with travel, lodging and meal arrangements.

ADOPTION AND FOSTER CARE

Children residing out of state and receiving a state funded adoption subsidy may be eligible for Medicaid until the age of 21. The child may be eligible to receive Medicaid in his/her state of residence through the provisions of the Interstate Compact on Adoption and Medical Assistance (ICAMA). When moving out-of-state, the adoptive parent is to notify the county social service office administering their subsidy payment of their move. If the residence state has facilitated joinder in the Interstate Compact and gives reciprocity to other member states, the child will qualify for Medicaid in the state of residence. The state of residence is then notified of the child's eligibility for Medicaid through the ICAMA notification process. This is done through the state office, Children and Family Services Division. If the child is not eligible for Medicaid in the residence state, they may continue to receive Medicaid through North Dakota. It is the responsibility of the adoptive parents to approach the out-of-state provider about enrolling in Medicaid. Children in out-of-state placements with Title IV-E adoption subsidy or foster care payments are eligible for Medicaid in the state in which they reside. This includes temporary foster care placements. For children with a North Dakota subsidy agreement, funds for services not covered by the Medicaid program may be available through the subsidy program.

The costs of foster care placements not covered by the Medicaid program are reimbursed by a public agency and/or family. However, if the child is placed in a foster care setting, such as a treatment center, is eligible for Medicaid, out-of-state providers must enroll as a North Dakota provider in order to bill for covered services.

OUT-OF-STATE EMERGENCY SERVICES

Out-of-state emergency services are reviewed retrospectively by North Dakota Medicaid. The out-of-state facility must submit the admission history and physical and discharge summary to North Dakota Medicaid with their claim submittal.

TRAUMATIC BRAIN INJURY (TBI) PROGRAM

Out-of-state placement for an individual with a traumatic brain injury into a specialized program requires the referral source to send a written request for prior authorization for out-of-state services. Requirements include:

- A letter of medical necessity from the attending physician;
- Complete documentation of clinical history;
- Treatment and test results;
- A listing of past placements and placement date; and
- Information regarding attempt to place in state.

The clinical services administrator and medical consultant will review the clinical information furnished by the referral source to determine if out-of-state placement is appropriate and medically necessary. If approval is granted, North Dakota Medicaid will send an approval notice.

If the placement is a Minnesota nursing facility specializing in TBI, an out-of-state placement is not required. However, the admitting Minnesota nursing facility must obtain a level of care determination from the department's current contractor. Information regarding level of care procedures and screening forms are available on the web
http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider-all.html

OUT-OF-STATE PSYCHIATRIC SERVICES FOR CHILDREN UNDER 21

Out-of-state psychiatric placement for children under 21 requires prior approval by Medicaid. A North Dakota agency requesting out-of-state placement for a child under 21 must validate the unavailability of appropriate placement in North Dakota. The referring agency must be able to substantiate that:

- Treatment options within North Dakota have been provided with little to no improvement in the child's behavioral disorder (e.g., outpatient, acute inpatient, residential treatment centers); and

- The child has been denied admission to available North Dakota facilities; or

- The program out of state is so unique that similar services are not available in North Dakota and previous treatment attempts have failed.

After departmental approval and prior to the child's admission, the out-of-state facility must complete an admission review with the department's current contractor to assure the child's cares and conditions meet the minimum medical necessity of North Dakota's certificate of need (CON) criteria. Additional information and CON forms are available in the manuals for children under 21 located on the web http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider-all.html

EMERGENCY SERVICES FOR RECIPIENT'S TEMPORARILY OUT OF THE STATE/COUNTRY

In certain circumstances, health care coverage may be available for a recipient who is temporarily traveling outside of North Dakota and the local trade areas or outside of the United States and who remain eligible for Medicaid. If a recipient receives medical care, the out-of-state provider must enroll as a North Dakota provider in order to receive payment for services provided. The provider must submit supportive medical reports along with the claims submitted.

PUBLIC HEALTH CLINICS

BACKGROUND

Title XIX of the Social Security Act allows for the payment of medical services for Medicaid eligible recipients. Federal regulations require a cooperative agreement between the agencies that administer the programs. The North Dakota Department of Health administers the Maternal and Child Health Title V Grant. The Department of Human Services administers the Title XIX Medicaid program. These two agencies have completed the cooperative agreement as required by federal statute.

COVERED SERVICES

North Dakota Medicaid pays for medically related services provided by the local public health agency.

Billed services must be based on a specific service provided to an eligible Medicaid recipient. Public health agencies must maintain records to document the actual time spent delivering services to eligible recipients. At a minimum the records should indicate by individual recipient, the type of service provided, the date and time it was provided, and who provided the service. The records must be maintained for audit purposes for three full fiscal years after the services are provided.

Medicaid will cover the following services:

- Nursing Assessment and Diagnostic Testing;
- Health Promotion and Counseling;
- Nursing Treatment;
- Administration of Injections;
- Fluoride Varnish Application when applied by a Registered Nurse;
- Immunizations;

- Child and Teen Checkups (ND Health Tracks);
- Perinatal High Risk Services.

BILLING PROCEDURES

Public health agencies must be enrolled as a provider for North Dakota Medicaid.

Services can be billed electronically or on the HCFA 1500 claim form. Claims must contain services for only one calendar month because of recipient liability (RL) or eligibility.

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REBILLING AND ADJUSTMENTS

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

HOW LONG DO I HAVE TO REBILL OR ADJUST A CLAIM

- Providers may resubmit, modify, or adjust any initial claim within a year from the date of the remittance advice.
- The allotted time periods do not apply to overpayments that the provider must refund to the Department.

WHEN TO REBILL

A provider may rebill when:

- The claim is denied in full. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim on a regular billing form (not the adjustment form).
- An individual line is denied on a multiple-line claim. The denied service may be rebilled on a regular billing form, not an adjustment form. (In the case of a UB-92, it should be adjusted rather than rebilled.)
- The claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating what information is needed. Correct the information as directed and resubmit your claim.
- Sixty days or more have passed since the crossover claim was sent to Medicare and it has not appeared on the RA.

Rebill denied claims only after appropriate corrections have been made.

HOW TO REBILL

- When making corrections on a copy of the claim, remember to line out or omit all limes that have already been paid.
- Attach insurance information to corrected claim if applicable.

ADJUSTMENTS

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or submit a Provider Request for an Adjustment form (SFN 639).

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction.

WHEN TO REQUEST AN ADJUSTMENT

Adjust the claim only when:

- The claim was 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 code, diagnoses, units, etc.).
- An individual line is denied on a multiple-line UB-92 claim. The entire claim must be submitted as an adjustment rather than a re-bill with a copy of the correct claim.

HOW TO REQUEST AN ADJUSTMENT

- To request an adjustment, use the Provider Request for an Adjustment (SFN 639). The requirements for adjusting a claim are as follows:
- Adjustments can be submitted on paid claims or denied claims.
- Claims Processing must receive individual claim adjustments within 12 months from the date of the most recent remittance advice.

- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and correct each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and the items that need to be adjusted in the **Remarks** section.

COMPLETING AN ADJUSTMENT REQUEST FORM

The adjustment should be completed as it appears on the Remittance Advice.

Field	Description
(1) Reason for Request	Check appropriate box
(2) Recipient Block: a. I.D. Number (9 digits) b. State Use Only c. Patient's Name d. Case Number (10 digits)	 Medicaid ID number Leave blank The recipient's name is here. 10 digit number assigned by the county
(3) Provider's Name	Provider's name and address (and mailing address if different)
(4) Claim's Internal Control Number: (13 digits)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
(5)	Leave blank
(6) Provider Number	The provider's Medicaid ID number
(7) Remittance Advice Date (MM/DD/YY)	Date claim was paid found on Remittance Advice Field #1 (see the sample RA in the Remittance Advice Chapter)
(8) Date of Service:	The date the service was provided
(9) Units	Units/days of service.
(10) Place of Service	Where the service was provided
(11) Procedure/Ancillary/ Accommodation Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
(12) Mod	Modifier.
(13) Tooth No./Tooth Sur.	The tooth # or surface.
(14) Amount Billed	The amount billed by the provider.

(15) Amount Paid	The Department reimbursement.
(16) Total	The total of all charges on claim.
(17) Explanation/Remarks	Indicate reasons for adjustment. Explain in detail.
(19) Provider's Signature	Signature of person completing the adjustment, and telephone number.

MASS ADJUSTMENTS

Mass adjustments are initiated by DHS when it is necessary to reprocess a large number of claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A payment system error that affected claims processing is identified.

ELECTRONIC FUNDS TRANSFER

Electronic funds transfer (EFT) for payment of medical claims and/or premiums is available to Medicaid providers. With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the Remittance Advice that providers currently receive with payments. RAs will continue to be mailed to providers who receive paper RAs.

To participate in EFT, providers must complete a direct deposit sign-up form (SFN 661). One form must be completed for each provider number. For questions or changes regarding EFT, contact Provider Enrollment.

RECIPIENT LIABILITY

WHAT IS RECIPIENT LIABILITY

Recipient liability is the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is a monthly amount that is the recipient's responsibility to pay towards their 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 recipients 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 notified on their remittance advice once the claim has been processed. The recipient is also notified of the requirement to make payment to the provider.

TAKING RECIPIENT LIABILITY (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, 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 they 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.

north dakota department of human services

REMITTANCE ADVICE

REMITTANCE ADVICE DESCRIPTION

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services provided. The RA provides details of all transactions that have occurred during the previous week. Each line of the remittance advice represents all or part of a claim, and explains exactly what has happened to the claims, (paid, denied) and the reason the claim was denied. See the sample RA on page 3.

If a claim was denied, please read the description of the EOB before taking any action on the claim.

EXAMPLE OF MEDICAL, DENTAL OR PHARMACY REMIT ADVICE

(KEY FIELDS ON THE REMITTANCE ADVICE)

FIELD	DESCRIPTION
1. Date	The date the RA was issued.
2. Provider number	The 6-digit number assigned to the provider after enrollment.
3. Check or ACH number	System assigned # to check or Automated Clearinghouse (ACH) transaction.
4. Page number	The page number of the RA.
5. RA #	State assigned number.
6. Provider name and address	Provider's business name and address as recorded with the Department.
7. Internal control number (ICN)	Each claim is assigned a unique 13-digit number (ICN). Use this number when you have any questions concerning your claim.
8. Recipient ID	The client's Medicaid ID number.
9. Name	The client's name.
10. Case #	The 10-digit number assigned by the local county social service agency.
11. Patient control #	The number assigned by the provider.
12. Performing Physician	The number assigned to the performing provider.
13. Service dates	Date(s) services were provided. If service(s) were

	performed in a single day, the same will appear in both columns.
14. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
15. Unit of service	The number of services provided under this procedure code.
16. Billed charges	The amount a provider billed for this service.
17. Recipient liability or other insurance	Amount deducted due to recipient liability or other insurance payment.
18. Payment	Medicaid's allowed amount.
19. Message/Explanation of Benefits (EOB)	A code that explains how or why the specific service was denied or paid. These codes and their meanings are listed at the end of the Remittance Advice.
20. Third Party Liability (TPL)	If applicable, name of third party payer will be listed.
21. Co-pay/deductible information	Indicated amount deducted that is recipient responsibility.
22. Total charge/payment amount	Total of claims on remittance advice, and total of charges billed by provider.
23. Explanation of message codes used above	Summary of codes that were used to pay or deny a service.

MEDICAL, DENTAL OR PHARMACY REMITTANCE ADVICE EXAMPLE

(**1**)09/17/04 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE
(**2**)Provider Number 012345 REMITTANCE ADVICE (**4)**Page 1
(**3**)Check Number 00000001 (**5**)R/A Number 14

(**6**) Main Street Clinic
Anytown, USA

Control No. ID Number Recipient Name Case Number Pat. Control Num Prog. ID
P.Phys Service Dates RX. No. Service Code/Mod QTY Billed RL/OI Payment MSG

(**7)** (**8**) (**9**) (**10**) (**11**)
1 1004162304510 000-11-1234 Mouse Mickey 02-00015-007 415503840
(**12)** (**13**) (**14**) (**15**) (**16**) (**17**) (**18**) (**19**)
2 000052565 052604-052604 99214 1.0 132.00 .00 .00 22
(**20**)
TPL Carrier Code: 0382 Name: Workers Compensation

(**7**) (**8**) (**9**) (**10**) (**11**)
1 1004162304500 000-00-5555 Duck Daisy 23-00023-203 041550106
(**12**) (**13**) (**14**) (**15**) (**16**) (**17**) (**18**)
(**19**)
2 000036529 052404-052404 99243 1.0 177.00 .00 96.17
N14
(**21**)
Collect this co-pay amount from the recipient 2.00

(22)TOTAL CHARGE/Payment Amounts 2 309.00 96.17

(**23**) Explanation of message codes used above
22 Payment adjusted because this care may be covered by another payer per coordination of benefits
N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount

EXAMPLE OF INPATIENT HOSPITAL REMITTANCE ADVICE
(KEY FIELDS ON THE REMITTANCE ADVICE)

FIELD	DESCRIPTION
1. Date	The date the RA was issued.
2. Provider number	The 6-digit number assigned to the provider after enrollment.
3. Check or ACH number	System assigned # to check or Automated Clearinghouse (ACH) transaction.
4. Page number	The page number of the RA.
5. RA #	State assigned number.
6. Provider name and address	Provider's business name and address as recorded with the Department.
7. Internal control number (ICN)	Each claim is assigned a unique 13-digit number (ICN). Use this number when you have any questions concerning your claim.
8. Recipient ID #	The client's Medicaid ID number.
9. Name	The client's name.
10. Case #	The 10-digit number assigned by the local county social service agency.
11. Patient control #	The number assigned by the provider.
12. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same will appear in both columns.
13. DRG	Diagnosis Related Group – assignment of payment classification for procedures billed.
14. Quantity	Number of days billed.
15. Billed charges	The amount a provider billed for this service.
16. Recipient liability or other insurance	Amount deducted due to recipient liability or other insurance payment.
17. Payment	Medicaid's allowed amount.
18. Message/Explanation of Benefits (EOB)	A code that explains how or why the specific service was paid or denied. These codes and their meaning are listed at the end of the Remittance Advice.
19. Pass Through	Capital payment portion for each inpatient admission.

20. Basic	DRG payment of classification.
21. Day outlier	Payment for lengths of stay exceeding the norm.
22. Cost outlier	Payment for costs exceeding the norm.
23. Non-covered items	Services and cost not included in DRG payment.
24. Co-Pay/deductible	Indicated amount deducted that is patient's responsibility.
25. Total Charge/Payment Amounts	Total number of claims & amounts billed on this RA.

INPATIENT HOSPITAL REMITTANCE ADVICE EXAMPLE

(1)10/19/04
(2)PROVIDER NUMBER- 001234 PAGE 1 **(4)**
(3)CHECK NUMBER ACH A0291 R/A NUMBER
1 **(5)**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE
(6) Main Street Hospital
Anytown USA

Control No. ID Number Recipient Name Case Number Pat. Control Num Prog. ID
P.Phys Service Dates RX. No. Service Code/Mod QTY Billed RL/OI Payment MSG

(**7**) (**8**) (**9**) (**10**) (**11**)
1 4004051850141 000-00-5555 Duck Daisy 23-00023-203 302687
(**12**) (**13**) (**14**) (**15**) (**16**) (**17**) (**18**)
2 011104-011304 DRG: 207 2.0 1750.37 764.00 876.00 N14
(19) **(20)** **(21)** **(22)** **(23)**
3 PASS: 275.00 BASIC: 2799.00 DAY OUT: .00 COST OUT: .00 NCOV: .00

(24)
COLLECT THIS DEDUCTIBLE AMOUNT FROM THE RECIPIENT 75.00
(25)
TOTAL CHARGE/PAYMENT AMOUNTS: 1 1750.37

EXPLANATION OF MESSAGE CODES USED ABOVE

N14 PAYMENT BASED ON A CONTRACTUAL AMOUNT OR AGREEMENT, FEE SCHEDULE, OR MAXIMUM ALLOWABLE AMOUNT

FINANCIAL TRANSACTIONS

Financial transactions may be used to process a claim that is too old to adjust. Financial transactions will appear on your remittance advice. There are three types of financial transactions.

- Payout

  A payout may appear on your RA for:

  - Co-pay or deductible for recipient that the system cannot adjust.
  - Cost effective group health insurance premium for qualified recipients.
  - Cost settlements.
  - Rate increases that cannot be processed by an adjustment.
  - Cash advance to provider for pending claims.

  A message (MSG) code or N85 final installment plan will appear at the end of your RA.

- Recoupment

  A recoupment may appear on your RA:

  - When a claim is past the 2-year adjustment process and the provider owes ND Medicaid an outstanding amount.
  - For cost settlements.
  - For a rate decrease that cannot be processed by an adjustment.
  - For incorrect billing.

  A message (MSG) code of 88 “adjustment amount represents collection against receivable created in prior overpayment will appear at the end of your RA.“ The money will be withheld from your payment. If this payment is insufficient to recover the recoupment amount, a negative balance will be carried forward and withheld from future payments until the total amount is reclaimed.

- Refund for overpayment

  A refund may occur:

  - When the claim is past the 2-year adjustment limit.
  - The provider is no longer participating in the ND Medicaid program.

  The refund should be sent within 30 days of discovering the overpayment.

  Attach a copy of the RA with a short note explaining that the check is a refund for an overpayment.

REVIEW BY NORTH DAKOTA HEALTHCARE REVIEW

OVERVIEW

The Department of Human Services (DHS) contracts with North Dakota Health Care Review, Inc. (NDHCRI) to perform reviews and prior authorizations of services provided by participating hospitals to North Dakota Medicaid recipients. These include hospitals located within 50 statute miles of the North Dakota border.

The Department requires a prior authorization and a retrospective review of various procedures for all North Dakota hospitals as part of its utilization and quality control measures.

PREAUTHORIZATION PROCESS

The following procedures require preauthorization:

- Cosmetic Surgery
- Obesity Procedures

NDHCRI will also review all of the above procedures (principal or secondary) retrospectively on an inpatient or outpatient basis.

Preadmission and pre-procedure review is a responsibility of NDHCRI and the practicing physicians of North Dakota. The areas of required review listed above are identified to the state and will not be paid unless the claim denotes review has been preformed and the admission is necessary and the setting is appropriate. The primary responsibility of initiating preadmission review rests with the admitting physician or his/her designee.

- Physicians or their designees are encouraged to review and be familiar with the required areas of review. When a physician decides to schedule a procedure/admission either inpatient or outpatient, which is within the identified areas of review, he/she or other designated personnel should mail the required information to NDHCRI. Minimal information to include for NDCHRI review consists of:

- Patient information (Medicaid ID#, Name, Address, Age)
- Dates of Service (Admission/Procedure dates)
- Contact person (Name, Phone Number)
- Procedure to be performed (Complete narrative of the procedure and CPT/ICD-9-CM code if available)
- Physician Name and North Dakota License number/UPIN
- Provider Name and number (Facility where procedure is being performed)
- Criteria (Utilize criteria in NDHCRI's manual)
- Supportive documentation which must consist of, but is not limited to medical history, previous treatment, and present treatment.

- The NDHCRI cannot approve an admission or procedure if the data is incomplete. NDHCRI recommends that the information be submitted prior to the scheduled admission or surgery date. A request for cosmetic surgery must be submitted two (2) weeks prior to the surgical procedure and four (4) weeks must be allowed for obesity procedures.

- The NDHCRI Case Review Coordinator (CRC) needs the necessary patient, physician, outpatient, or hospital information and will require medical indications for the admission or surgical procedure as appropriate. When the CRC is able to determine that the criteria is met based on the information received, the following will occur:

  - The admission is authorized for payment. The admitting physician will need to wait for the NDHCRI preadmission authorization form to admit the patient or perform the procedure.

  - A computer generated form identified as a "Request for Preadmission/ Preprocedure Review" is then completed by the CRC and copies are mailed to the admitting physician and hospital or hospital outpatient department within one (1) business day.

  - Upon receipt of the authorization form, the hospital or hospital outpatient department should maintain the document with the medical record. The NDHCRI authorization number must be transcribed by the provider to the UB-92 or HCFA-1500 billing form to assure payment. The NDHCRI authorization number is verified by the Department, and if not valid, the claim will be denied until corrected, and/or retrospectively reviewed by NDHCRI.

- When the CRC is unable to approve the admission or procedure, the CRC contacts the Physician Reviewer (PR) to discuss the case. The PR subsequently contacts the admitting physician and provides an opportunity to discuss the case. If the PR approves the case, the CRC is informed and the review is completed.

- If the PR, after consultation with the admitting physician, determines that the admission or procedure is inappropriate or not medically indicated, or is not at the appropriate level, the admitting physician will be informed in writing that the proposed admission or procedure is not authorized and a letter of adverse determination will be issued. The admitting or attending physician may then:
  - Perform the procedure in an outpatient setting if the PR determined that the procedure could be safely performed on an outpatient basis;
  - Cancel the procedure if medical necessity was not determined. If the attending or admitting physician chooses to proceed, he/she may admit the patient or perform the procedure. Upon receipt of denial for payment by the Department, the admitting or attending physician may request a reconsideration from NDHCRI.

PROCEDURES REQUIRING PREAUTHORIZATION

CPT-4 Procedure Codes

Cosmetic Procedures

Ear Procedures	15576, 69300, 69399
Nose procedures	30400-30630
Breast Reconstructive Surgery/Mammoplasty	19140, 19182, 19316-19380, 19499
Facial Surgery	15780-15829, 67900-67924
Elective Cosmetic Surgery	15775-15776, 15831-15839, 15876-15879
Obesity Procedures	43842-43848, 43999

ICD-9-CM Procedure Codes

Cosmetic Procedures

Ear Procedures	18.5, 18.71, 18.79
Nose Procedures	21.5, 21.83-21.89
Breast Reconstructive Surgery/Mammoplasty	85.0, 85.21, 85.31-85.36, 85.50-85.54 85.6, 85.7, 85.82-85.89, 85.94, 85.95

Facial Surgery	08.31-08.49, 08.61-08.74, 86.82
Elective Cosmetic Surgery	86.83
Obesity Procedures	42.62, 43.19, 43.3-43.7, 43.81,43.89 43.91, 43.99, 4400-44.03, 44.21, 44.29, 44.31 44.39, 44.5, 44.69, 44.93, 44.94

The above codes may not be entirely inclusive due to updates in the ICD-9-CM and CPT-4 procedure codes.

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human services

RURAL HEALTH CLINICS (RHC) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

PROVIDER ENROLLMENT

A Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) may enroll to become a North Dakota provider. To obtain designation as a RHC or FQHC, the clinic must receive certification from the Center for Medicare and Medicaid Services.

COVERED SERVICES

- Physician's services and services and supplies if furnished incidental to a physician's professional service.
- Vaccines.
- Services provided by a physician assistant, nurse practitioner, or clinical psychologist, and services and supplies furnished incidental to a physician's service.

BILLING PROCEDURES

Rural Health Clinics and Federally Qualified Health Centers bill for services on the UB92 form using a revenue code of 521 or 951. One encounter per day is covered unless another separate and distinct encounter is medically necessary.

The Department sets a prospective payment rate that is clinic specific and is all inclusive per visit.

All claims must be billed within one year from the date of service and private insurance must be billed before any payment by Medicaid will be allowed. Attach all insurance EOBs to the submitted claim. Bill each day of service for charges on separate lines with the date if billing for more than one (1) day. Only bill one (1) month at a time for each claim.

PRIMARY CARE PROVIDER (PCP) DESIGNATION

While RHC and FQHC can be designated as a PCP these facilities cannot be used as a referring physician on claims. Referrals from these clinics must contain an authorization of the referral (signature, initials) from a physician associated with the clinic or a supervising physician of the clinic. IHS facilities have an assigned unique PCP number that is used on the claim when referring.

Primary care provided by a colleague of the designated PCP (same clinic and same specialty) does not require a referral from the PCP. Services that require a referral, even in the same clinic as the PCP, must have a referral from the PCP if payment is expected.

SPEECH-LANGUAGE PATHOLOGY

GENERAL INFORMATION

A Speech-Language Pathologist is an individual possessing a master's degree or its equivalent in the area of speech-language pathology or audiology, and is licensed to practice in the state in which the individual provides services. The Speech-Language Pathologist must adhere to applicable state requirements established for Speech-Language Pathology.

Speech-Language Pathology includes diagnostic, screening, preventative, consultative or corrective services provided by or under the directions of a Speech-Language Pathologist.

Speech-Language Pathology services must relate directly and specifically to a written treatment regimen established by the physician, after any needed consultation with the qualified Speech-Language Pathologist, or by the Speech-Language Pathologist providing services.

The following must be documented in the recipient's plan of care:

- The recipient's medical diagnosis and any contraindications to treatment;
- A description of the recipient's functional status;
- The objectives of the speech-language pathology service;
- A description of the recipient's progress toward the objectives.

The recipient's physician must sign the plan of care. Recertification of the treatment plan must occur at 60-day subsequent intervals from the date of the initial evaluation or first encounter.

COVERED SERVICES

Speech-Language Pathology includes services necessary for the diagnosis and treatment of speech, hearing and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphasia) regardless of the presence of a communication disability.

Speech-Language Pathology services are limited to 30 visits per calendar year, and one evaluation per year. Prior authorization is required for services exceeding this limit. Procedures addressing the prior authorization are addressed in the following section.

The counts for Speech-language Pathology will be accrued on an encounter basis. This means that a count of one (1) will be applied per date of service occurrence regardless of length of service or frequency of services provided in a given day.

The following is a list of Medicaid covered CPT codes for speech-language pathology services.

92506	Evaluation of speech, language, voice, communication, auditory processing, and / or aural rehabilitation status.	Per date of service occurrence
92507	Treatment of speech, language, voice, communication, and / or auditory processing disorder (includes aural rehabilitation)	Per date of service occurrence.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Per date of service occurrence
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	15 min./1 unit
All other services for speech-language pathology are non-covered by ND Medicaid.		

PRIOR AUTHORIZATION PROCESS

Prior authorization is required for services exceeding these limits. The provider must complete and submit, prior to the recipient's receipt of additional services, an SFN 481 Service Limits Prior Authorization Request to ND Medicaid.

Information needed is:

- Prior short-term goals
- Prior long-term goals
- Progress since previous update
- New short-term goals
- New long-term goals

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals
- Progress
- Reasonable new goals
- Maintenance care

If the services requested appear to be at the maintenance level, ND Medicaid will contact the pathologist to discuss. If the services are determined necessary to sustain a

level of function or the recipient's condition would digress, the services would be covered by Medicaid. The services must be medically necessary and physician ordered.

ND Medicaid will not pay for services that are provided without submitting required information.

NON-COVERED SERVICES

- Speech-Language Pathology that is provided without a prescription from a physician;
- Services that are not medically necessary;
- Services that are not documented in the recipient's health care record;
- Services that are not part of the recipient's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary as part of a re-certification process;
- Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan;
- Speech-Language Pathology services provided in a nursing facility or ICF/MR. Medicaid pays for those services through the rate established for the facility;
- Maintenance therapy.

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human services

STERILIZATION

CONSENT FOR STERILIZATION

Medicaid payment will be made for sterilization if the recipient is at least 21 years old at the time consent is obtained and is mentally competent, is not institutionalized, and informed consent is given voluntarily. The person obtaining the consent must give the recipient:

- An opportunity to ask questions about the sterilization process;
- An oral explanation about the procedure and any procedural risks in accordance with consent form requirements;
- A copy of the consent form; and
- Advice that the decision to be sterilized will not affect future care or benefits and that the sterilization will not be performed until at least 30 days have passed, except in the case of premature delivery.

A female recipient may **not** consent to a sterilization when:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the recipient's state of awareness.

A male recipient may **not** consent to a sterilization when:

- Under the influence of alcohol or other substances that affect the recipient's state of awareness.

WRITTEN CONSENT FORM

Consent forms are available on the Department's website at http://www.state.nd.us/eforms/. **SFN 989** must be used in order for the Medicaid program to approve payment for any sterilization services.
The provider who obtains consent for sterilization must answer the recipient's questions regarding the procedure, provide a copy of the Consent Form, and explain the requirements for informed consent that are listed on the Consent Form. Shortly before

the sterilization, the physician who will perform the procedure must explain the requirements for informed consent that are listed on the Consent Form.

A sign language interpreter must be provided to ensure that information regarding the sterilization is communicated effectively to a hearing impaired or non-English speaking recipient.

The Consent Form must be signed and dated by all of the following or the claim will not be processed.

- The individual to be sterilized. An informed consent is valid only if at least 30 days have passed, but not more than 180 days have passed from the date of signature, except in cases of premature delivery or emergency abdominal surgery. If a recipient is sterilized at the time of a premature delivery or emergency abdominal surgery, payment will be made if at least 72 hours have passed since the patient gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been signed at least 30 days before the expected delivery date. An emergency caesarean section can be considered premature delivery, but is not emergency abdominal surgery.

- The interpreter, if one was provided. The interpreter must sign and date the form after the patient signs it but before the day of the surgery.

- The person who obtained the consent. The person obtaining consent also must sign and date the form after the patient signs it but before the day of surgery.

- The physician who performed the sterilization procedure. The physician must sign the form the day of surgery, or after the surgery.

FILING OF CLAIMS

The recipient may not be billed if the provider fails to accurately complete the Consent Form.

When billing, the provider must include a copy of the Consent Form with the paper claim.

Breakdown of tubal charges is required on all inpatient claims - Box 84 on UB92.

STANDARDS FOR RETROACTIVE ELIGIBILITY

Consent Form requirements cannot be met retroactively. Providers may want to complete a Consent Form and allow for the 30-day waiting period when individuals without financial resources or insurance coverage request sterilization and indicate that

they are considering application or have applied for Medicaid. An alternative approach would be to inform the recipient, preferably in writing, that retroactive eligibility does not apply to sterilization procedures unless a Consent Form is signed and the 30-day waiting period adhered to. Recipients must be informed that they will be held accountable for charges before the service is provided.

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SURVEILLANCE UTILIZATION (SURS) REVIEW

WHAT IS THE FUNCTION OF SURS

The Department's Surveillance/Utilization Review Section (SURS) is a federally mandated program that performs retrospective review of paid claims. SURS is required to safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments. If the Department pays a claim and later discovers that the service was incorrectly billed or the claim was erroneously paid, the Department is required by federal regulation to recover any overpayment. Referrals are received from the following sources or processes:

- Providers
- Clients
- Departmental staff
- Other agencies such as Medicare
- Legislators
- Private citizens
- Internal data reports

DESK AUDITS

When a desk audit is completed, SURS will determine the corrective action to stop an activity and recoup any overpayments. The process of a desk audit is:

- Complaint or referral is received from one of the sources above.
- Analyst determines what time frame to review paid claims, i.e., 6 months, 12 months, 18 months, etc.
- History is pulled from paid claims data bank.
- Payment history is reviewed for patterns of misuse, over utilization or fraud.
- Services are reviewed for correctness and continuity for quality care issues.
- Professional consultants are used for quality, standards, appropriateness and ethics issues.
- Some cases may require obtaining records from a provider for further review.
- Some cases require on-site visits and audits.

- The SURS administrator normally will conduct the audits and reviews on-site, accompanied by other specialists, i.e., nurses, program administrators and consultants as needed.
- If the audit/review indicates a problem with quality care, procedures or policy issues without overpayment, the appropriate specialist or SURS administrator will talk to the provider/recipient to correct the problem.
- If there is an overpayment, the SURS administrator or analyst will calculate the overpayment.
- The administrator will process any forms, notices and other documents needed to notify the provider/recipient of the problem.
- The SURS administrator will compose a demand letter for recouping the overpayment.
- The SURS administrator will determine the cost effectiveness of pursuing claims under $50.
- Under the SURS administrator's direction, provider overpayments can be recouped by adjusting current and future claims.
- The SURS administrator will set up a payment plan if full recoupment is not possible in one lump payment.
- The SURS administrator will determine if a case is to be turned over to a collection agency or legal entity for civil or criminal processing.
- The SURS section will track all payments and cases and update as needed.
- The SURS administrator acts as a consultant to the Medicaid Director advising him/her on penalties, sanctions, and corrective actions to take based on review outcomes.
- Medicaid and Medicare programs fall under the Office of Inspector General (OIG) and various regulations found in section 14 of Public Law 100-93 lists specific business practices that are allowed and are not subject to penalties. "Safe Harbor" provisions are codified at 42 CFR 1001.952.

KEY POINTS

- Providers are encouraged to use the provider relations unit for questions on how and what to bill.
- SURS and provider relations can give general guidance in what codes can be used for services.
- The provider is ultimately responsible to choose the code that matches the services provided.
- Medicaid is entitled to recover payment made to providers when a claim was paid incorrectly for any reason.
- Medicaid pays for only those prescriptions and services that are covered by Medicaid.
- Medicaid can go back six years when conducting audits.
- Medicaid can charge interest as prescribed by law on recovered funds.

- Medicaid may withhold payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid provider agreement, federal and state laws, regulations and policies.
- Prior authorization does not guarantee payment; a claim may be denied or money paid to providers may be recovered if the claim is found to be inappropriate.

BILLING TIPS

The best way to avoid an audit is to make sure all claims are billed accurately. The following suggestions may help reduce billing errors:

- Be familiar with the current Medicaid provider manuals. If you do not have one, you may request one from Provider Enrollment or check the web for the manual: http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider.html
- Be familiar with prior authorization and referral processes.
- Use current Level I CPT, Level II HCPCS, and current ICD-9 coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.
- Maintain complete records.
- Attend classes on coding offered by certified coding specialists.
- Utilize services and training offered by Medicaid. Medicaid newsletters and other training programs offered should be accessed by the appropriate staff.
- Out-of-state services require a prior authorization and are to be utilized only when services are not available in North Dakota.
- Out-of-state emergency referrals must be reported to Medicaid within 48 hours after the recipient is transferred.
- Avoid billing for the same service/supply twice. Duplicate billings delay the processing time of claims.
- Use specific codes and not miscellaneous codes. Example: 99213 is more specific (problem-focused visit) than 99499 (unlisted evaluation and management service).
- Bill only for services covered by Medicaid.
- Bill only under your own provider number.
- Bill only for services you provide.
- Bill for the appropriate level of service provided. Example: The Level I CPT coding book contains detailed descriptions and examples of what differentiates a level I office visit (99201) from a level 5 office visit (99205).
- Services covered within “global periods” for certain Level I CPT procedures are not paid separately and should not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure

- Pay close attention to modifiers used with Level I CPT and Level II HCPCS codes. Modifiers are becoming more prevalent in health care billing and they often affect payment calculations.
- Choose the least costly alternative that meets the recipient's medical need. Example: If a client is able to operate a standard wheelchair, then a motorized wheelchair should not be prescribed or provided.
- For repeat patients, use established patient code (e.g. 99213) instead of a first time patient code (e.g. 99203). First time patient code may be used when:
- The provider sees the patient the first time.
- It has been at least three years since the client has seen the provider or another provider of the same specialty who belongs to the same group practice.
- Check provider manual to determine what constitutes a unit of measure for the services being provided.
- Physical, occupational and speech therapy may bill for restorative services.
- Professional interpretation of x-rays and other diagnostic tests can only be billed once - typically by the radiologist.
- Durable medical equipment, orthotics, prosthetics and supplies (DMEOPS) must be medically necessary and prescribed in writing by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law, prior to delivery.
- Prescriptions for medical supplies used on a continuous basis must be renewed by a physician at least every 12 months and must specify the monthly quantity of the supply. Only a 30-day supply for the current eligibility month can be dispensed and billed to Medicaid.
- Observe rental time restrictions on durable medical equipment. Medicaid will recover rental payments paid past the purchase price of the item. Rental fees include supplies, maintenance, and repairs. These items should not be billed separately from the rental charges.
- When in doubt about a patient's Medicaid eligibility, use the Medicaid Verify Telephone system. Eligibility, recipient liability, insurance, and restrictions can be accessed 24 hours a day. Other methods are to ask the patient or contact the County Social Service Office.

north dakota
department of
human services

THIRD-PARTY LIABILITY

In 1986, federal law required state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid.

Providers must obtain information about a recipient's health care coverage from the recipient, the recipient's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits. The providers may also obtain third party payer information by using the Medicaid Verify or Medifax System to verify eligibility information. Providers may also obtain an assignment of benefits from the recipient to ensure direct payment from the third party payer.

For Medicaid purposes, health insurance is defined as any third party benefit that is available to the eligible Medicaid recipients for medical treatment and related services.

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS

Providers and Medicaid eligible recipients are required to follow the third party payer's policies and procedures to maximize the available benefit. If the third party payer applies a penalty because the recipient or provider did not follow the third party policies, Medicaid will not pay the penalty amount. If the third party payer does not pay anything on the claim because policy and procedures were not followed, Medicaid will not pay the claim.

Services for which payment has been denied by the third party payer for reasons other then noncompliance may be eligible for Medicaid reimbursement. Explanation of benefits (EOB's) or other documentation is required before payment is authorized.

Third party EOB's and other required documents must be provided only on those billings in which the third party has paid less then 60% of the billed charges or when the recipient is covered by more than one insurance plan and a balance needs to be billed to Medicaid.

Payment received from accident liability insurers, i.e. auto, business and homeowners, must be entered on the claim form in the space noted for insurance or other payments. The Explanation of Benefits or other documentation must be included with the claim.

Billing Medicaid and another third party for the same service at the same time is considered a violation under Medicaid rules. Medicaid is the payer of last resort and can only be billed after the third party has paid its legal liability.

Medicaid covers co-pays to the extent that the third party payment and the co-pay do not exceed the Medicaid allowed amount.

For any claims with TPL, providers must bill their usual and customary charge to ND Medicaid. The claim will be adjudicated in the following manner:

- 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 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 is greater than the ND Medicaid allowable amount, ND Medicaid makes no payment.

If the provider has third party information that is not on Medicaid's system, the provider must advise the Medicaid program by sending an EOB from the third party payer. The provider must adequately identify the EOB by writing the provider number, recipient's name and Medicaid ID number on the EOB. If Medicaid has third party information that the provider is not aware of, Medicaid will supply the provider with adequate information for the provider to bill the third party if the third party payer is not known to the provider at the time of billing. The Medicaid FAX Number to send EOB's when reporting third party information is (701) 328-1544, attention TPL Unit.

When a third party payer denies a claim, an explanation must accompany the claim.

Medicaid requires a provider to make a reasonable attempt to bill a third party payer. If after thirty days no response has been received, the provider can bill Medicaid with documentation that the third party was billed. If the claim is submitted to Medicaid and Medicaid determines that the third party information was not correct, the billing will be returned to the provider with the correct billing information.

Providers must bill the third party and Medicaid. Providers are not allowed to bill the Medicaid recipient for any balances after payment is received from the third party and Medicaid. Medicaid payment is the last adjudication of the claim, and if there is a balance left after Medicaid has made a payment determination, this constitutes a write-off to the provider. Medicaid payment is considered payment in full, even if payment is zero.

Providers may bill recipients to recover payments made by the third party payer directly to the recipient.

Providers cannot refuse services because a Medicaid eligible recipient has third party coverage. Providers cannot demand payment, and require the recipient to bill the third party, unless specific terms of the third party require that benefits be paid to the recipient. Medicaid may be billed only to the extent there is a recipient legal obligation to pay.

RECIPIENT COOPERATION WITH TPL BILLING

If a Medicaid recipient is non-cooperative or fails to cooperate with the third party payer, the provider may contact the applicable county social service office or the TPL Unit at North Dakota Medicaid for assistance.

north dakota
department of
human services

TRANSPORTATION SERVICES

GENERAL REQUIREMENTS

- Medical Transportation is the transporting of a recipient for the purpose of obtaining a health service. Medicaid covered transportation consists of:
    - Ambulance transportation defined as the transport of a recipient whose medical condition or diagnosis required medically necessary services before and during transport.
    - Handicap transportation defined as the transport of a recipient who, because of a physical or mental impairment, is unable to use a common carrier. The impairment must be a physiological disorder, physical condition, or mental disorder that prohibits access to or safe use of common carrier transportation. Special transportation is designed for a recipient such as the wheelchair-bound individual who needs a special vehicle with tie-down apparatus.
    - Common carrier transportation defined as the transport of a recipient by a bus, taxicab, or other commercial carrier or by private automobile.
- A transportation service provider must be enrolled as a provider in the ND Medicaid program and can be an individual, taxi, bus, airline service, or other commercial form of transportation.
- The county agency must determine the most efficient, economical, and appropriate means of travel to meet the medical needs of the recipient. The county agency is responsible for authorizing travel and issuing the necessary billing forms.
- The cost of travel provided by a parent, spouse, or any other member of the recipient's medical assistance unit may be allowed as an expense of necessary medical or remedial care for recipient liability purposes. No parent, spouse, friend, household member or family member of the recipient may be paid as an enrolled provider for transportation to that recipient.

- Travel services may be provided by the county agency as an administrative activity.

- Emergency transport by ambulance is a covered service.

- Non-emergency transport by ambulance is a covered service only when medically necessary and ordered by the attending physician.

- A recipient may choose to obtain medical services outside the recipient's community. If similar medical services are available within the community and the recipient chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the recipient. The recipient must follow the policies established by the local county agency.

- All transportation providers receive billing instructions in their enrollment packet.

TRANSPORTATION BETWEEN PROVIDERS

Medical transportation of a recipient between providers is eligible for Medical Assistance payment as specified below:

- Except for an emergency, transportation between two long-term care facilities must be medically necessary because the health service required by the recipient's plan of care is not available at the long-term are facility where the recipient resides.

- Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the recipient was when the medical necessity was diagnosed.

PAYMENT LIMITATIONS

To be eligible for payment, medical transportation must be to or from the site of a covered service to a recipient. A covered service is one which is provide by a North Dakota enrolled health care provider, billed using the recipient's North Dakota ID# and is a reimbursable service.

PAYMENT LIMITATION FOR TRANSPORT OF DECEASED PERSON

The following information clarifies Medicaid policy related to the death of a recipient and the payment for any ambulance services.

The death of a recipient is recognized when the pronouncement of death is made by an individual legally authorized to do so by the state where the pronouncement is made. The following three scenarios apply to payment for ambulance services when the recipient dies before a ground air ambulance arrives.

- If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment based on the base rate may be made. However, mileage will not be paid.
    - Payment is made based on the BLS level of service if a ground vehicle is dispatched.
    - If an air ambulance is dispatched, payment is made based on the fixed wing or rotary wing base rate, as appropriate.
- The recipient is pronounced dead after being loaded into the ambulance, regardless of whether the pronouncement is made during or subsequent to the transport. A determination of “dead on arrival” (DOA) is made at the facility to which the recipient is transported.
    - Payment is made following the usual rules of payment (as if the recipient had not died).
- No payment will be made if the recipient was pronounced dead prior to the time the ambulance is called or dispatched.

PAYMENT LIMITATION FOR AMBULANCE TRANSPORTATION

To receive Medicaid payment on ambulance transportation, the recipient must receive medically necessary services before and during transport, and the transportation must comply with the following conditions:

- The ambulance provider must be licensed under North Dakota statues as an advanced life support or basic life support.
- The recipient’s transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider. Claims in question may be denied for non-emergency transportation.
- Ambulance transportation that responds to a medical emergency is covered by Medical Assistance for no load transportation only if the ambulance transportation provided medically necessary treatment to the recipient at the pickup point of the recipient. The payment is limited to charges for transportation to the point of pickup and for ancillary services.

- Out-of-state travel expenses for non-emergency out-of-state medical services, including follow up visits, may be compensated only if the out-of-state medical services are first approved by the department.

HANDICAP-ACCESSIBLE TRANSPORTATION

Two primary criteria must be met for handicap transportation to be considered for payment:

- The recipient must have a mobility impairment of a severity that prevents the recipient from safely accessing and using a bus, taxi, private automobile, or other common carrier transportation; **and**

- The trip must be to or from a North Dakota covered service. A North Dakota covered service is one that is provided by an enrolled health care provider, is billed using the recipient's North Dakota ID number, and is a reimbursable service.

USUAL AND CUSTOMARY CHARGES FOR HANDICAP-ACCESSIBLE TRANSPORTATION

North Dakota Rules require that providers bill the ND Medicaid the usual and customary fee charged to their largest share of business other than Medicaid recipients and sliding fee-scale-type riders. Any handicap accessible transportation provider whose business includes riders in addition to Medicaid and sliding fee-scale riders cannot charge Medicaid more than the provider charges its non-Medicaid business that makes up the largest share of business (excluding sliding fee-scale riders). If transportation providers offer free rides or reduced fees to non-Medicaid riders, those providers must charge the same rates or offer free rides to Medicaid recipients. If a provider serves only Medicaid and sliding fee-scale schedule riders, then the Medicaid rate charged to Medicaid recipients is the usual and customary fee.

This policy includes multiple rider trips. If a special transportation provider discounts multiple rider trips for non-Medicaid riders, the provider also must discount Medicaid rides.

AIR AMBULANCE

Transportation by air ambulance is a covered Medicaid service if the recipient has a potentially life threatening condition that precludes the use of another form of transportation.

Providers must submit documentation for medical necessity and the need for air ambulance with claims for instate transportation.

For out-of-state transfers, the transferring facility must follow criteria for emergency out-of-state transportation. Air ambulance transportation originating outside of North Dakota or to a destination outside of North Dakota, must inform ND Medicaid within 48 hours of the transfer. Documentation to ND Medicaid must include:

- Destination and date of transfer
- Mode of transportation
- Discharge summary **and**
- If trip is less than 50 miles, the facility must verify why air rather than ground ambulance was used.

OUT-OF-STATE TRANSPORTATION

All medical transportation to a site located more than 50 statute miles from the nearest North Dakota border requires prior approval. Exceptions include emergency transportation or transportation provided to a recipient for whom the state makes adoption assistance or foster care maintenance payments.

Transportation provided by private automobile, bus or other commercial carrier must be authorized by the local county social service agency. Limitations on travel expenses for medical purposes are addressed in NDAC 75-02-02-13.1.

EXCLUDED SERVICES

The costs of items listed below are not covered by Medicaid as medical transportation:

- Transportation of a recipient to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when life support transportation is medically necessary;

- Transportation of a recipient to a facility for alcohol detoxification that is not a medical necessity;

- No load transportation except as described under transportation of deceased persons and payment limitations for life support transportation;

- Additional charges for luggage, stair carry of the recipient, and other airport, bus, or railroad terminal services;

- Transportation of a recipient to a non-covered Medical Assistance health service (eg: grocery store, health club, school, church, synagogue).

TRANSPORTATION BY PRIVATE VEHICLE

- Private vehicle mileage compensation is limited to an amount set by Medcaid no less than twenty cents per mile. This limit applies even if more than one recipient is transported at the same time. Mileage is determined by map miles from the residence or community of the recipient to the medical facility. When necessary to ensure volunteer drivers continue to provide transportation services to a recipient, the county agency may authorize payment for additional mileage. Private vehicle mileage may be billed to Medicaid only upon completion of the service. Private vehicle mileage may be allowed if the recipient or a household member does not have a vehicle that is in operable condition or if the health of the recipient or household member does not permit safe operation of the vehicle. Private vehicle mileage will not be allowed if free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member.

- Meals compensation is allowed only when medical services or travel arrangements require a recipient to stay overnight. Compensation is limited to an amount set by Medicaid no less than three dollars and fifty cents for breakfast, five dollars for lunch, and eight dollars and fifty cents for dinner.

- Lodging expense is allowed only when medical services or travel arrangements require a recipient to stay overnight. Lodging compensation is limited to an amount set by Medicaid, provided Medicaid may set no limit lower than thirty-five dollars per night, plus taxes for in-state travel and fifty dollars per night, plus taxes for out-of-state travel. Lodging receipts must be provided when lodging is not billed directly by an enrolled lodging provider. Enrolled lodging providers shall bill Medicaid directly.

- Travel expenses may be authorized for a driver. No travel expenses may be authorized for an attendant unless the referring physician determines an attendant is necessary for the physical or medical needs of the recipient. Travel expenses may not be authorized for both a driver and an attendant unless the referring physician determines that one individual cannot function both as driver and attendant. No travel expenses may be allowed for a driver or an attendant while the recipient is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area.

- Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized of another driver, attendant, or parent unless the referring physician determines that person’s presence is necessary for the physical or medical needs of the child.

- Compensation for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by Medicaid.

TAXI TRANSPORTATION

- Taxi vouchers are required to be given to the taxi driver upon taking a Medicaid recipient to a medical appointment and upon taking them home from their appointment. The county social service staff arrange this with Medicaid recipients.

- Taxi service will only be allowed from the recipient's home, school, or work to their medical appointment. The return trip from the medical appointment will only be allowed to the recipient's home, work, or school.

- If it is an urgent medical situation, the taxi driver must document why the taxi is being used for a Medicaid recipient. This should be kept on file with the taxi company to refer to if any questions arise concerning a claim.

- Medicaid would allow exceptions when an emergency arises at another location other than those listed above, i.e. a Medicaid recipient becomes ill while at a restaurant and needs medical attention with no other means of transportation available. This exception would need to be documented by the taxi company for review by Medicaid.

north dakota
department of
human services

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program consisting of women under age sixty-five (65) who:

- Are uninsured and not otherwise eligible for Medicaid;
- Have been screened for breast and cervical cancer through Women's Way under the Centers for Disease Control and Prevention's breast and cervical cancer early detection program and have been found to require treatment for breast cancer, cervical cancer, or a pre-cancerous condition relating to breast cancer of cervical cancer;
- Have family income below 200% of the poverty level; and
- Meet the residence citizenship, social security number, and inmates of public institutions requirements.

The earliest date of eligibility is the month of diagnosis, but not more than three months prior to the month of application. Eligibility can continue until the woman reaches age 65, is no longer a state resident, is admitted to a public institution, is eligible for Medicaid through a different category, becomes insured, or no longer needs treatment for breast or cervical cancer.

Eligibility for this group is determined by the Women's Way program of the North Dakota Department of Health and the Medicaid Eligibility Unit of North Dakota Medicaid.

Individuals determined to be eligible for Women's Way are entitled to receive the entire array of services permitted under the Medicaid program.

For more information call 1-800-44WOMEN or go to http://www.womensway.net/.