



MEDICAID BULLETIN

North Dakota Department of Human Services
Medical Services Division
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Bismarck, ND 58505-0261

DAVID J. ZENTNER, DIRECTOR

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PLEASE ROUTE TO BILLING CLERKS, INSURANCE PROCESSORS, SCHEDULERS AND OTHER APPROPRIATE MEDICAL PERSONNEL. PLEASE MAKE COPIES AS NEEDED.

HIPAA Electronic Transaction Update

The Department's contingency expired on June 14, 2004; therefore, only HIPAA compliant transactions are now accepted via electronic transmissions.

We are accepting the following transactions:
837 P (Professional Claims)
837 I (Institutional Claims)
837 D (Dental Claims)

** We are unable to accept electronic ambulance claims at this time, as they require reports to be submitted with the claim.

The Department strongly encourages all providers to perform electronic transactions in order to efficiently exchange health care information. There are several advantages in using electronic transactions for billing, payment funds transfer, etc. Some of the benefits include:

- Reduction in paper, postage and administrative costs.
- Quicker claims turnaround time and faster claims processing amount to improved cash flow.
- Claims entered electronically are edited for accuracy and consistency before being processed. This leads to more accurate claims processing which means less chance your claim will suspend for errors.
- Providers can have more control of claims. This can minimize costly claim submission errors that result in resubmission costs and delay of payment.
- With the Health Insurance Portability and Accountability Act (HIPAA) standards, providers exchange electronic data with multiple entities using the same format structure that increases efficiencies.

We encourage providers to submit electronically, as the claims are processed and paid in a timelier manner. If you have not tested your electronic transactions, please contact Tammy Henderson at 701-328-2325 to schedule an appointment for testing.

Retention Period for Files submitted via the Web

All transaction files posted to the Web File Transfer system will be maintained for 90 days. After that point, they will be purged; therefore, providers must retrieve their incoming transactions within 90 days of posting.

997 Transaction

All providers using the Web File Transfer will be signed up to receive a 997 transaction. This allows each provider to return to the Web to ensure the claim file submitted has been received. Providers are responsible for checking the 997 transaction and ensuring that the file was received.

Checkwrite cut-offs for file receipt:

If you are submitting HIPAA compliant transactions via the Web-File transfer, you must submit your files no later than 2pm, CST on checkwrite (Medicaid payment) days to ensure the files are included.

If you are submitting files via PC-Ace (through Noridian), you must submit your file to Noridian by 1pm, CST on checkwrite days to ensure the file is included.

Local code crosswalks are on the web site. Please note: we cannot accept electronic claims that contain local codes, as they are not HIPAA compliant.

Claredi is a HIPAA validation tool that ensures your claim file will pass through the HIPAA translator. The Claredi validation does not contain the same "business" edits that occur within the MMIS. It is possible that your file will meet the testing requirements of Claredi, but still suspend within MMIS with errors.

General Medicaid Provider Manual Information

The Medical Services Division has begun publishing the General Medicaid provider manual on the web. The following chapters are now available:

| | |
|--|-----------------------|
| Key Contacts | Provider Requirements |
| Medicaid Covered Services | Abortion Services |
| Anesthesiology Services | Chiropractic Services |
| Family Planning Services | Hysterectomy |
| Nurse Midwife Services | Nutritional Services |
| Surveillance Utilization (SURS) Review | |
| Home Health Private Duty Nursing | |
| Human Service Center Services | |
| Medicaid Eligibility of Recipient | |

To view the manual, please visit our web site at: <http://www.state.nd.us/humanservices/providers/>
From this page, select Medical Services. After accepting the statement, you will have access to all Medical Services information.

Additional chapters are being added on an ongoing basis, so check back often!

Billing Updates

Dental Sealants

W1350 is no longer a valid procedure code. Sealants cannot be billed per quadrant as of October 16, 2003. They must be billed per tooth using code D1351.

Routine Exams

V705 (routine exams) is no longer covered, except when billing for sports physicals. If applicable, please indicate the service rendered was a sports physical, next to the procedure code.

EPSDT Screenings

The HIPAA compliant code for a Health Tracks or Early Periodic Screening Diagnosis and Treatment (EPSDT) is S0302. All providers must use this code for screenings billed with dates of service March 1, 2004 or after.

SL replaces XV MODIFIER:

We have replaced the 'XV' modifier that was previously used when billing a vaccine under the Vaccine For Children program. The new HIPAA compliant modifier to be used for dates of service May 1, 2004 and after is the 'SL' (State Supplied Vaccine) modifier. The Vaccines for Children (VFC) Program - provides vaccine to private providers for children through 18 years of age in the following groups: 1) Medicaid eligible; 2) Native American; 3) Uninsured; and, 4) Underinsured who receive services at either a rural health clinic or federally qualified health center.

Residential Treatment Centers

The former local code of 02782 used for residential treatment services has been changed to the HIPAA compliant code of H0019. This is effective for dates of service of September 1, 2004 or after.

Screening Pap-Smear Automated Thin Prep Codes

The screening code G0123 is now covered by North Dakota Medicaid effective for dates of service January 1, 2004 and after.

The fee for the G0123 and the G0124 is \$28.31.

Women's Way Prior Authorizations

Prior authorizations for Women's Way recipients are now on the payment system. If you have been waiting to submit bills, please submit them now. Providers may need to re-bill old services – if the dates of service are over a year old, please send the claims to Juli Johnson, Claims Supervisor.

Home Health Therapies

Home Health agencies are required to bill private insurance prior to billing Medicaid. There is an exception for Medicare. A Home Health provider that renders therapy services to recipients who are both Medicare and Medicaid eligible, must bill Medicare at least annually to receive a denial. Once an Explanation of Benefits (EOB) denial is received from Medicare, the Home Health provider can bill Medicaid for the therapy services. In form locators 32-36 of the UB-92, enter occurrence code 27 and the date of the Medicare EOB.

If the EOB date is more than one year old, North Dakota Medicaid will deny the claim. The Home Health agency will need to re-bill Medicare to receive a new EOB denial.

Services that cover two months:

Due to Eligibility and Recipient Liability, do NOT combine two calendar months on one claim. This does not apply to inpatient Hospital claims.

For example: If service dates are June 17 – July 3, one claim will have dates of service June 17 – June 30 and another claim will have dates of service July 1 – July 3.

Resubmissions and/or Adjustments

When the provider resubmits claims or adjustments for reconsideration of payment they MUST submit supporting documentation (i.e. progress note(s), operative report, discharge summary, etc.).

Resubmitted claims or adjustments submitted without supporting documentation will be DENIED

Nutrition Therapy

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Group (2 or more individual(s)), each 30 minutes

REMINDER: Medicaid will allow four (4) visits per calendar year. Services must be provided by a licensed registered dietitian (LRD) or nutrition professional meeting certain requirements.

For medical nutrition therapy assessment and/or intervention performed by a physician, see the E/M or Preventive Medicine codes (per CPT 2004).

For a list of the *covered diagnosis codes* for Medical Nutrition Therapy please see MEDICAID CODING GUIDELINES on our website at:

<http://www.state.nd.us/humanservices/providers/>

From this page, select Medical Services. After accepting the statement, you will have access to all Medical Services information.

Endometrial Ablation

58353 Endometrial ablation, thermal, without hysteroscopic guidance

58563 Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electro-surgical ablation, thermoablation)

CRITERIA: Verification of a procedure* to rule out malignancies must be performed prior to the date of the endometrial ablation (within the preceding 12 months).

* Endometrial biopsy; Endometrial curettage; D&C-diagnostic or therapeutic; Hysteroscopy - diagnostic or therapeutic. A pathology report must be available to support one of these procedures.

NOTE: Only one endometrial ablation per lifetime will be allowed.

COVERED DIAGNOSIS

626.2 Excessive or frequent menstruation; menometrorrhagia, menorrhagia

626.8 Dysfunctional or functional uterine hemorrhage NOS

Please go to NDDHS website to view other Medicaid Coding Guidelines:

<http://www.state.nd.us/humanservices/providers/>

From this page, select "Providers", then Medical Services. After accepting the statement, you will have access to all Medical Services information

Ambulatory Surgical Center Code Additions and Deletions

The following Ambulatory Surgical Center (ASC) procedures have been added/deleted from the list of payable ASC procedure codes effective for services performed on or after January 1, 2004.

ASC Additions

| Procedure Code | Payment Group |
|----------------|---------------|
| 36555 | 01 |
| 36556 | 01 |
| 36557 | 02 |
| 36558 | 02 |
| 36560 | 03 |
| 36561 | 03 |
| 36563 | 03 |
| 36565 | 03 |
| 36566 | 03 |
| 36568 | 01 |
| 36569 | 01 |
| 36570 | 03 |
| 36571 | 03 |
| 36575 | 02 |
| 36576 | 02 |
| 36578 | 02 |
| 36580 | 01 |
| 36581 | 02 |
| 36582 | 03 |
| 36583 | 03 |
| 36584 | 01 |
| 36585 | 03 |
| 36589 | 01 |
| 36590 | 01 |

ASC Deletions

| Procedure Code | Payment Group |
|----------------|---------------|
| 36488 | 01 |
| 36489 | 01 |
| 36490 | 01 |
| 36491 | 01 |
| 36530 | 03 |
| 36531 | 02 |
| 36532 | 01 |
| 36533 | 03 |
| 36534 | 02 |
| 36535 | 01 |

Self-Administered drugs

North Dakota Medical Assistance does not cover self-administered drugs. If the cost of the self-administered drug is included in the rate for any outpatient observation setting, it cannot be charged to the patient. The cost of the self-administered drug can be written off by the facility.

Chiropractic Services

Payment for manual manipulations of the spine is limited to one manipulation per day and may not exceed 12 manipulations per calendar year. An office visit for manual manipulation of the spine is considered part of the payment for manual manipulation and cannot be billed separately to Medicaid recipients.

Psychiatric Services Provided to Individuals Under 21

Inpatient psychiatric services provided under the direction of a physician to the under 21 population require a certificate of need review regardless of the length of stay. This federal requirement applies to a psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a psychiatric facility that is not a hospital and is accredited by JCAHO or any other accrediting organization with comparable standards.

Days that are not authorized by Dual Diagnosis Management (DDM) and admissions that occur for evaluation and observation by the facility to determine whether the individual requires an acute stay are not a covered Medicaid service and cannot be billed as inpatient or observation.

Billing the recipient for non-covered services would be appropriate provided the recipient was so informed prior to the receipt of services. Questions may be directed to Joan Ehrhardt at 701-328-4864.

Check out the Easy-To-Use E-Forms And Provider Manuals

The following forms are online and fillable at <http://www.state.nd.us/eforms/> or you can access <http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider.html> and click on the heading 'Online Forms'.

SFN 15 Home Health Request for Prior Authorization
SFN 481 Service Limits Prior Authorization Request
SFN 509 Out of State Enrollment Clarification
SFN 614 Physician Certification for Hysterectomy and Recipient Acknowledgement of Sterility
SFN 615 Medicaid Program Provider Agreement
SFN 620 Non-Medical Provider
SFN 634 Claim Form - Drug/Pharmacy
SFN 639 Provider Request for an Adjustment
SFN 640 Pharmacy Request for an Adjustment
SFN 661 Electronic Funds Transfer (EFT) Form

SFN 662 Personal Care Services Plan
SFN 705 Health Tracks Appointment Slip
SFN 710 Health Tracks Referral and Request for Information
SFN 850 Proton Pump Inhibitor Prior Authorization
SFN 851 Anti-Histamine Prior Authorization
SFN 871 ND Health Tracks Screening Results
SFN 905 Technology/Procedure Assessment
SFN 973 Enrollment Questionnaire
SFN 989 Sterilization Consent
SFN 1115 Prior Authorization Request
SFN 1169 Pharmacy Agreement/Medical Assistance Program
SFN 1818 MCH/Health Tracks Health History
SFN 1819 MCH/Health Tracks Pediatric Assessment

The following **provider manuals** are located on the web:

Ambulatory Behavioral Health Care for Adults
(Recently Revised – see web site)
Ambulatory Behavioral Health Care for Children and Adolescents **(Recently Revised – see web site)**
Dental Manuals
Durable Medical Equipment Provider Manual
General Information for Providers
Nursing Facility Rate Manual
Pharmacy Provider Manual

The following **billing manuals** are located on the web:

ND Medicaid CMS-1500 Claim Form Billing Instructions
ND Medicaid CMS-1500 Claim Form Billing Example
ICF/MR Billing Procedures
Long Term Care Nursing Facilities (In-State)
Long Term Care Nursing Facilities (Out-of-State)
Swing Bed Facilities Billing Manual

Physical Therapy and Occupational Therapy Fee Changes

Please note the following fee changes effective for dates of service June 1, 2004 and after.

97001 – Physical therapy evaluations - \$55.00
(limit 1 per year)
97002 – Physical therapy re-evaluations - \$35.00
(limit 1 per year)
97003 – Occupational therapy evaluations - \$55.00
(limit 1 per year)
97004 – Occupational therapy re-evaluation - \$35.00
(limit 1 per year)

LTC Preadmission Activities and Certificate of Need for the Under 21 Programs

Dual Diagnosis Management (DDM) has been providing preadmission and certificate of need services for the Medical Services Division since July 1, 2003. Medical Services has received many favorable comments from providers regarding the responsiveness of service delivered by DDM. The current average response time from the receipt of faxed reviews to the verbal determination to the provider is as follows:

Level I: 1.87 hours (Contractual requirement is within 6 business hours)

Level II: 5 business days (Contractual requirement is within 5 business days. CMS allows an annual average of 7 to 9 business days)

Level of Care Determination: 1.64 hours (Contractual requirement is within 6 business hours)

CON Under 21 admission reviews and continued stay reviews: 1.84 hours (Contractual requirements of within 1 business day)

Tracking requests: requested information is sent in less than 2 business days (Contractual requirement is within 2 business days)

DDM is very approachable to problem solving and welcomes any issues you may have. Karen Peterson, ND Clinical Manager, with DDM is the contact person for troublesome issues/problems that may occur. She is available at 1-877-431-1388, extension 242. Joan Ehrhardt with Medical Services is also available at 701-328-4864. Claims payment problems should be referred to Medical Services. Contact persons are Joan Ehrhardt or Laura Holzworth at 701-328-4035.

Topical Fluoride Application (Varnish)

Effective for dates of service July 1, 2004 and after North Dakota Medicaid (NDMA) will cover the topical application of fluoride (prophylaxis not included) for **children**, age six (6) months to three (3) years. A maximum of two (2) applications per year will be allowed. It is highly recommended that this service be rendered during a well child check versus a separate visit. The following professionals can apply the topical fluoride, after receiving the appropriate training: physician, nurse practitioner, physician assistant and registered nurse*.

CDT code: D1203 – Topical application of fluoride (prophylaxis not included) – **child**

Covered ICD-9-CM code: V07.31 – Prophylactic fluoride administration

*The registered nurse must work under the direct supervision of the physician and the claim must be submitted under the physician's provider ID number (PIN).

EXEPTION: NDMA will reimburse topical fluoride varnish application when rendered by a registered nurse in the Public Health clinics without the direct supervision of a physician. They must have verification that they completed the **Dental Health Screening and Fluoride Varnish** application course. You can access this course via the Internet, at meded1.ahc.umn.edu/fluoridevarnish/

NOTE: This service is presently covered when rendered by a dentist.

Please go to NDDHS website to view this and other Medicaid Coding Guidelines:

<http://www.state.nd.us/humanservices/providers/>

From this page, select Medical Services. After accepting the statement, you will access to all Medical Services information.

Licensed Independent Clinical Social Worker

Effective July 1, 2004 a Licensed Independent Clinical Social Worker (LICSW) can enroll as a provider with North Dakota Medicaid.

LICSW's can render and bill for services covered by Medicaid and within their scope of practice.

Services provided by a LICSW do not require a PCP referral; however, services are subjected to the same limits as psychological visits (40 per year).

For enrollment information, please contact Rhonda Rud at 328-4033 or dhselement@state.nd.us

Minimum Data Set (MDS) Submission

The Department has begun efforts to transition the submission of the MDS information from the Expedite system to a Web-File Transfer system. The transition is expected to be complete by the end of the calendar year.

Nursing facilities will be receiving a separate letter with the necessary information and forms.

Nurse Practitioner, Nurse Midwife, Licensed Clinical Social Worker

When you bill NDMA for services as an enrolled provider, with **your** Medicaid provider number, you **should not** append the procedure (CPT) code with a modifier: SA – nurse practitioner; SB – nurse midwife; AJ – licensed clinical social worker).

When you are working under the general supervision of a physician (MD/DO) and billing NDMA under the physician's Medicaid provider number, you **MUST** append the procedure (CPT) code with the appropriate modifier.

Please refer to the enclosed Provider Enrollment chart for further clarification.

NOTE: The physician assistant, nurse practitioner, or clinical nurse specialist rendering services as assistant at surgery **MUST** append the procedure (CPT) code(s) with modifier -AS.

Approval for Out of State Services

Out of State services at sites more than fifty miles from the North Dakota border must be authorized PRIOR to the service being received. Physicians must send a referral letter to North Dakota Medicaid asking for authorization.

Even if a Medicaid recipient has primary insurance, such as Medicare or Blue Cross/Blue Shield, they must obtain an authorization from Medicaid to receive services out of state. If approval is not received, it may result in Medicaid denying claims for out of state services that are submitted.

Upon a physician sending a prior authorization request, along with appropriate documentation, the request will be reviewed and the recipient, the requesting physician, the out of state provider, and the county will receive a letter of approval or denial.

Travel expenses for out of state services must also be prior approved. Once approved, County Social Service Staff are responsible for assisting recipients with travel, lodging, and meal arrangements.

Please remember to allow 2 weeks for review of requests.

Flu Vaccine and FluMist Updates

Effective for dates of service September 1, 2004 Medical Services will reimburse for the Flu Vaccine and FluMist as follows:

Flu Shot

Use 90471 to bill for flu vaccine **administration**. The Medicaid allowed fee for the administration is \$8.00. This code must be billed with an immunization code.

Use 90655 and 90657 with the SL modifier for flu vaccines administered to children 6 months through 35 months. Medicaid does NOT pay for the vaccine, as it is available through the Vaccines for Children (VFC) Program. The vaccine code must appear on the claim accompanied by the administration code (90471).

Use 90658 for flu vaccines administered to persons over 3 years of age.

For children 3 through 18, use the SL modifier. Medicaid does NOT pay for the vaccine, as it is available through the Vaccines for Children (VFC) Program. The vaccine code must appear on the claim accompanied by the administration code (90471).

For adults 19 and over, DO NOT use the SL modifier. (These patients do not qualify for State supplied vaccine.) The Medicaid allowed fee for the non-State supplied flu vaccine is \$7.00

FluMist

Medicaid will cover the FluMist code (90660) at the same rate paid for the Flu shot (\$7.00). There will be no administration fee paid.

Check the Medical Services web site for updates on this and other vaccination updates.

Dental Manual Revised

The North Dakota Medicaid Dental Manual has been revised and distributed to Dental providers. To view a copy of the manual, please visit our web site at: <http://www.state.nd.us/humanservices/providers/>

Update on Office Limits and Lab/ X-ray Copays

North Dakota Medicaid has indefinitely postponed the implementation of the Office Visit Limits (12/year) and the Lab/X-ray copays (\$1 per test).

Children's Special Health Services Program (CSHS)

CSHS GENERAL INFORMATION

Diagnostic Services - CSHS pays for health care visits and tests needed to diagnose many chronic conditions seen in children. This service helps identify children with chronic illnesses or disabilities as early as possible so they can get the help they need. To qualify, children must be suspected of having a CSHS-eligible condition. There is no financial eligibility requirement for diagnostic services; however, insurance or other sources of health care coverage are used when available.

Treatment Services – CSHS pays for specialty care that is needed to treat an eligible condition. Services that CSHS might help pay for could include visits to a pediatric specialist, therapies, medications, etc. To qualify, children must have a CSHS-eligible condition. Families must also meet income eligibility guidelines currently set at 185% of the federal poverty level. Families with incomes over 185% may still be eligible with a monthly cost share. Insurance or other sources of health care coverage are used when available. Health visits must be made with a specialist who is approved to provide services through CSHS.

CSHS BILLING INFORMATION

Services need to be billed on a HCFA 1500, UB92, ADA (Dental) or pharmacy claim form. CSHS cannot reimburse for services from a billing statement or invoice received from a provider. These will be returned to you and you will be asked to submit charges on the appropriate claim form.

Modifiers need to be utilized when appropriate. Services performed by CRNA's, Nurse Practitioners, Anesthesiologists and Physicians Assistants always require a modifier. Utilize the same modifiers for the above services as required by ND Medicaid.

CSHS uses the same provider number assigned to your facility group and/or physician by Medicaid. Enter the provider number in the appropriate blocks on the claim forms.

CSHS is the secondary payer when clients have a primary insurance. Attach the appropriate explanation of benefits (EOB) to each claim. You must complete the prior payment fields on each claim with the balance due. Claims received with missing or incomplete information will be returned for correction.

A medical report is required prior to reimbursement. The medical reports are reviewed to assure services are related to the child's eligible condition. Attach the medical reports for the date of service listed on the

claim(s) to the HCFA 1500 and UB92 forms. A complete list of eligible conditions can be found on our website at www.state.nd.us/humanservices, then click on 'Medicaid and Other Medical Services.'

CSHS PHARMACY CLAIMS

Providers that submit claims electronically will need to use BIN # 610110. All physicians and pharmacy identifiers will remain as ND Medicaid provider ID numbers (Do not use the NABP number). To submit CSHS claims, copy the specifications from your current ND Medicaid billing parameters to your new third party file for the above BIN #. After submitting your first claim, you will be prompted to call the switch and register for Medicaid. After you call your switch and provide them with your ND Medicaid provider number, you will be able to submit claims and receive responses from Medicaid as before.

All pharmacy claims will suspend/capture for review as CSHS only covers services related to the child's eligible condition. At the time the claim suspends/captures, the medications will be reviewed to assure they are prescribed for the client's eligible condition.

CSHS SPECIALIST LIST

A complete list of specialists enrolled with CSHS can be found on our website. Specialists who wish to enroll can contact the state CSHS office for more information.

Family Practice physicians may be reimbursed if the services performed are in conjunction with a specialist or if the services are an emergency.

CSHS OPTOMETRIC SERVICES

Strabismus is a covered condition for children through age ten (10). Initial exams can be covered through Diagnostic Services. Office visits, patches, and surgery can be covered through Treatment Services.

CSHS will cover dilated eye exams for children with Diabetes over the age of ten (10).

CSHS ELIGIBILITY/CLAIMS ISSUES

Contact the state CSHS office with any questions regarding eligibility or billing at (701) 328-4815 or toll-free at 1-800-755-2714. Information may be faxed to our office at (701) 328-1645.

Ambulance Service Updates

North Dakota Medicaid requires notification of all emergency transfers to out of state facilities within 48 hours of the transfer. If a transfer involves another 3rd party payer, Medicaid must still be notified.

The new HIPAA compliant ambulance codes went into effect for dates of service August 1, 2004 or after. The fees for the base codes were increased as the fees include supplies. For claims that cover ALS transfers, pharmacy drugs can be billed with appropriate J-codes.

The new ambulance codes are available on the website at: <http://www.state.nd.us/humanservices/providers/> From this page, select Medical Services. After accepting the statement, you can access all Medical Services information.

Payment Accuracy Measurement (PAM) Pilot

North Dakota Medical Services is currently participating in Year 3 of the Payment Accuracy Measurement (PAM) Pilot. The pilot has offered State Medicaid offices the opportunity to help the Centers for Medicare and Medicaid services design a process to review claims payments and recipient eligibility. The finalized process, which will be known as Payment Error Rate Measurement (PERM) is slated for implementation in Federal Fiscal Year 2006. Proposed regulations on the specifics of the PERM process were published in the Federal Register on August 27, 2004.

During the first two years of the pilot, North Dakota Medical Services tested the accuracy of the Fee for Service payments. The accuracy rates for Year 1 and 2 were 98.71 and 99.35%, respectively.

If you have questions about the pilot project or the upcoming PERM implementation, please contact Maggie Anderson at 701-328-2321.

MMIS Replacement Project

During the 2003 Legislative Session, the Department received an appropriation for the planning phase to replace the existing Medicaid Management Information System (MMIS). The current MMIS is over 25 years old and its age and structure is problematic for daily use. It is also not conducive to incorporating new technology.

The planning phase consists of defining requirements for a new system, reviewing the cost and benefit of several

replacement options, and preparing a Request for Proposal for the replacement.

The Department will be requesting the appropriation for the MMIS replacement during the 2005 Legislative session, with rollout of a new system slated for 2007.

Third Party Payment

Third Party Payment Billing

If using the HIPAA 837 transaction to bill, a provider can enter the COB amounts using the segments in Loop 2320 (contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber). By billing COB payments using the 837 transaction, our system is able to differentiate between the prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. The system will calculate Medicaid's liability and distinguish the actual patient responsibility and contractual obligations per detail line.

Third Party Payment Adjustments

If you are submitting an adjustment form (SFN 639) because of a correction or change to 'other insurance' payments from a primary payer, please submit a new corrected claim form with the revised 'other insurance' amounts on the claim along with the adjustment form. On the adjustment form, you must indicate to deny the original submission and reprocess the corrected, attached claim through the system. This is the only way to get the correct 'other insurance' amounts considered by our system and will speed the processing of your corrected bill.

Interim Final Rule - Physician Self-Referrals

The Centers for Medicare and Medicaid Services has issued an Interim Final Rule, which addresses physician self-referrals. The Rule became effective July 26, 2004.

According to a press release from CMS, "The physician self-referral law prohibits a physician from referring Medicare and Medicaid patients for certain designated health services* to entities with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies."

A financial relationship can be with either a compensation arrangement or an ownership or investment interest, and it can be either direct or indirect.

* The designated health services include:

- ◆ clinical laboratory services
- ◆ physical therapy services
- ◆ speech-language pathology services
- ◆ occupational therapy services
- ◆ radiology and certain other imaging services
- ◆ radiation therapy services and supplies
- ◆ durable medical equipment and supplies
- ◆ parenteral and enteral nutrients, equipment and supplies
- ◆ prosthetics, orthotics, and prosthetic devices and supplies
- ◆ home health services
- ◆ outpatient prescription drugs
- ◆ inpatient and outpatient hospital services

If you have questions about this regulation, please contact Ray Feist at 701-328-4024.

Medifax and Verify

The Medifax and Verify systems are used to obtain patient information such as:

- Eligibility
- Recipient Liability
- Primary Care Provider or Managed Care Organization requirement and selection
- Coordinated Service Program Provider
- Co-pays
- Third Party Liability
- Dental allowance benefits
- Vision allowance benefits

VERIFY is a telephone response system that uses instructional prompts for providers to obtain patient information. The VERIFY telephone numbers are 701-328-2891 or 1-800-428-4140. A reminder that a repeat function is available which is activated by pressing the pound key (#) on the touch pad of the telephone.

Medifax EDI is a Medicaid ID card-swipe system that provides online access to critical patient eligibility and benefit information. With the development of the HIPAA 270 and 271 transaction, some changes were implemented in the Medifax format to become HIPAA compliant. To obtain a guide on accessing the database on North Dakota Medicaid Eligibility/Benefits, please go to the following website: <http://www.medifax.com>.

Billing Modifiers Updated

The North Dakota Department of Human Services (NDDHS) is a covered entity under HIPAA as a payer of health care services and must comply with the Administrative Simplification provisions. The federal

Health Insurance Portability and Accountability Act (HIPAA) requires all payers to use current, valid modifiers and replace invalid or local modifiers. Covered entities must use standard code sets (and, therefore, may not use local or invalid modifiers) in conducting covered transactions. The Department's Medicaid Management Information System (MMIS) previously used modifier code sets that would not comply with HIPAA EDI provisions.

The North Dakota Medicaid state specific/invalid modifiers will be replaced with new, nationally recognized modifiers. For dates of service on or after July 1, 2004, you will be required to begin using these national standard modifiers. For dates of service before July 1, 2004, you would continue to bill with the old modifier code set you have always used.

Please note: If you bill electronically under a national HIPAA EDI transaction, you cannot bill invalid or ND Medicaid state specific local modifier(s) regardless of the date of service. These modifiers will not be accepted through our validation process as HIPAA compliant. You would need to bill any dates of service older than July 1, 2004 on paper if using an invalid modifier.

Following is a list of the modifiers that are invalid and the new modifiers that should now be used. Please note that you need to bill for the service rendered using the nationally recognized code set.

Claims with missing or invalid modifiers will be denied. The change to valid HIPAA compliant modifiers will affect all claims with dates of service July 01, 2004 and after. Please refer to the nationally recognized HIPAA code sets for complete descriptions of the modifiers.

New Modifiers

53, 74, 91, A1, A2, A3, A4, A5, A6, A7, A8, A9, AX, BA, BO, CA, CB, EY, G7, G8, G9, GF, GG, GK, GL, GM, GQ, GU, GV, GW, GY, GZ, H9, HA, HB, HC, HD, HE, HF, HG, HH, HI, HJ, HK, HL, HM, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HW, HX, HY, HZ, JW, KF, KR, KX, KZ, QV, SA, SB, SC, SD, SE, SH, SJ, SK, SL, SM, SN, SQ, ST, SU, SV, SW, TD, TE, TF, TG, TH, TJ, TK, TL, TN, TP, TQ, TR, TS, TT, TU, TV, TW, U1, U2, UF, UG, UH, UJ, UK, UN, UP, UQ, UR, US

Invalid Modifiers after 07/01/2004

20, 27, 86, 87, 97, AB, AC, AE, AF, AG, AK, AL, AN, AY, DD, KC, KD, KE, KF, KG, KK, KL, MP, Q1, QO, QR, SP, YY, ZX, ZY, ZZ

Invalid Modifiers after 05/01/2004

'XV' (invalid for DOS 05/01/2004)
'SL' Modifier replaced.

| OLD MOD | OLD DESCRIPTION | NEW MOD | NEW DESCRIPTION |
|----------------|---|----------------|---|
| 27 | TECHNICAL COMPONENT | TC | TECHNICAL COMPONENT |
| 59 | RENTAL | RR | RENTAL |
| | | 59 | (Please note, MOD 59 has new meaning: DISTINCT PROCEDURAL SERVICE) |
| 86 | PA SERVICES FOR OTHER THAN ASSISTANT-AT-SURGERY, NON-TEAM MEMBER | U1 | <State defined> PHYSICIAN ASSISTANT (PA) SERVICES FOR OTHER THAN ASSISTANT-AT-SURGERY, OFFICE |
| 87 | PHYSICIAN ASSISTANT, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST SERVICES FOR ASSISTANT AT SURGERY | AS | PHYSICIAN ASSISTANT, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST SERVICES FOR ASSISTANT-AT-SURGERY |
| 97 | AMBULATORY SURGICAL CENTER (ASC) FACILITY SERVICE | SG | AMBULATORY SURGICAL CENTER (ASC) FACILITY SERVICE |
| AK | NURSE PRACTITIONER, RURAL, TEAM MEMBER | SA | NURSE PRACTITIONER... |
| AL | NURSE PRACTITIONER, NON-RURAL, TEAM MEMBER | SA | NURSE PRACTITIONER... |
| AN | PA SERVICES FOR OTHER THAN ASSISTANT-AT-SURGERY, NON-TEAM MEMBER | U1 | <State defined> PHYSICIAN ASSISTANT (PA) SERVICES FOR OTHER THAN ASSISTANT-AT-SURGERY, OFFICE |
| AU | PHYSICIAN ASSISTANT FOR OTHER THAN ASSISTANT-AT-SURGERY, TEAM MEMBER | U1 | <State defined> PHYSICIAN ASSISTANT (PA) SERVICES FOR OTHER THAN ASSISTANT-AT-SURGERY, OFFICE |
| AW | CLINICAL NURSE SPECIALIST, NON-TEAM MEMBER | U2 | <State defined> CLINICAL NURSE SPECIALIST (CNS) |
| AY | CLINICAL NURSE SPECIALIST, TEAM MEMBER | U2 | <State defined> CLINICAL NURSE SPECIALIST (CNS) |
| | | | |
| XV | STATE SUPPLIED VACCINE | SL | STATE SUPPLIED VACCINE |

North Dakota Department of Human Services
Medical Services
Guidelines for Submission of Paper Claims

September 2004

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.

1. Use only blue or black ink. Do not use Red ink to complete claims.
2. Make sure the ink is dark enough to be picked up by the scanner. Times New Roman font is preferred.
3. All information must be legible, typed or printed, and within the boxes.
4. Do not use highlighter on claims or attachments.
5. 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.
6. Do not staple any items. This includes two-page claims and attachments.
7. Do not submit carbon copies of claims or attachments.
8. Do not submit two-sided documents.
9. 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 different claim.
10. 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.
11. Do not use dashes or slashes in the Recipient ID, Patient Account Number or other fields.
12. The Revenue Code cannot be greater than three positions. Do not enter a leading zero.
13. If there is an individual doctor's name in the provider area, the last name MUST be first.
14. 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.

**North Dakota Department of Human Services
Medical Services
Definitions of Direct and General Supervision**

Direct Supervision

Office Setting: Direct supervision in an office setting means that the physician (MD, DO) must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service. However, the physician does not need to be physically present in the same room as his/her/clinic employee.

Physician Directed Clinic: In clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians, as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by the employee are covered even though they are performed in another department of the clinic. The service would be billed under the PIN of the supervising physician.

General Supervision

General supervision means that the enrolled Provider need not be physically present at the facility the service is rendered but must be immediately available by phone or by other means of communication. However, the service must be performed under his/her overall supervision and control and the following criteria must be met.

1. The service is an integral part of the enrolled Provider's services to the patient;
2. The services are reasonable and necessary, and not otherwise excluded from Medicaid coverage.

An enrolled Provider cannot hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under state law, or whose professional qualifications exceed those of the "supervising" provider.

Addendum: This is not part of the definition, however this is an example of how we would apply this definition to LICSW/LCSWs working under the direct supervision of a physician.

Services rendered by the LICSW/LCSW under the direct supervision of the physician must bill for his/her services under the supervising physician's PIN and append the procedure (CPT) code with modifier -AJ (clinical social worker)

This document supercedes all previous information distributed by the Department related to Provider Enrollment and Supervision.
