

PROVIDER MANUAL FOR

OPTOMETRIC AND

EYEGLOSS SERVICES

Ophthalmologists, Optometrists,
Opticians and Eyeglass Providers



Published By:

Medical Services
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Bismarck, ND 58505

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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@nd.gov

Provider Relations

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

(800) 755-2604
(701) 328-4043

Send written inquiries to:

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

Prior Authorization

For prior authorization, print the [Vision Services Pre-Authorization](#) form on our website or from Page 11 of this Manual and fax to:

Medicaid Prior Authorization
ND Dept of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

FAX: (701) 328-1544

Claims

Send paper claims to:

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

Eyeglass Contractor

Walman Optical Company is under contract with DHS to provide eyeglasses to Medicaid clients. Providers should call VERIFY to ensure the client is eligible for eyeglasses or visit the Medifax website at www.medifax.com for additional information for online eligibility options.

(800) 428-4140 VERIFY phone #
(701) 328-2891 VERIFY phone #

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for Provider Enrollment:

(800) 755-2604

(701) 328-4033

HIPAA/EDI Electronic Data Interchange

For questions regarding electronic claims submissions:

701-328-2325

Provider Information Website

<http://www.nd.gov/dhs/>

- Updates for Providers
- Provider manuals
- Fee schedules
- Forms – [Vision Prior Authorization Form](#)
- Provider enrollment
- Newsletters
- Links to other websites



VERIFICATION OF ELIGIBILITY

ND VERIFY

VERIFY is a recipient eligibility verification system provided by the ND Medicaid program for providers. This system allows the provider to enter the patient identification number using a touchtone telephone and receive a verbal response from the computer indicating the name and date of birth of the patient; the patient's eligibility for a given date of service; Coordinated Services Program information; existence of any third party liability (TPL); and if so, the name of the TPL carrier and the TPL policy number; amount of recipient liability, if any; co-pay; date of last eye exam, frames and lenses, and also the name of the primary care provider (PCP). All responses reflect the latest information available on the data base at the time of the call.

MEDIFAX

Eligibility may be checked at the following Web site: <http://www.medifax.com>.

CSHS AND VR

Children's Special Health Services (CSHS) and Vocational Rehabilitation (VR) eligibility information is not available on the VERIFY or MEDIFAX systems. Eligibility for VR recipients must be determined by contacting the regional VR office. Eligibility for CSHS recipients must be determined by contacting the state CSHS office.

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program available to eligible North Dakota women. Women who are in active treatment for cancer and are ND Medicaid eligible through Women's Way coverage are entitled to full ND Medicaid benefits. Women's Way eligibility information is not available on the VERIFY or MEDIFAX systems. Women's Way recipient identification numbers begin with WW000000. Questions on Women's Way eligibility can be directed to Provider Relations at 701-328-4030.



COVERED SERVICES

GENERAL COVERAGE PRINCIPLES

This manual provides covered services information that applies specifically to ophthalmologists, optometrists, and opticians. It also covers information for the prescription of corrective lenses. Like all health care services received by Medicaid clients, services provided by these practitioners must also meet the general requirements. Please refer to the [General Information for Providers](#) manual.

SERVICES WITHIN SCOPE OF PRACTICE

Services are covered when they are within the scope of the provider's practice, and are also a covered service by North Dakota Medicaid.

DISPENSING SERVICES

Dispensing services may be provided by ophthalmologists, optometrists, and opticians.

SERVICES FOR CLIENTS WITH LIMITED MEDICAID COVERAGE

Medicaid generally does not cover eye exams or eyeglasses for clients with Qualified Medicare Beneficiary (QMB) coverage. Always check client eligibility before providing services. However, Medicaid may cover eye exams for these clients under the following conditions.

- **Following cataract surgery.** Clients who have QMB only coverage are only eligible for eyeglasses following cataract surgery when Medicare approves the eyeglasses claim. Medicaid considers the Medicare coinsurance and deductible for this claim
- **Diabetic diagnosis.** Medicaid covers eye exams for clients **with basic Medicaid coverage**, not QMB, who have a diabetic diagnosis (see following table). Eyeglasses are not covered for these clients.

- **Medically Necessary Eye Examinations.** Medicaid covers eye exams for clients **with Basic Medicaid coverage**, not QMB, who have certain eye conditions (see following table). Eyeglasses are not covered for these clients.

NON-COVERED SERVICES

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational.
- Dispensing fees for a client who is not eligible for lenses and/or frames within the two (2) year time period for adults, one (1) year for children.
- Services that the provider did not personally provide. The main exception is that the dispensing service may be performed by the provider's employee when it is allowed by law.

IMPORTANCE OF FEE SCHEDULES

The easiest way to verify coverage for a specific service is to check the Department's fee schedule. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Use the current fee schedule for your provider type to verify coverage for specific services.

Current fee schedules are available on the Provider Information website <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html>.

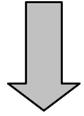
RETROACTIVE ELIGIBILITY

Medicaid **does not cover eyeglasses** for clients who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, Medicaid does cover eye exams for retroactively eligible clients. For example, suppose that a client had an **eye exam** and purchased eyeglasses on July 15. On September 1, the Department determined the client was eligible for Medicaid retroactive to July 1. Medicaid would pay for the eye exam but not for the eyeglasses.



COVERAGE OF SPECIFIC SERVICES

The following are coverage rules for specific services provided by ophthalmologists, optometrists, and opticians. Due to limits on exams and eyeglasses, before providing these services, the provider should contact VERIFY or Medifax to ensure the client is currently eligible for an exam and to verify the client is eligible for eyeglasses. Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor. All services are subject to post payment review and payment recovery if they are not medically necessary.

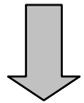


Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor.

CONTACT LENSES – PRIOR AUTHORIZATION AND INVOICE REQUIRED

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees. The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. When billing for services after prior approval has been obtained, the claim must be submitted with an invoice. Medicaid covers contact lenses when the client has one of the following conditions:

- Keratoconus
- Sight that cannot be corrected to 20/40 with eyeglasses
- Aphakia
- Anisometropia of 2 diopters or more



If a provider does not check eligibility prior to an exam, and the claim is denied because the client's exam limit was exceeded, the provider cannot bill Medicaid or the client.

EYE EXAMS

Medicaid clients ages 21 and over are limited to one eye examination and refraction every two (2) years. Medicaid clients ages 20 and under are limited to one eye examination and refraction every 365 days. The Department allows exceptions to these limits when one of the following conditions exists. Prior authorization is required.

- Following cataract surgery, when more than one exam during the respective period is medically necessary.
- Adult diabetic clients may have exams every 365 days.

EYEGLOSS SERVICES

Adults ages 21 and older are eligible for eyeglasses every two (2) years. Children ages 20 and under are eligible for eyeglasses every 365 days.

- If the client has a diagnosed medical condition that prohibits the use of bifocals, an exception may be made allowing eyeglasses to be dispensed outside of the limit requirement. Providers are required to submit a prior authorization. The provider must document the client's inability to use bifocals.

FRAME SERVICES

The eyeglass contractor will provide a list of Medicaid-covered frames to dispensing providers.

Medicaid clients have the option of using their "existing frames" and Medicaid will cover lenses. The existing frame is a frame that the client owns or purchases. When a client chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame, but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.
- Code 92370, repair and refitting of spectacles, requires prior authorization.

Lens Add-Ons		
Lens Feature	Medicaid Covers For Children (Ages 20 and Under)	Medicaid Covers For Adults (Ages 21 and Older)
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary with Prior Authorization	Yes – if medically necessary with Prior Authorization
Photochromic - Glass (i.e. photogray, photo-brown)	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Progressive	No	No
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes	Yes
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	No
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Ultraviolet	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Slab-off and fresnell prism	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the eyeglass contractor's normal and customary charges.

LENS STYLES AND MATERIALS

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 28
- Round 22
- Flattop trifocals 7 x 28
- Executive style bifocals

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonates

REPLACEMENT LENSES AND FRAMES

All frames provided by the Medicaid eyeglass contractor carry a 12-month manufacturer warranty on replacement fronts and temples. Medicaid clients must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses or breaks his or her eyeglasses within the 24 months, Medicaid will not cover another pair.

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, Medicaid will replace one pair of eyeglasses within the 12 month period. All replacement requests must be prior authorized by the Medicaid office.

EYEGLOSS ORDERING PROCEDURES

Providers must complete the North Dakota Medicaid Rx form to order eyeglasses from the Medicaid eyeglass contractor.

Prescription change is used when a lens is ordered due to a prescription change, which meets Medicaid guidelines.

SUBMITTING THE MEDICAID RX FORM

- Mail or fax the order form to the Medicaid eyeglass contractor. Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.
- Errors in the fabrication of eyeglasses made by the Medicaid eyeglass contractor will be corrected by the contractor at no additional charge.



PRIOR AUTHORIZATION

Some services require prior authorization (PA). When seeking PA, keep in mind the following:

- The Performing/Rendering provider should initiate all authorization requests. Requests for authorization must be submitted in writing. (mail, fax, or electronic document)
- Have all required documentation included when submitting for PA.

PA Criteria for Specific Services	
Service	Documentation Requirements
Dispensing and fitting of contact lenses	PA required for contact lenses and dispensing fees. Diagnosis must be one of the following: <ul style="list-style-type: none"> • Keratoconus • Aphakia • Sight cannot be corrected to 20/40 with eyeglasses • Anisometropia of 2 diopters or more
Transition lenses Tints other than Rose 1 and Rose 2 (including photochromic tints) UV and scratch resistant coating	Include diagnosis and sufficient documentation from the optometrist or ophthalmologist that transition lenses, tints, or UV and scratch resistant coating are medically necessary.
Eye prosthesis	Documentation that supports medical necessity. Documentation regarding the client's ability to comply with any required after care. Letters of justification from rendering physician. Documentation should be provided at least two weeks prior to the procedure date.
Vision Training (CPT code 92065) Recipients under 21 only	Documentation that supports medical necessity; Guidelines: <ul style="list-style-type: none"> • Binocular vision • Amblyopic lazy eye • Eye turn problems that need therapy, but does not require surgery.



REQUEST FOR PRIOR AUTHORIZATION FOR VISION SERVICES

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 292 (02-2011)

SEND FORM TO:

Clear Fields

Medicaid Prior Authorization
ND Dept of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58802-0250

FAX: 701-328-1544

Phone: 701-328-4030 (Provider Relations)

I. Recipient Information

Patient Name		Medicaid ID	Date of Birth	
Street Address		City		State ZIP

II. Service Requested

Appointment Date	<input type="checkbox"/> Exam <input type="checkbox"/> Refraction <input type="checkbox"/> Frame <input type="checkbox"/> Other Procedure <input type="checkbox"/> Lens: <input type="checkbox"/> Right <input type="checkbox"/> Left						
Explain Medical Necessity (Required):							
Date of Previous Eye Exam	Present Rx:	Sph	Cyl	Axis	Add	VA / HOTV	Prism
Date of Previous Lens		OD		X			
Date of Previous Frame	New Rx:	Sph	Cyl	Axis	Add	VA / HOTV	Prism
		OS		X			

III. Provider Information

Provider Name	NPI	Provider Number	Telephone Number	FAX Number
Street Address		City		State ZIP
Signature			Date	

STATE USE ONLY

Exam/Refraction: <input type="checkbox"/> Approve <input type="checkbox"/> Deny	Frame: <input type="checkbox"/> Approve <input type="checkbox"/> Deny	Lens (ES): <input type="checkbox"/> Approve <input type="checkbox"/> Deny	Other Procedure: <input type="checkbox"/> Approve <input type="checkbox"/> Deny
Comments			Start Date
			End Date
Signature of Reviewer		Authorization Number	Date Reviewed



COORDINATION OF BENEFITS

WHEN CLIENTS HAVE OTHER COVERAGE

Medicaid clients often have optical services coverage through Medicare, Workforce Safety and Insurance, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions.

WHEN A CLIENT HAS MEDICARE

Medicare Part A Claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services.

Medicare Part B Crossover Claims

Medicare Part B covers physician care, eye exams, and other services. The Department of Human Services has an agreement with Medicare Part B carriers for North Dakota (Blue Cross Blue Shield of ND). In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not cross over).
- Submit their Medicare and Medicaid provider numbers to ND Medicaid Provider Enrollment.

Once the above conditions are met for clients who have coverage through Medicare Part B and ND Medicaid, providers need **NOT** submit Medicare Part B claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When Medicare Pays or Denies a Service

- When Medicare pays an eye exam claim for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit these claims to Medicaid.

Providers that are not set up for automatic crossover should submit a claim to Medicaid with the EOMB after Medicare pays, and Medicaid will consider the claim for payment.

If Medicare denies an eye exam claim, providers are to submit the claim with EOMB to Medicaid.

- For clients who have QMB only coverage, the provider bills Medicare first for eyeglass claims, and if Medicare pays the claim, Medicaid will process the claim for coinsurance and deductible. If Medicare denies the claim, Medicaid will also deny the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. The claim must also include the Medicaid provider number and Medicaid client ID number.



BILLING PROCEDURES

CLAIM FORMS

Services provided by ophthalmologists, optometrists, and opticians must be billed either electronically on a professional claim (HIPAA 837-P), or on a CMS-1500 paper claim form. CMS-1500 forms are available from various publishing companies; they are not available from the ND Medicaid program.

TIMELY FILING LIMITS

Providers must submit clean claims to Medicaid within the latest of:

Twelve months from whichever is later:

- The date of service
- The date retroactive eligibility or disability is determined
- **Medicare Crossover Claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by ND Medicaid, Clearinghouse, or Billing Agency.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly.
- If a claim submitted to Medicaid does not appear on the remittance advice within 60 days, contact Medicaid Provider Relations for claim status.

- If another insurer has been billed and 90 days have passed with no response, you should bill Medicaid for the proper denial ensuring timely filing is in accordance with ND Medicaid guidelines.

USUAL AND CUSTOMARY CHARGE

Providers must bill Medicaid their usual and customary charge for each service; that is, the same charge that is assessed to other payers for the service.

BILLING FOR RETROACTIVELY ELIGIBLE CLIENTS

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the eligibility determination letter to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

If the provider is informed the recipient has retroactive eligibility and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s).

MULTIPLE VISITS ON SAME DATE

When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit for review.

SUBMITTING ELECTRONIC CLAIMS

The ND Department of Human Services accepts electronic medical claims that are in the HIPAA compliant format.

- Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment.

To test HIPAA transactions, contact Medical Services at (701) 328-2325.

CLAIM INQUIRIES

The ND Medicaid Web site, <http://www.nd.gov/dhs/services/medicalserv/medicaid/>, contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more. The information may be downloaded and shared with others in your office. If you cannot find answers to your questions on the website, or if you have questions on a specific claim, contact Medicaid Provider Relations.

COMMON CLAIMS ERRORS

Common Claims Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions after this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field; verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field; check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 9-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see Prior Authorization in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim, 837-P).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.



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 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. The recipient is obligated to pay the provider directly for any amount applied to the recipient liability.

TAKING RECIPIENT LIABILITY AT THE TIME OF SERVICE

With the exception of Pharmacy Point of sale, providers are not to collect Recipient Liability (RL) 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.



REMITTANCE ADVICES AND ADJUSTMENTS

REMITTANCE ADVICE

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 RA 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.

KEY FIELDS IN THE REMITTANCE ADVICE (RA)

FIELD	DESCRIPTION
1. Date	The date the RA was issued
2. Provider number	The 9-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 Remittance advice (RA) 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 a 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 physician.
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.
FIELD	DESCRIPTION
18. Payment	Medicaid's allowed amount. The Medicaid payment may not be allowed amount if there is Other Insurance or RL.
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.

PAYMENT AND THE REMITTANCE ADVICE

Providers may receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. The Department encourages EFT as providers receive payment sooner than via normal mail delivery.

With EFT, the Department deposits the funds directly to the provider's bank account. 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.

To participate in EFT, providers must complete a SFN 661. The form may be obtained at: <http://www.nd.gov/humanservices/services/medicalserv/medicaid/online-forms.html>. One form must be completed for each provider number.

Once electronic funds transfer is established, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact Provider Enrollment.

(Sample of Remittance Advice (RA) has been provided on the next page.)

(1)09/17/04

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE

(2)Provider Number 012345

REMITTANCE ADVICE

(4)Page 1

(3)Check Number (or ACH) 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

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 or adjust any initial claim within the timely filing limits.

When to Re-bill Medicaid

- **Claim Denied.** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the corrected claim on a CMS-1500 form (not the adjustment form).
- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Submit the denied service on a new CMS-1500 form. (Do not use an adjustment form.)
- **Claim Returned.** Rebill Medicaid when 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 that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to Re-bill

- Check any EOB code listed and make your corrections on a new claim with the correct information.
- When making corrections on a claim, remember the claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim.

ADJUSTMENTS

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

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

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a 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.).

How to Request an Adjustment

To request an adjustment, use the Provider Request for an Adjustment form. The requirements for adjusting a claim are as follows:

- ND Medicaid must receive individual claim adjustment requests within 12 months from the payment date.
- 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 include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section of the adjustment form.

Completing an Adjustment Request Form

- Below are instructions on how to fill out the Provider Request for an Adjustment (SFN 639) form. You may also download the form from the website at <http://www.nd.gov/efrms/Doc/sfn00639.pdf>. Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
- Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):

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.
(14) Amount Billed	The amount billed by the provider.
(15) Amount Paid	The amount reimbursed by the department for that service.
(16) Total	The amount reimbursed by the department for the entire claim.
(17) Explanation/Remarks	The reason for adjusting the claim. Explain in detail.
(19) Provider's Signature	Signature, date, and telephone number of person initiating the adjustment.



Medical Services
(701) 328-2321
Toll Free 1-800-755-2604
Fax (701) 328-1544
ND Relay TTY 1-800-366-6888
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.

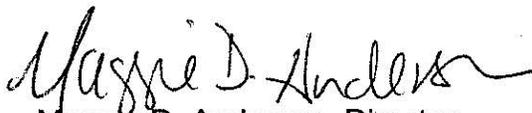
The manual will be updated on an ongoing basis, and will be posted to our web page at <http://www.nd.gov/dhs/>.

For other updates, please check out the Updates for Providers feature at <http://www.nd.gov/dhs/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, Director
Division of Medical Services