

# PROVIDER BULLETIN

## THE REIMBURSEMENT NEWS SOURCE

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**NORTH DAKOTA  
DEPARTMENT OF  
HUMAN SERVICES**

~  
**MAGGIE ANDERSON,  
INTERIM EXECUTIVE DIRECTOR**

**Issue 70 – February 2013**

### RECIPIENT LIABILITY / CLIENT SHARE

#### What is Recipient Liability?

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

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

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

#### **Taking Recipient Liability at the Time of Service**

With the exception of pharmacy point of sale and long term care facilities, providers are not to collect recipient liability at the time of service. Rather, providers are to file the claim, and then collect the RL only if directed by the information on the Remittance Advice.

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

## UTILIZATION REVIEW

### **Service Limits Prior Authorization Update**

Effective November 1, 2012, all service limit providers (chiropractor, physical therapy, occupational therapy, speech therapy, psychological therapy and testing) are to use the updated and revised prior authorization for service limits form (SFN 481) which can be found on the Department of Human Services website at: [www.nd.gov/eforms/Doc/sfn00481.pdf](http://www.nd.gov/eforms/Doc/sfn00481.pdf)



### **Telemedicine Medical Policy**

The Telemedicine Medical Policy is available on the web at [www.nd.gov/dhs/services/medicalserv/medicaid/provider-policies.html](http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-policies.html).



### **Coding for Psychiatry & Psychotherapy**

The American Medical Association (AMA) made significant changes to Current Procedural Terminology (CPT®) codes for psychiatry and psychotherapy services effective January 1, 2013. North Dakota Medicaid has now implemented these changes with the 2013 Psychiatry CPT® codes 90785-90840 effective for dates of service January 1, 2013 and after.

If you have submitted claims with these CPT® codes for dates of service January 1, 2013 and after that have been denied due to code implementation, please resubmit those claims to ND Medicaid.

If you have submitted claims with dates of service January 1, 2013 and after using the obsolete psychiatry CPT® codes (codes that were effective previous to 01/01/13), you must submit an adjustment to deny the claim in conjunction with submission of a revised corrected claim using the current psychiatry CPT® codes by July 1, 2013. If you do not submit an adjustment by July 1, 2013, ND Medicaid will adjust the claim and deny it for invalid procedure code.

### **DME Medical Documentation Requirements**

ND Medicaid requires medical documentation to accompany durable medical equipment (DME) prior authorizations to substantiate policies and coverage criteria. Documentation requirements are as follows:

- The recipient must have been examined within the past 60 days and the ND Medicaid prescribing practitioner must provide sufficient clinical rationale to substantiate the medical need of the ordered equipment or supplies.
- The recipient's history and current medical condition must be carefully considered before any prescription for equipment or supplies is written.
- The ND Medicaid prescribing practitioner and DME providers need to collaborate to ensure the recipient's medical record contains sufficient documentation, proof of delivery and original prescriptions.

The abovementioned information must be made available, upon request, to ND Medicaid. The recipient's medical record is not limited to the ND Medicaid prescribing practitioner's office records. The record may include hospital, nursing home, or home-health agency records or records from other medical professionals.



### **Community Wrap-Around Services**

Community based wrap around services (HCPCS code H2021 in 15-minute increments) is a method of providing mental health services to children. It is an intensive case management model facilitated by a single care coordinator/case manager with a single plan of care.

In previous correspondence, ICD-9-CM diagnosis code 799 was provided and was instructed to be submitted in Box 21 as the primary diagnosis code when billing North Dakota Medicaid. Because 799 is no longer a valid ICD-9-CM diagnosis code, effective July 1, 2012 diagnosis 799.9 or any current valid ICD-9-CM diagnosis is required.

## CLAIMS & APPEALS

### Claim Errors versus Medicaid Appeals

The Department has two distinct processes for claims errors and for Medicaid appeals. It is important to follow these guidelines to receive a timely and accurate response.

Please do not submit a Medicaid appeal if:

- Requesting an adjustment. Please submit the SFN 639 located at [www.nd.gov/eforms](http://www.nd.gov/eforms)).
- Resubmitting a correct or new claim form. Please send claims to the address below.
- Sending in missing information, such as notes, charts, Explanation of Benefits (EOB), invoices, etc. for any electronic claim (partially paid, or paid or denied). Please submit the SFN 639 located at [www.nd.gov/eforms](http://www.nd.gov/eforms), with the additional information, to the address below.
- Sending in missing information, such as notes, charts, EOB's, invoices, etc. for partially paid or fully paid paper claims. Please submit the SFN 639 located at [www.nd.gov/eforms](http://www.nd.gov/eforms), with the additional information, to the address below.
- Receiving a denial code on the Remittance Advice (RA) of B6: "This payment is adjusted when performed/billed by this type of provider, in this type of facility, or by a provider of this specialty" Please submit the SFN 639 form located at [www.nd.gov/eforms](http://www.nd.gov/eforms), with the supporting medical documentation, to the address below.

All documentation related to claims should be mailed to:

**North Dakota Department of Human Services  
ATTN: Medicaid Claims  
600 E. Boulevard Avenue, Dept. 325  
Bismarck, ND 58505-0250**

Providers can contact Provider Relations by telephone at 701-328-4043 to resolve claims questions.

### Medicaid Appeals:

Medicaid appeals must be timely. Pursuant to North Dakota Century Code § 24.1-24(2), a provider may request a review of a denial of payment by filing a request for review within 30 days of the date of the department's denial of the claim [i.e. the Remittance Advice (RA) date.] When filing an appeal, please include SFN 168, the North Dakota Medicaid Provider Appeal Form, found at [www.nd.gov/eforms](http://www.nd.gov/eforms). Please include the RA number you are appealing and any other supporting information.

Direct the appeal to:

**North Dakota Department of Human Services  
ATTN: Legal Advisory Unit  
600 E. Boulevard Avenue, Dept. 325  
Bismarck, ND 58505-0250**

If you have any questions on the appeals process, please contact the Legal Advisory Unit of the Department by telephone at 1-800-755-2604.

### Long Term Care Facilities and Recipient Liability

If a Medicaid eligible individual is residing in a nursing facility, intermediate care facility or basic care facility, any recipient liability should be collected by the facility. For Medicaid eligible individuals residing in their home or in a living arrangement other than those listed above, any recipient liability will be applied to claims submitted by providers in the order that they are processed.

### Lab Panel Edits:

Effective January 1, 2013, North Dakota Medicaid implemented lab panel edits for processing professional claims. Per Current Procedural Terminology (CPT), when a lab panel is billed, all components of the lab panel must have been performed; and the CPT® codes within the lab panel cannot be billed separately. If other laboratory tests are performed in conjunction with the lab panel, those tests may be billed in addition to the lab panel.

## PROGRAM INTEGRITY

### Surveillance Utilization Review Section Provider Audits

The Surveillance Utilization Review Section (SURS) conducts quarterly audits in order to determine areas where potential overpayments may exist. These audits have resulted in recoveries, policy creation and policy clarification. SURS is finishing the 3rd quarter audit for 2012, which included Residential Child Care Facility (RCCF) medical care documentation. The 4th quarter 2012 is focusing on Intermittent Urinary Catheter (A4351) utilization with respect to quantities provided to North Dakota Medicaid recipients. Along with these audits, SURS is also conducting analysis of full-body Magnetic Resonance Imaging (MRI), Computed (Axial) Tomography (CT) and Positron Emission Tomography (PET) scans to determine if they are being ordered under appropriate situations.



### Announcement from CMS

ND Medicaid encourages providers to consider reviewing new program modules developed by the Centers for Medicare and Medicaid Services (CMS). The first module, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients," relates to CMS' provider-focused materials in the Fraud Awareness & Prevention Month Toolkit. It is posted at [www.medscape.org/viewarticle/764496](http://www.medscape.org/viewarticle/764496).

The second module, "How CMS is Fighting Fraud: Major Program Integrity Initiatives," describes strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module is posted at [www.medscape.org/viewarticle/764791](http://www.medscape.org/viewarticle/764791).

Continuing medical education (CME) credit can be earned for certain health care professionals. Medscape accounts are free and users do not have to be health care professionals to register for one. Register online at [www.medscape.com](http://www.medscape.com).

### Coordinated Services Program

Coordinated Services Program (CSP) providers must be enrolled with ND Medicaid and must have their National Provider Identification (NPI) number registered with ND Medicaid to be a valid CSP Provider.

- Referrals can be:

faxed to (701-328-1544),  
called in (701-328-2321) or,  
mailed to

Department of Human Services  
600 East Blvd Avenue; Dept. 325  
Bismarck ND 58505-0250.

All referrals must be received prior to the date of service.

- For CSP recipients that are seen in the office by a physician assistant (PA) rather than the physician, please contact the medical services staff to verify that the appropriate authorization is on file. This will help ensure that proper payment is made for the claim and for any prescription written by the PA.
- For any CSP providers that may take an extended leave from the clinic, please contact ND Medicaid so the appropriate update is made to the recipient file. This will help ensure that proper payment is made for the claim and for any prescriptions written by the provider.
- ND Medicaid does not allow back dated referrals for CSP recipients. The CSP provider should fax referrals to ND Medicaid at 701-328-1544. If you have questions about the CSP or about the referral process, please call 1-800-755-2604 or 701-328-2321.



### North Dakota Administrative Code

North Dakota Administrative Code 75-02-05 Provider Integrity, was revised and the changes were effective July 1, 2012. [www.legis.nd.gov/information/acdata/html/Title75.html](http://www.legis.nd.gov/information/acdata/html/Title75.html)



## PROGRAM INTEGRITY—Continued

### Provider Enrollment

Provider enrollment staff has been updating provider files to ensure that a current version of the Medicaid Program Provider Agreement (SFN 615) and an Ownership/Controlling Interest and Conviction Information (SFN 1168) are included in the provider files. Facilities need to ensure that they include the social security numbers and dates of birth for all managing employees, owners, board of directors and individuals who have controlling interest in the facility. The CFR that addresses the requirement for both the social security number and date of birth is 42 CFR §455.104.



### Payment Error Rate Measurement:

The Payment Error Rate Measurement (PERM) review is a federal requirement and every state takes part in a PERM cycle once every three (3) years.

ND Medicaid's first PERM review was fiscal year 2006. The fiscal year 2012 review is currently underway. Randomly selected providers have started receiving requests to provide medical records to the review contractor (A+ Government Solutions). Providers will have 75 days to submit the requested documentation. If no documentation or insufficient documentation is submitted, the claim(s) will be considered an error and subject to recoupment.



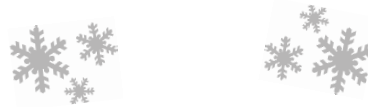
### Recovery Audit Contractor:

The Medicaid Recovery Audit Contractor (RAC), Cognosante, is slated to begin their first phase of audits the first quarter of 2013. The first phase includes reviewing professional claims. If audit recoveries are identified for your entity, you will receive notification that indicates the necessary action to take. To ensure timely communication, if your office, clinic, or facility would like to designate a specific person to receive RAC audit information, please forward that contact

information to Larry Stockham at [lstockham@nd.gov](mailto:lstockham@nd.gov).

If you have questions specific to the RAC audit process, you may contact the Medicaid RAC at the following:

- Toll-free number - (855)637-2212 or (855) NDRAC12.
- Fax Number (701) 281-4300
- Email – [northdakotarac@cognosante.com](mailto:northdakotarac@cognosante.com)
- Website – [www.ndrac.com](http://www.ndrac.com)



## MEDICAID MANAGEMENT INFORMATION SYSTEM

The Department of Human Services (DHS) is beginning the transition to a new Medicaid Management Information System (MMIS). The new MMIS will offer providers a user friendly self-service web portal that has many new features and benefits. The North Dakota MMIS web portal will be implemented in two phases:

- ✦ Phase One: Provider Enrollment
- ✦ Phase Two: Claims Payment

Phase One, Provider Enrollment, is scheduled to go live April, 2013. Additional details and training information will be available in April at: [www.nd.gov/dhs/info/mmis.html](http://www.nd.gov/dhs/info/mmis.html)

The Department is excited to reach this milestone on the MMIS project and we look forward to working with you on the successful implementation of Phase One.



# NORTH DAKOTA MEDICAID POLICY— REVENUE CODE 278



## North Dakota Department of Human Services Medical Services Division North Dakota Medicaid Policy – Revenue Code 278

Available online at : [www.nd.gov/dhs/services/medicalserv/medicaid/docs/rev-code-278-policy.pdf](http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/rev-code-278-policy.pdf)

### **Revenue Code 278: *Medical/Surgical Supplies: Other implants***

**Effective Date: January 1, 2013**

- Code indicates charges for supply items required for patient care
- Revenue code 278 always requires a valid HCPCS on outpatient claims

### **Inpatient Hospital Claims**

[This policy applies to all hospitals reimbursed on a cost-to-charge ratio for inpatient services.](#)

Billed charges over \$15,000.00 for revenue code 278 will require a vendor's invoice to support supplies used that correspond to the services rendered.

The units billed for the revenue code 278 must match the invoice – these units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue code 278 will be denied as a contractual obligation to the provider. If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue code 278 will be denied as a contractual obligation to the provider.

If vendor invoices support the payment of the revenue code 278, claims will be reimbursed at invoice price plus 20 percent.

Hospitals reimbursed on a cost to charge ratio, must submit vendor invoices with the initial submission of the revenue code 278. Without vendor invoices the revenue code 278 will be denied as a contractual obligation to the provider.

Charges billed under \$15,000.00 for revenue code 278 will be audited randomly on post payment review.

### **Outpatient Hospital Claims**

This policy applies to all hospitals reimbursed on a cost-to-charge ratio for outpatient services.

Billed charges over \$3,000.00 for revenue code 278 will require a vendor's invoice to support supplies used that correspond to the services rendered.

The units billed for the revenue code 278 must match the invoice – these units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue code 278 will be denied as a contractual obligation to the provider. If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue code 278 will be denied as a contractual obligation to the provider.

If vendor invoices support the payment of the revenue code 278, claims will be reimbursed at invoice price plus 20 percent.

If no HCPCS code is appended to revenue code 278, it will be denied as a contractual obligation to the provider.

## NEW FACES IN MEDICAID



**Sue Burns, RN, BNSc:** Quality Review Coordinator with Utilization Review works with Out of State Services and State Review. She may be reached at 328-1829 or by email at: [sburns@nd.gov](mailto:sburns@nd.gov).



**Tammy Holm, BSN, RN:** Disability & Durable Medical Equipment (DME) Program Administrator works with State Review and DME. She may be reached at 701-328-2764 or by email at: [tamholm@nd.gov](mailto:tamholm@nd.gov).



**Annette Fischer, RN, BSN** Administrator of Managed Care, Disease Management, the Primary Care Case Management program, and PACE Program. She may be reached at 701-328-3598 or by email at: [afischer@nd.gov](mailto:afischer@nd.gov).



**Cliff Rhodes;** Surveillance Utilization Review Section (SURS) Administrator. He is the point of contact for accident cases, Third Party Liability issues and fraud and abuse referrals. He may be reached at 701-328-4024 or by email at: [cprhodes@nd.gov](mailto:cprhodes@nd.gov).



**Julie Lagro:** Provider Enrollment Specialist. She joins Rhonda Rud as a full-time Provider Enrollment staff. Julie may be reached at [jmlagro@nd.gov](mailto:jmlagro@nd.gov) or 701-328-4176.



**Kathy Rodin:** Administrative Assistant supports several programming areas, and serves as a backup receptionist.



**Symonne Gessle:** Cooperative Office Education Student helps the Administrative Assistant staff.



**Cindy Seado,** Administrative Assistant supports Out of State Services and the Utilization Review Administrator, and serves as a backup receptionist.



Provider Enrollment has two new temporary staff, **Peggy Heid** and **Tammy Keena**. They update all provider files and will be working on provider re-enrollment for the new Medicaid claims processing system.

## 2013 CHECK-WRITE EXCEPTIONS

Typically, check-write occurs every Monday evening; however, the following exceptions will occur from January 2013 through June 2013.

No Check-Write	Rescheduled Date
April 1, 2013	April 2, 2013
May 27, 2013	May 28, 2013



## ENROLLMENT UPDATE

Effective September 1, 2012, North Dakota Medicaid began accepting enrollment applications for clinical nurse specialists (CNS), provider type 46, specialty 76; and physician assistants (PA), provider type 47, and specialty 77. These providers receive an individual North Dakota Medicaid provider number. The enrolled CNS and PA will bill for services they perform and submit claims with their own North Dakota Medicaid provider number, effective for dates of service beginning September 17, 2012.

Effective January 1, 2013, North Dakota Medicaid will no longer allow clinical nurse specialists and physician assistants to submit claims under a supervising physician's North Dakota Medicaid provider number and appending modifier *U2* or *UI*, respectively, to the CPT® code.

Please note, clinical nurse specialists and physician assistants are NOT authorized to be primary care providers in the North Dakota Medicaid Primary Care Case Management program.

To enroll, and receive a provider number for clinical nurse specialists and/or physician assistants, please complete the North Dakota Medicaid provider application available at: [www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-info.html](http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-info.html) and submit with the required license information.

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

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