

GENERAL INFORMATION FOR PROVIDERS

NORTH DAKOTA MEDICAID AND OTHER MEDICAL ASSISTANCE PROGRAMS



Published by:

Medical Services Division
North Dakota Department of Human Services
600 E. Boulevard Avenue, Dept. 325
Bismarck, North Dakota 58505

July 2020

TABLE OF CONTENTS

SUMMARY OF CHANGES	4
KEY CONTACTS	5
AUTOMATED VOICE RESPONSE SYSTEM (AVRS)	7
PROVIDER ENROLLMENT	9
PROVIDER INFORMATION	14
MEDICAID COVERED SERVICES	19
ABORTION	24
ALLERGY IMMUNOTHERAPY – ALLERGY TESTING	25
AMBULANCE SERVICES	26
AMBULATORY SURGICAL SERVICES	28
ANESTHESIA SERVICES	30
BASIC CARE FACILITIES	32
BREAST AND CERVICAL CANCER DETECTION	34
CARDIAC REHABILITATION	35
CHIROPRACTIC SERVICES	37
COORDINATED SERVICES PROGRAM (CSP)	39
DENTAL SERVICES	43
DURABLE MEDICAL EQUIPMENT (DME)	44
FAMILY PLANNING SERVICES	45
FORENSIC EXAMINATIONS AND INTERVIEWS	49
HEALTH TRACKS (EPSDT)	51
HOME HEALTH AND PRIVATE DUTY NURSING	56
HOSPICE SERVICES	60
HOSPITAL SERVICES	65
IMMUNIZATIONS	70
INDIAN HEALTH SERVICES AND TRIBALLY OPERATED 638 FACILITIES	71
IEP MEDICAID SERVICES BILLED BY SCHOOLS	73
ICF/IID	76

LAB, RADIOLOGICAL, AND DIAGNOSTIC SERVICES	78
LOCAL PUBLIC HEALTH UNITS (LPHU)	80
MEDICAID ELIGIBILITY OF MEMBER	82
MEDICAL NUTRITIONAL THERAPY	83
MEDICARE COVERAGE	85
NONCOVERED MEDICAID SERVICES	86
NON-EMERGENCY MEDICAL TRANSPORTATION	88
NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS	94
NURSING FACILITIES	95
OCCUPATIONAL THERAPY	98
OPTOMETRIC AND EYEGLASS SERVICES	103
OUT OF STATE SERVICES	107
PARTIAL HOSPITALIZATION PSYCHIATRIC (PHP) SERVICES	111
PHARMACY	112
PHYSICAL THERAPY	113
PHYSICIAN SERVICES	118
PRIMARY CARE CASE MANAGEMENT	122
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)	126
REHABILITATIVE SERVICES	128
RECIPIENT LIABILITY	138
REVIEW BY QUALITY HEALTH ASSOCIATES	139
RURAL HEALTH CLINICS (RHC)	142
SPEECH-LANGUAGE PATHOLOGY	144
STERILIZATION AND HYSTERECTOMY	148
SUBSTANCE USE DISORDER TREATMENT SERVICES	152
SURVEILLANCE UTILIZATION REVIEW SECTION (SURS)	153
SWING BED FACILITIES	155
TELEMEDICINE	157
THIRD PARTY LIABILITY (TPL)	159

SUMMARY OF CHANGES

Providers will want to carefully review the following chapters for substantive updates:

1. Provider Enrollment
2. Provider Information
3. Medicaid Covered Services
4. Coordinated Services Program
5. Federally Qualified Health Centers
6. Local Public Health Units
7. Medical Nutrition Therapy
8. Primary Care Case Management
9. Psychiatric Residential Treatment Facilities
10. Recipient Liability
11. Rural Health Clinics
12. Nurses Practitioners and Physician Assistants

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
(701) 328-4030 (fax)

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

Call Center

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

(701) 328-7098
(877) 328-7098

or e-mail inquiries to:

mmisinfo@nd.gov

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

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

Send written inquiries to:

Primary Care Case Management

dhsmci@nd.gov

Coordinated Services Program

Inquiries regarding coordinated services program members:

(800) 755-2604
(701) 328-2346

or e-mail inquiries to:

MedicaidCSP@nd.gov

Medicaid Expansion through Sanford Health Plan

(855) 305-5060

Third Party Liability

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

(800) 755-2604
(701) 328-2347

Send written inquiries to:

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

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

or e-mail inquiries to:
medicaidtpl@nd.gov

Or e-mail inquiries to:
dhsmed@nd.gov

Service Authorization Contacts

Behavioral Health	(701) 328-7068 (ph) (701) 328-1544 (fax)
Dental	(701) 328-4825 (ph) (701) 328-0350 (fax)
Durable Medical Equipment	(701) 328-2764 (ph)
Long Term Care, for Members Under 21 Inpatient Psychiatric Services and PRTFs	(701) 328-4864 (ph) (701) 328-1544 (fax)
Non-Emergency Medical Transportation	(701) 328-4312 (ph)
Optometry	(701) 328-4825 (ph) (701) 328-0325 (fax)
Out of State Medical Care	(701) 328-7068 (ph) (701) 328-0376 (fax)
Pharmacy	800-755-2604 (ph) (701) 328-1544 (fax)
Service Limits	(701) 328-4825 (ph) (701) 328-0377 (fax)
Quality Health Associates	(701) 852-4231 (ph) (701) 857-9755 (fax)
Ascend (Long Term Care and Inpatient Psych Services for Members Under 21	(877) 431-1388

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- Member Inquiry
- Payment Inquiry
- Service Authorization Inquiry
- Claims Status

AVRS Access Telephone Numbers (available 24/7)

Toll Free: 877-328-7098

Local: 701-328-7098

Providers are granted access to the Automated Voice Response System (AVRS) by entering their ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One provider PIN number is assigned to each Medicaid ID number.

Touch Tone Phone Entry	Function
*	Repeat the options
9 (nine)	Return to main menu
0 (zero)	Transfer to Provider Call Center (M-F 8am – 5pm CT) –or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVRS at any point to speak with a provider call center customer service representative. The call center is available during regular business hours from 8am to 5pm central time, Monday through Friday, and observes the same holidays as the state of North Dakota. Providers may leave a voicemail message when the call center is not available. Provider voicemail messages will be responded to in the order received; and except during heavy call times, response will be the following business day during regular business hours.

AVRS Options	Secondary Selections
<p>Option 1: Member Inquiry</p>	<p>Callers may select any of the following options:</p> <ul style="list-style-type: none"> • Eligibility/Recipient Liability • Primary Care Provider (PCP) • Coordinated Services Program (CSP) enrollment • Third Party Liability (TPL) • Vision • Dental • Service Authorizations
<p>Option 2: Payment</p>	<p>Remittance Advice payment information is available for the specific time frame entered.</p>
<p>Option 3: Claims Status</p>	<p>Claim information is available based upon the Member ID number entered, including:</p> <ul style="list-style-type: none"> • TCN (Transaction Control Number) • Billed Amount • Claim Submit Date • Date(s) of Service • Claim Status (paid, denied, suspended) • Paid Amount (if applicable)
<p>Option 4: Service Authorization Inquiry</p>	<p>Service Authorization information is available based upon the Member ID number entered, including:</p> <ul style="list-style-type: none"> • Service Authorization (SA) Number • Date(s) of Service • Authorization Status

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT ELIGIBILITY

To be eligible for enrollment, a provider must:

- Provide services to at least one ND Medicaid eligible member.
- Meet the conditions in this chapter and conditions of provider agreement (SFN 615) regarding the specific type of provider, program, and/or service.
- Be a provider with a valid license, certification, accreditation or registration according to the state laws and regulations of the state in which services are rendered.

Providers that are on the List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM) or excluded by another State Medicaid Agency will be denied enrollment.

ENROLLING

Providers interested in enrolling with ND Medicaid must complete an online application. The application is located at <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>.

In addition to the online application, providers must submit a complete packet of supporting documentation for the application to be reviewed and processed. Processing does not begin until a complete packet of supporting documentation (in addition to the online application) is received. Do not send Social Security Numbers or EFT information by unsecure email. Supporting documentation checklists and form packets can be found on the Provider Enrollment section of the DHS website along with other enrollment and records update request resources:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html>.

Documents cannot be attached to the online application. They must be submitted by fax or email to:

- fax to 701-328-4030 ATTN: Provider Enrollment; or
- email to dhsenrollment@nd.gov.

A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a complete application packet is received. Providers must request a retroactive enrollment effective date, when submitting the complete enrollment packet. Providers who have requested a retroactive effective enrollment date may submit claims for covered services provided prior to receipt of all required enrollment documents if the provider met all eligibility requirements at the time the service was provided and only if

appropriate documentation of the services provided is maintained. ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety days for situations involving emergent care provided to a ND Medicaid member.

Medicaid payment is made only to enrolled providers.

Once an application is approved, each newly enrolled provider will receive a letter via the United States Postal Service with enrollment information that includes a 7-digit Medicaid ID and login information to access the web portal (if the security information section was completed during the enrollment process). If the security information section was not completed during the enrollment process, providers with an approved application can register for web access using the Provider Registration section on the Home page of the MMIS Web Portal. To register for web access, click the "Register" link, enter the 7-digit Medicaid ID and Social Security Number (for individual practitioners) or Employer Identification Number (for billing groups).

ENROLLMENT REVALIDATION

Providers are required to revalidate their enrollments at least once every five (5) years. ND Medicaid will determine revalidation dates and send notifications to the email address(es) associated with the enrollment record. A revalidation roster is updated each month and published on the ND Medicaid website that lists Provider Revalidation Dates that are due within 90 days of the published date <http://www.nd.gov/dhs/info/mmis/revalidation.html>. The revalidation date also appears in the online provider portal.

RESIDENCY PROGRAM

All physicians in a residency program who have been granted a license to practice medicine in North Dakota by the ND Board of Medical Examiners or have been granted a temporary special license for foreign medical school graduates as outlined in the Medical Practice Act of ND (Chapter 43-17-18.4) must enroll with ND Medicaid in order to bill for services rendered to ND Medicaid members. Residents who are eligible to enroll with ND Medicaid shall not bill using a supervising physician's NPI.

OUT OF STATE PROVIDERS

An "out of state provider" is a provider located more than 50 miles from a North Dakota border. All out of state services require service authorization (except in the local trade area within 50 miles of the North Dakota border or services provided in response to an emergency). Out of state emergency services require a retroactive authorization in order to receive payment.

An out of state provider may apply for a retroactive enrollment date for the date of service provided to a ND Medicaid member. Timely filing applies for claims processing purposes. Providing a claim to provider enrollment for enrollment purposes does not equate to submitting a claim for timely filing purposes.

A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a complete application packet is received. Providers shall indicate, on the enrollment checklist, the desired claim submission date (enrollment effective date). Provider enrollment staff will not approve a date beyond 90 days of receipt of a complete application packet unless it involves an emergency service provided to a ND Medicaid member. If the application involves an emergency service, a copy of the claim and medical notes must be submitted with the application packet. If not submitted, a date beyond 90 days of receipt of a complete application will not be approved.

Providers interested in enrolling with ND Medicaid must complete an online application. The application is located at <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>. In addition to the forms indicated in the online application, an Out of State Enrollment Clarification form (SFN 509) is required. The form is available at www.nd.gov/eforms.

In addition to submitting the online application and SFN 509, providers who wish to enroll, must submit a complete packet of supporting documentation before the application will be reviewed and processed. Social Security Numbers and EFT information sent electronically, should only be sent via secure email. Supporting documentation checklists and form packets can be found on the Provider Application Information and Forms page of the ND Medicaid website along with other enrollment resources: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html>.

Documents cannot be attached to the online application. They must be submitted by fax or email to:

- fax to 701-328-4030 ATTN: Provider Enrollment; or
- email to dhsenrollment@nd.gov.

CHANGES IN ENROLLMENT

Providers are responsible for ensuring that enrollment information remains current. Changes that cannot be updated through the provider web portal may be emailed to dhsenrollment@nd.gov. Changes that include sensitive information such as social security numbers, dates of birth, etc., may be sent via secure fax at 701-328-4030, attn. Provider Enrollment.

To avoid payment delays, notify Provider Enrollment of address or Automated Clearing House (ACH) changes in advance.

CHANGE IN OWNERSHIP

Providers are required to furnish changes in owners who have 5% of more ownership interest within 35 days. Refer to 42 Code of Federal Regulation (CFR) § 455.104 for more information. For tax reporting purposes, Provider Enrollment must be notified at least 30 days in advance of any changes that cause a change in a tax identification number.

Providers that are enrolled with both Medicare and Medicaid must ensure that the owners and managing employees match. Discrepancies delay application approvals and for enrolled providers, may result in payment suspensions.

PROVIDER UPDATES

Provider updates (affiliations, terminations, EFT, taxonomy, address, name, etc.) must be submitted to Provider Enrollment for processing. See the Provider Enrollment section of the DHS website for more information on how to request these updates:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html>

Provider Enrollment Frequently Asked Questions:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/provider-enrollment-faq.pdf>

TERMINATING MEDICAID ENROLLMENT

Medicaid enrollment may be terminated by submitting a notice either via email to dhsenrollment@nd.gov or via fax to 701-328-4030, Attn: Provider Enrollment. Include name, national provider identifier (if applicable) and the termination date. Termination without cause must be provided in writing and requires 30 days' advance notice. ND Medicaid may also terminate enrollment under the following circumstances:

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

North Dakota Administrative Code [75-02-05](#) provides additional information.

PROVIDER REQUIREMENTS

By signing the application to enroll as a provider for North Dakota Medicaid, providers agree to abide by the conditions of participation addressed on the provider agreement.

The Medicaid Program Provider Agreement (SFN 615) is available at www.nd.gov/eforms. Additional requirements may apply based on the provider type or provider specialty. Requirements include:

- No member should be abandoned in a way that would violate professional ethics.
- Members may not be refused service because of race, color, national origin, age or disability.
- Members enrolled in Medicaid must be advised in advance if they are being accepted only on a private pay basis.
- When a provider arranges ancillary services for their Medicaid member through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the member as a Medicaid member and they may not bill the member directly.

PROVIDER OBLIGATIONS

As a condition to participate in the Medicaid program, the provider agrees to, upon reasonable request, release information needed to support the services billed to ND Medicaid.

ND Medicaid is a covered entity under HIPAA and is acting within its authority to request documentation. Providing the requested documentation is not a HIPAA violation. 45 CFR §164.506 outlines the uses and disclosures to carry out treatment, payment, or health care operations and 45 CFR § 164.512(d) permits the disclosure of protected health information to a health oversight agency (which includes ND Medicaid as a government benefit program).

42 CFR § 456.23 outlines ND Medicaid's authority to conduct a post payment review. North Dakota Administrative Code 75-02-05-04(2) outlines provider responsibilities which includes providing documentation upon request. In addition, 42 CFR § 431.107(a)(2), requires providers to submit information regarding Medicaid payments for furnishing services.

ELECTRONIC CLAIMS SUBMISSION

Medicaid claims that are submitted electronically experience fewer errors and quicker payment. Electronic claims submitted for Medicaid services must be in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. More information on the format and data requirements is available at the following link:

www.nd.gov/dhs/info/mmis/guides.html.

Providers submitting claims for non-medical services are exempt from submitting HIPAA compliant claims. These services include home and community-based services, waiver services and travel/lodging services.

PROVIDER INFORMATION

COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND POLICIES

Providers enrolled with ND Medicaid must follow all applicable rules of ND Medicaid and all applicable state and federal laws, regulations and policies including:

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

DOCUMENTATION GUIDELINES FOR MEDICAID SERVICES

ND Medicaid providers are required to keep records that completely and thoroughly document the extent of services rendered to members and billed to ND Medicaid. Records are used by ND Medicaid to determine medical necessity and to verify that services were billed correctly.

Medical records must be in their original or legally reproduced form, which may be electronic.

Documentation must support the time spent rendering a service for all time-based codes.

Records must be retained for a minimum of six years from the date of its creation or the date when it was last in effect, whichever is later. State law may require a longer retention period for some provider types.

Documentation includes:

- Medical records including:
 - Patient's name and date of birth;
 - Date and time of service;
 - Name and title of provider rendering the service, if other than the billing practitioner;
 - Chief complaint or reason for each visit;
 - Pertinent medical history;
 - Pertinent findings on examination;
 - Medication, equipment and/or supplies prescribed or provided;

- Description and length of treatment;
- Recommendations for additional treatments, procedures or consultations;
- Diagnostic tests and results;
- Dental photographs/teeth models;
- Certification of medical necessity (if applicable)
- Plan of treatment and/or care and outcome; and
- Signature and date by the person ordering or rendering the service.
- Service authorization information;
- Claims, billings and records of Medicaid payments and amounts received from other payers for services provided to Medicaid members;
- Records and original invoices for items that are prescribed, ordered or furnished; and
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers and other financial information.

SIGNATURES

Documentation submitted to ND Medicaid must be signed by the ND Medicaid enrolled provider rendering the service. If there is no signature appended to medical record documentation, claims will be denied for no signature.

All medical record entries must be legible, promptly completed, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy.

Signatures on medical records must follow Medicare signature requirements, which are published here: <https://med.noridianmedicare.com/web/ifb/cert-reviews/signature-requirements>

CONFIDENTIALITY AND AVAILABILITY OF RECORDS

All Medicaid member and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of protected health information subject to applicable laws. Providers are required to permit ND Medicaid personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the member because the purpose for the disclosure is to carry out treatment, payment or healthcare operations permitted under the HIPAA Privacy rule under 45 CFR §164.506. Health plans contracting with ND Medicaid must be permitted access to all information relating to Medicaid services reimbursed by the health plan.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records and other

documents and records that must be maintained. If providers are using electronic medical records, they must have a medical record system that ensures the record may be accessed and retrieved promptly. (Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid.)

Records may only be released to other individuals if they have a release signed by the member authorizing access to the records or if the disclosure is for a permitted purpose under applicable confidentiality laws.

MEMBER PARITY

Providers must treat Medicaid members and private-pay clients equally in terms of scope, quality, duration and method of delivery of services (unless specifically limited by regulations).

VERIFICATION OF MEMBER ELIGIBILITY

It is the responsibility of the rendering provider to verify a member's Medicaid eligibility status and PCCM enrollment prior to providing services to the member. If the member is enrolled in PCCM, the rendering provider must assure referrals from the member's designated PCP are in place for any services received by the member in order to receive consideration of payment by ND.

USUAL AND CUSTOMARY CHARGES

Providers are required to bill ND Medicaid their usual and customary charge for each service provided. "Usual and customary charge" refers to the amount the provider charges the general public in most cases for a specific item or service.

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

NATIONAL CORRECT CODING INITIATIVE (NCCI)

ND Medicaid follows the National Correct Coding Initiative (NCCI) Edits. These edits were developed by the Centers for Medicare and Medicaid Services (CMS) based on coding conventions defined in the American Medical Association's Correct Procedure Terminology Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review

of current coding practices. CMS annually updates the National Correct Coding Initiative Coding Policy Manual. For additional information reference <https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>

WHEN MEMBERS HAVE OTHER INSURANCE

If a Medicaid member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's health care, claims should not be submitted to Medicaid until the charges are processed by the primary payer. See Third Party Liability chapter for additional information.

PAYMENT FOR SERVICES

Providers are entitled to Medicaid payment for covered services when the following conditions are met:

- Provider must be enrolled with ND Medicaid.
- Services must be rendered by practitioners licensed and operating within the scope of their practice as defined by law.
- Member must be eligible for Medicaid.
- Service must be medically necessary. ND Medicaid may review medical necessity at any time before or after payment.
- Service must be covered by ND Medicaid and not be considered experimental or investigational.
- Service authorization requirements must be met where applicable.
- Medicaid and/or third party payers must be billed according to rules and instructions as described in this manual, the most current Provider Bulletin and the ND Medicaid website.
- Billed charges must be usual and customary.
- The services rendered are not being provided free to other individuals.
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at \$0.
- Claims must meet timely filing requirements. ND Medicaid Timely Filing Policy is located at www.nd.gov/dhs/services/medicalserv/medicaid/provider-policies.html

MEDICAID PAYMENT IS PAYMENT IN FULL

Providers must accept Medicaid payment as payment in full for any covered service, except recipient liability that should be collected from the member.

WHEN CAN A MEDICAID MEMBER BE BILLED?

In most circumstances, providers may not bill members for services covered by Medicaid. Providers may bill Medicaid members directly under the following circumstances:

- For recipient liability (RL) amount documented on the remittance advice. Providers (except for Point of Sale Pharmacy) may not collect RL at the time of service.
- For services not covered by ND Medicaid, if the member was given advance notice prior to rendering services.
- If a provider chooses not to enroll as a Medicaid provider, the member is responsible for all charges if the member was given advance notice prior to rendering services.

Providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid;
- When the provider bills Medicaid for a covered service and Medicaid denies the claim because of billing errors; or
- When the provider fails to secure the necessary service authorization.

MEDICAID COVERED SERVICES

This table contains general information about services. For detailed information regarding service authorization and coverage information for specific services, refer to the specific service manual or chapter within this manual.

Covered services are subject to change based on changes in funding, legislative action, and changes in administrative rules.

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Ambulance services	No	No	For emergency out of state transport: referring providers have 48 hours following the service to notify ND Medicaid of transport	No
Ambulatory surgical services	Yes	No	Some services require SA from QHA	No
Audiology	Yes	No	No	No
Autism Spectrum Disorder Applied Behavioral Analysis Service	No	No. Services must be included in the plan of care.	Yes, annual and 180-day update.	Yes, must be under 21 years of age.
Behavioral health services	No	40 therapy visits per year; testing 10 hours per year	Yes, after limits are met	No
Certified nurse midwife services	No	No	No	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Chiropractic services	No	12 manipulations per year; x-rays 2 per year	Yes, after limits are met	No
Dental services	No	Some limits apply - see Dental manual	Some services require SA – see Dental manual.	Some age restrictions apply. See Dental manual
Durable medical equipment, medical supplies, prosthetic providers, hearing aids	Yes	Some limits apply - see DME manual	Some services require SA - see DME manual	Some age restrictions apply. See DME manual
Emergency Services, and follow-up care	For services received in the emergency room that are billed as an emergency, no referral required. Referral required for follow-up care, unless follow-up care is provided by the PCP.	No	No	No
Family planning	No	No	Some services require SA	No
Federally qualified health centers (FQHC)	No unless the FQHC is the PCP or a practitioner affiliated with the FQHC is the PCP.	No	No	No
Health Tracks (EPSDT) Screening	No	No	No	Yes, must be under 21 years of age.
Home and community-based services (HCBS waiver)	No	No	Must be screened and meet level of care	No
Home health care services	Yes	50 visits per year	Yes, after limit is met	No
Hospice	No	Some limits apply	Hospice election and certification required	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Hospitals (inpatient)	No	rehab limited to 30 days per year for adults; psychiatric admission limited to 21 days with maximum of 45 days per year	Some in-state services require SA. All out of state admissions require SA	No
Hospital swing bed services	No	No	Yes, must meet level of care	No
Immunizations	No	No	No	Yes, some age restrictions apply
Individualized Education Program Medicaid Services billed by Schools	No	No	Some services require SA	Under 21 only
Inpatient psychiatric services	No	Yes	Yes, must meet certificate of need if under age 21	Yes, services provided in an IMD to members 21 through 64 are noncovered
Intermediate care facilities for individuals with intellectual disabilities	No	No	Yes, must meet level of care	No
Laboratory	Yes, except for independent labs	No	Some services require a SA	No
Local Public Health Units	No	No	No	No
Medical Nutritional Therapy	Yes	Yes, 4 hours per year	Yes, after limit is met.	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Medication Therapy Management	No	Some limits apply. See ND Medicaid Medication Therapy Manual	Service Authorization recommended. See ND Medicaid Medication Therapy Manual.	No
Nonemergency medical transportation	No	No	Yes, administered by human service zones	No
Nurse practitioner services	Yes, unless care received in same clinic as PCP	No	No	No
Nursing facility services	No	No	Yes, must meet level of care	No
Occupational therapy	Yes	20 visits per year for ages 21 and over	Yes, after limit is met	No
Optometric services	No	Some limits apply – see Optometric and Eyeglass Services chapter	Some services require SA – see Optometric and Eyeglass Services chapter	No
Orthodontia	Must be referred by Health Tracks	No	Yes, must be referred by Health Tracks	Up to age 21
Partial hospitalization program	No	Yes	Yes, after limits are met	No
Personal care services in a member's home	No	Service limits apply	Yes	No
Pharmacy	No	Some limits apply - see pharmacy manual	Some services require SA - see pharmacy manual	No
Physical therapy	Yes	15 visits per year for ages 21 and over	Yes, after limit is met	No
Physician services, Primary Care	Yes, unless care received in same clinic as PCP	No	No	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
Physician Services, Specialty Care	Yes, except for services provided by a psychiatrist or obstetrician/gynecologist	Limits apply to some specialist services	Some services require	No
Podiatry	No	No	No	No
Private duty nursing providers in non-institutional settings	Yes	Yes	Yes	No
Psychiatric Residential Treatment facilities (PRTF)	No	No	Yes, must meet certificate of need	Under 21 only
Radiology	Yes, unless independent provider	No	No	No
Rehabilitative Services	No	Some limits apply. See Rehabilitative Services chapter	Some services require SA. See Rehabilitative Services chapter	Some services are restricted to certain ages. See Rehabilitative Services chapter
Rural health clinics (RHC)	No, unless the RHC is the PCP or a practitioner affiliated with the RHC is the PCP.	No	No	No
Speech therapy	Yes	30 visits per year for ages 21 and over	Yes, after limit is met	No
Substance Use Disorder Treatment Services	No	Some Limits Apply	Yes, after limits are met	No
Targeted case management	No	No	No	Yes, for child welfare, serious mental illness and serious emotional disturbance

ABORTION

All claims for an abortion must be accompanied by documentation that establishes the reason why it was necessary to perform the abortion. The information provided by the physician will be reviewed by the Medical Services Division's medical consultant and the director of Medical Services to ensure the abortion was necessary to save the life of the woman or was the result of an act of rape or incest. If the documentation provided meets ND Medicaid guidelines, payment will be approved. If the documentation does not meet these guidelines, the claim will be denied payment.

DOCUMENTATION REQUIREMENTS

Abortions to Save the Life of the Woman - The treating physician must provide a signed written statement that, in the physician's professional judgment, the life of the woman would be endangered if the fetus were carried to term. The statement must contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term.

Abortions that are a Result of an Act of Rape or Incest - If a member has reported an act of rape or incest to an appropriate law enforcement agency or, in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports, the physician must provide ND Medicaid with a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made.

- If the rape or act of incest was not reported to an appropriate agency, the member must sign a written statement indicating that her current pregnancy resulted from either an act of rape or incest. The treating physician must provide a signed written verification that, in the physician's professional judgment, the woman's pregnancy resulted from rape or incest.
- North Dakota statutes specifically describe the crime of "incest." North Dakota statutes do not specifically describe the common law crime of "rape," which is unlawful carnal knowledge of a female without her consent. North Dakota statutes prohibiting "gross sexual imposition," "sexual imposition," and "sexual abuse of a ward" all describe the common law crime of rape. Each of these statutes uses the term "sexual act." You may wish to consult an attorney for assistance if you are not certain that the sexual act that produced the pregnancy was an act of rape or incest.

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

ALLERGY IMMUNOTHERAPY – ALLERGY TESTING

COVERED SERVICES

- Professional services to administer the allergenic extract;
- Preparing and providing injectable allergenic extract;
- Professional services to monitor the member's injection site and observe the member for an anaphylactic reaction;
- Allergy testing; and
- Providing inhalants (an inhalant is a pharmaceutical).

NONCOVERED SERVICES

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

COVERAGE LIMITATIONS

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

Only licensed practitioners of the healing arts operating within their scope of practice who perform the refinement of raw antigens to allergenic extract may bill for the service. This service involves the sterile preparation of an allergenic extract by titration, filters, etc. and checking the integrity of the extract by cultures or other qualitative methods. Purchasing refined antigen, measuring dosages, and adding diluents is not refining raw antigens.

Adding diluents is not a separately covered service as it is an integral part of providing an allergenic extract.

The payment of the injection administration will include and will reflect the monitoring of the injection site and the observation of the member for anaphylactic reaction. A separate office visit charge for the provision of allergy services is not allowed unless other identifiable services are rendered such as a physical examination including vital signs, review of systems, laboratory services or obtaining a history of current symptoms or illness.

AMBULANCE SERVICES

ND Medicaid covers services provided by ambulance providers that are licensed and enrolled with ND Medicaid.

Emergency transport by ambulance is a covered service. Nonemergency transport by ambulance is a covered service only when medically necessary and ordered by an attending practitioner.

AMBULANCE TRANSPORTATION

To receive Medicaid payment on ambulance transportation, the member must receive medically necessary services before and/or during transport and the transportation must comply with the following conditions:

- The ambulance provider must be licensed per state requirements.
- The member's transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider.
- Out of state ambulance transport for nonemergency medical services, including follow up visits, may be reimbursed only if the out of state medical services are approved by ND Medicaid and the member's medical condition substantiates transportation by ambulance.

AIR AMBULANCE

Transportation by air ambulance is a covered Medicaid service if the member has a potentially life-threatening medical condition that precludes the use of another form of transportation. Claims submitted for air ambulance transport must include documentation of medical necessity, including the need for air transport.

For out of state air ambulance transport, the transferring facility must follow criteria for emergency out of state transportation. Air ambulance transportation originating outside of North Dakota or to a destination outside of North Dakota, must inform ND Medicaid within 48 hours of the transfer. Documentation to ND Medicaid must include:

- Destination and date of transfer;
- Mode of transportation;
- Discharge summary; and
- If trip is less than 50 miles, the facility must verify why air rather than ground ambulance was used.

TRANSPORTATION BETWEEN PROVIDERS

Ambulance transportation of a member between providers is covered as specified:

- Transportation between two long term care facilities must be medically necessary because the health service required by the member's plan of care is not available at the long-term care facility where the member resides.
- Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the member was when the medical necessity was diagnosed.
- Transportation between a hospital and long-term care facility must be medically necessary.

COVERAGE LIMITATIONS

Ambulance transportation must be to or from the site of a covered service to a member. A covered service is one which is provided by a ND Medicaid enrolled health care provider and is a covered under the North Dakota Medicaid State Plan.

The death of a member is recognized when the pronouncement of death is made by an individual legally authorized to do so by the state where the pronouncement is made.

Consistent with Medicare payment guidelines, if a member is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment will be based on:

- Basic life support (BLS) level of service base rate only, for a ground vehicle.
- Fixed wing or rotary wing base rate only, as appropriate, for an air ambulance.

NONCOVERED SERVICES

Services that are not covered include:

- Transportation of a member to a hospital or other health care services ordered by a court or law enforcement agency except when transportation via ambulance is medically necessary; or
- Transportation of a member that was pronounced dead prior to the time the ambulance was called or dispatched.

AMBULATORY SURGICAL SERVICES

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

AMBULATORY SURGICAL SERVICES

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

- Use of facility including operating and recovery rooms, patient preparation areas, waiting rooms and all other areas used by the patient or offered for use by persons accompanying the patient.
- Nursing and technical service including all services provided by employees of the ASC (e.g., nurses, technicians, orderlies).
- Drugs, biologicals, medical supplies and equipment, including:
 - All drugs, medical supplies, dyes and equipment common to the ASC provided in conjunction with a surgical procedure. Drugs and biologicals are limited to those that cannot be self-administered.
 - Urinary supplies, such as collection devices, indwelling and external catheters, drainage bags – any type, leg straps, external urethral clamps, irrigation supplies (bulbs, syringes, tubing, sterile saline or water), insertion trays and perianal fecal collection pouches.
 - Primary surgical dressings which are therapeutic and protective coverings applied directly to the skin or on openings to the skin and required as a result of a surgical procedure.
- Administrative, record keeping, and housekeeping services consisting of general administration and functions necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).
- Blood, blood plasma and platelets.
- Anesthesia and any supplies, whether disposable or reusable, that are necessary for its administration.

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

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

- Physician services, including the services of anesthesiologists administering or supervising the administration of anesthesia to a patient and the patient's recovery from anesthesia;
- Second surgical opinion;
- Patient specific laboratory, x-ray or diagnostic procedures performed according to protocol;
- Prosthetic devices (arm, leg, back, braces, artificial limbs, corneal lenses, titanium screws, etc.);
- Ambulance services;
- Durable medical equipment for use in the patient's home;
- Take home supplies, medications, splints and casts. These are separately billable if not furnished at the time of surgery;
- CRNA services; and
- Pathology services.

ANESTHESIA SERVICES

ND Medicaid covers services provided by an anesthesiologist or licensed certified registered nurse anesthetist (CRNA), enrolled with ND Medicaid, and trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures.

COVERED SERVICES

ND Medicaid will pay an anesthesiologist for the supervision of a CRNA.

ND Medicaid pays for anesthesia services personally furnished by an anesthesiologist or CRNA only if the anesthesiologist or CRNA:

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

OTHER ANESTHESIA SERVICES

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

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

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

Epidural Analgesia for Vaginal or Cesarean Section is used to provide continuous epidural analgesia for labor and vaginal or cesarean delivery. The CPT code that describes this service includes the placement of the epidural catheter. The number of minutes that the provider is physically present with the member must be recorded in the unit's box.

Payment for CPT 01967 will be capped at a maximum of 75 minutes.

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

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

BILLING GUIDELINES

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

The provider must:

- Submit the exact number of minutes from the preparation of the patient for induction to the time when the anesthesiologist or CRNA is no longer in personal attendance or continues to be required.
- Identify the exact nature of the services being provided with one of the following modifiers:

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

QK = Medical direction by a physician of two, three, or four concurrent anesthesia procedures.

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

QY = Medical direction of one qualified non-physician anesthetist by an anesthesiologist.

QX = CRNA services with medical direction by a physician.

QZ = CRNA services without medical direction by a physician.

Every claim for anesthesia must have at least one of the modifiers listed above.

BASIC CARE FACILITIES

ND Medicaid covers services provided by basic care facilities that are licensed and enrolled with North Dakota (ND) Medicaid.

AUTHORIZATION OF SERVICES

ND Medicaid will not cover personal care services unless an Authorization to Provide Personal Care Services form (SFN 663) is completed by the member's case manager. The completed form must be submitted to ND Medicaid.

The Department will not cover room and board services unless a Personal Care Plan (SFN 662) is completed by the member's case manager. The completed form must be submitted to the Department.

LIMITS ON LEAVE DAYS

The Department will cover a maximum of 30 days per occurrence for medical care leave. The purpose of the medical care leave policy is to ensure that a bed is available when a resident returns to the basic care facility. A basic care facility may not bill for medical care leave days if it is known that the resident will not return to the facility.

Once the basic care facility accepts payment for medical care leave on behalf of a Medicaid resident, the basic care facility must still bill ND Medicaid for medical care leave days beyond the 30th day that the resident's bed was held; however, any days exceeding the 30-day limit are noncovered days.

ND Medicaid will cover a maximum of 28 therapeutic leave days per resident per rate year. The rate year begins July 1st.

Once the basic care facility accepts payment for therapeutic leave on behalf of a Medicaid resident, the basic care facility must still bill ND Medicaid for therapeutic leave days beyond the 28th day the resident's bed was held; however, any days exceeding the 28-day limit are noncovered days.

BILLING GUIDELINES

A resident on medical or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of units billed must include the date of discharge or death.

The day of death for a resident is a covered day. The day of discharge for a resident is a noncovered day.

Basic care facility services must be broken down between personal care and room and board on separate lines on one claim using the following *Revenue Codes* when billing for:

Revenue Code 0110	In-House Medicaid Days for Room & Board (private)
Revenue Code 0120	In-House Medicaid Days for Room & Board (semiprivate)
Revenue Code 0183	Therapeutic Leave Days for Room & Board
Revenue Code 0185	Medical Leave Days for Room & Board
Revenue Code 0167	Personal Care Services Days

A facility must submit a claim for every month a Medicaid member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

BREAST AND CERVICAL CANCER DETECTION

The Centers for Disease Control and Prevention funds a breast and cervical cancer early detection program through the North Dakota Department of Health, known as *Women's Way*.

Information about the North Dakota *Women's Way* program can be found at:
<http://www.ndhealth.gov/womensway>

Individuals screened through *Women's Way* and found to require treatment for breast or cervical cancer or a precancerous condition relating to breast or cervical cancer may be eligible for Medicaid.

The Medicaid Breast and Cervical Cancer Early Detection eligibility group includes individuals under age 65 who:

- Are uninsured and not otherwise eligible for Medicaid;
- Have been screened for breast and cervical cancer through *Women's Way* under the Centers for Disease Control and Prevention's breast and cervical cancer early detection program/North Dakota Department of Health *Women's Way* program and have been found to require treatment for breast cancer, cervical cancer, or a pre-cancerous condition relating to breast cancer or cervical cancer;
- Have household income at or below 200% of the federal poverty level;
- Meet the residency, citizenship, and social security number requirements; and
- Are not an inmate of a public institution.

The earliest date of eligibility is the month of diagnosis, but not more than three months prior to the month of application. Eligibility can continue until the individual reaches age 65, is no longer a state resident, is admitted to a public institution, becomes eligible for Medicaid through a different group, becomes insured, or no longer needs treatment for breast or cervical cancer or a pre-cancerous condition.

Individuals determined to be eligible for Medicaid through the Breast and Cervical Cancer Early Detection eligibility group are entitled to receive all services covered under Traditional Medicaid.

CARDIAC REHABILITATION

ND Medicaid covers cardiac rehabilitation services that are provided by a Medicare-approved cardiac rehabilitation program. A copy of the Medicare notification of cardiac rehabilitation program approval must be provided to Provider Enrollment.

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

DEFINITION

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

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

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

COVERED SERVICES

ND Medicaid will only cover cardiac rehabilitation services that are provided by a Medicare-approved cardiac rehabilitation program. Services must be considered reasonable and necessary. ND Medicaid will cover up to 36 sessions consisting typically of three sessions per week in a single 12-week period.

At least one of the following services must be included in a cardiac rehabilitation session and are not separately payable:

- A new member comprehensive evaluation. The exam should include a history, physical, and an initial exercise prescription. If the exam has already been performed by the member's primary care provider, the medical record must

support the need for a repeat examination including documenting that the exam rendered by the attending primary care provider is not acceptable to the cardiac rehab program director;

- A limited examination to adjust medication, treatment or therapy;
- ECG rhythm strip with interpretation and revision of exercise therapy;
- Exercise therapy with continuous ECG telemetric monitoring (excludes physical therapy and occupational therapy); or
- Diagnostic and therapeutic services that are reasonable and necessary to perform cardiac rehabilitation services safely and effectively.

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

- Behavioral health services;
- Laboratory services that are not performed to monitor the member's cardiac condition and cardiac rehabilitation program progress;
- ECG stress tests – one is usually performed at the beginning of the program and after three months or at the completion of the program. Performance of these tests more frequently requires medical record documentation demonstrating medical necessity.
- Medical Nutritional Therapy (See Medical Nutrition Therapy chapter;
- Other services provided by a physician, nurse practitioner, physician assistant or clinical nurse specialist:
 - To provide medical care for diagnoses or conditions that are not a part of cardiac rehabilitation;
 - To interpret and report on ECG stress testing; and
 - To evaluate complications of cardiac rehabilitation.

NONCOVERED SERVICES

Services that are not covered include:

- Services provided absent Medicare approval of the cardiac rehab program.
- Formal lectures and counseling on health education that are normally furnished by the attending physician following a member's acute cardiac episode.
- Physical therapy and occupational therapy when furnished in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

CHIROPRACTIC SERVICES

ND Medicaid covers chiropractic services provided by a doctor of chiropractic, licensed under state law and enrolled as a ND Medicaid provider.

COVERED SERVICES

Coverage extends only to medically necessary treatment by means of manual manipulation (including use of activator or similar instrument) of the spine for treatment of subluxations (incomplete or partial dislocation) demonstrated by x-rays or exam.

Refer to the Chiropractic Services coding guideline for further information. The coding guidelines are available at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html

NONCOVERED SERVICES

Services that are not covered include:

- Any service other than manual manipulation for the treatment of subluxation of the spine.
- Chiropractic maintenance therapy. (Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promotes health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.)

PAYMENT LIMITATIONS AND BILLING PROCEDURES

Payment for manual manipulation of the spine is limited to one manipulation per day and may not exceed 12 manipulations per calendar year without a service authorization. New Patient E&M services (99201-99203) may be billed in addition to the chiropractic manipulative treatment (98940-98942) only when the patient has not received any professional (face-to-face) services from the chiropractor, or another chiropractor of the same group practice, within the past three years.

Payment for x-rays may not exceed two (2) per year per region. Full spine x-rays will count as 1 of the 2 allowed x-rays per each region.

MEDICAL NECESSITY FOR TREATMENT

Chiropractic services are considered medically necessary when all the following criteria are met:

- The member has a neuromusculoskeletal condition and the manipulative services rendered have a direct therapeutic relationship to the condition;
- The member has a subluxation of the spine as demonstrated by X-ray or physical exam; and
- The medical necessity for treatment is clearly documented.

SERVICES THAT ARE NOT MEDICALLY NECESSARY

- If no improvement is documented within the initial two weeks, additional chiropractic treatment is not medically necessary unless the chiropractic treatment is modified.
- If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is not medically necessary.
- Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is not medically necessary.
- Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is not medically necessary.
- Chiropractic care in persons, whose condition is neither regressing nor improving, is not medically necessary.
- Manipulation of infants is considered experimental and investigational for non-neuromusculoskeletal indications.
- Chiropractic manipulation has no proven value for the treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.
- Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, Breech or other malpresentations, scoliosis, dysmenorrhea, otitis media, asthma, epilepsy, etc.) because the evidence supporting its use is lacking and its effectiveness for the indication is unproven.

SERVICE AUTHORIZATIONS

Two diagnostic codes must be listed on the service authorization and claim to support medical necessity:

- The level of subluxation must be specified on the claim and must be listed as the primary diagnosis.
- The associated neuromusculoskeletal condition necessitating the treatment must also be listed as the secondary diagnosis.

COORDINATED SERVICES PROGRAM (CSP)

The CSP is utilized by ND Medicaid to:

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

CANDIDATES FOR CSP

ND Medicaid uses parameters to determine if a member may be referred to CSP. These parameters include:

- Use of multiple providers and clinics;
- Early prescription refills and use of multiple pharmacy providers;
- Use of emergency room services for other than emergent care; and/or
- Prescription use that is excessive or potentially threatening to the health of the member indicated by:
 - Multiple prescribing providers;
 - Use of multiple controlled drugs; or
 - Overlapping prescriptions with counterproductive therapeutic value.

PROGRAM REQUIREMENTS

Members that are referred to the CSP must choose a coordinated services provider by selecting one family practice, general practice, nurse practitioner, physician assistant or internal medicine provider of their choice. If the member is enrolled in the primary care case management (PCCM) program, the PCCM provider and the CSP provider must be the same practitioner. CSP members are also required to select one pharmacy of their choice to manage their prescription needs. Based on the usage of dental services, the member may also be required to select one dentist of their choice.

The member's selection of a CSP provider is subject to approval by ND Medicaid.

The determination to require coordinated services of a member is made by ND Medicaid upon recommendation of medical professionals who have identified utilization patterns that indicate the member may benefit from the CSP.

A review of services may be initiated by:

- A member audit of medical and pharmacy services; or
- A recommendation from a medical professional or from ND Medicaid staff.

Medical professionals may make recommendations for immediate placement of members into the CSP; however, the final decision remains with the fraud & abuse administrator and utilization review unit.

PHARMACY TRANSACTIONS

See the *Pharmacy Provider Manual* for further information regarding CSP members and pharmacy transactions.

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/pharmacy-manual.pdf>

SERVICES OBTAINED FROM A NON-DESIGNATED PROVIDER

ND Medicaid will not make payment for medical care or services furnished to a CSP member by any provider other than the member's CSP provider, except for:

- Medical care rendered in a medical emergency; or
- Medical care rendered by a provider upon referral by the CSP provider and approved by ND Medicaid.

TREATMENT BY A SPECIALIST

Only the member's CSP provider can authorize a referral to a specialist. Referrals must be medically necessary and submitted to ND Medicaid prior to the date of service. ND Medicaid will not approve retroactive referrals. Once authorized by ND Medicaid, the specialist may order medically necessary tests and treatment. If additional specialists are needed, the CSP provider must initiate the referral.

If a CSP provider is going to be absent from practice for an extended period of time, the CSP provider should refer the member to another provider to access necessary medical services. This information must be communicated to ND Medicaid prior to a member receiving services.

The CSP Referral (SFN 231) form is available online at <https://www.nd.gov/eforms> or by calling CSP at 1-800-755-2604 or 701-328-2346. A CSP provider may use their own referral form if the form contains the name and NPI of the CSP provider, the name and ND Medicaid ID number of the member being referred, the name and NPI of the provider to whom the member is being referred, the duration of the referral, and a dated signature of the CSP provider.

The referral form can be faxed, mailed or emailed to:

- Fax: (701) 328-1544
- Mail: Department of Human Services, Medical Services Division, Attn: CSP Referrals, 600 East Boulevard, Department 325, Bismarck, ND 58505-0250
- Email: medicaidcsp@nd.gov

If the CSP referral is urgent contact CSP at 701-328-2346 or email medicaidcsp@nd.gov.

COPAYMENT GUIDELINES

Effective October 1, 2019 ND Medicaid does not have copayments for services.

DENTAL SERVICES

ND Medicaid covers dental services provided by an enrolled ND Medicaid provider.

See the Dental Manual for specific billing and policy information at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES, PROSTHETICS, HEARING AIDS

ND Medicaid covers durable medical equipment and supplies, prosthetics and hearing aids provided by an enrolled ND Medicaid provider.

See the DME Manual for specific billing and policy information at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

FAMILY PLANNING SERVICES

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

PROVIDERS

Physicians, clinics, public health units, outpatient hospital departments, pharmacies, nurse midwives, nurse practitioners, physician assistants, clinical nurse specialists and family planning agencies may provide some or all the available family planning services and family planning supplies. All practitioners must operate within their scope of practice, including appropriate physician or other direction/supervision. Supervising physicians must be enrolled Medicaid providers.

COVERED SERVICES

Medicaid covers family planning services and supplies for Medicaid members of childbearing age, including minors. Members must be free of coercion or mental pressure, free to choose the method of family planning they will use, and must have full knowledge of the service and consent to it freely. The provider may not require that an unmarried minor's parent or guardian consent to family planning services for the minor.

The following family planning services and supplies are covered with an order or prescription from a licensed practitioner:

- Contraceptive counseling;
- Hormonal methods (pills, patches, rings and injectables)
- Emergency contraceptives;
- Long-acting reversible contraception (LARCs) – intrauterine devices, and implants
- Distribution of information and patient education;
- Consultation, examination and medical treatment;
- Genetic counseling;
- Laboratory examinations and tests; and
- Elective sterilization.

NONCOVERED SERVICES

- Reversal of elective sterilization;
- Diagnostic, medical, surgical or pharmaceutical services related to infertility;
- Hysterectomies for the purpose of sterilization; or
- Removal of long acting reversible contraceptive devices to regain fertility.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

ND Medicaid covers services provided by Federally Qualified Health Centers (FQHC) that are certificated from the Centers for Medicare and Medicaid Services and enrolled with ND Medicaid.

COVERED SERVICES

Payment to FQHCs for covered services furnished to ND Medicaid members is made by means of an all-inclusive rate for each encounter. Each encounter includes covered services and supplies.

For FQHCs, the term “encounter” is defined as a face-to-face visit with the member during which a FQHC service is rendered. FQHCs may furnish services that qualify as a medical, dental or behavior health encounter. See Telemedicine chapter for additional information on services rendered via telemedicine.

A **medical encounter** can be claimed for services rendered by a:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Visiting Nurse
- Nurse Practitioner
- Licensed Registered Dietitian

A **behavioral health encounter** can be claimed for services rendered by a qualified behavioral health professional, which includes:

- Licensed Clinical Social Workers,
- Licensed Professional Clinical Counselors,
- Licensed Marriage and Family Therapists,
- Licensed Psychologists,
- Licensed Addiction Counselors, and
- Licensed Addiction Programs

Dental services may also be provided at an FQHC. Dental visits are reimbursed an all-inclusive rate for each **dental encounter**. The dental encounter includes covered services and supplies.

Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single encounter, except when one of the following conditions exist:

- After the first encounter, the member suffers an illness or injury requiring additional diagnosis or treatment;
- The member has more than one type of visit: a medical visit, behavioral health visit or a dental visit.

Medical nutritional therapy or a diabetes self-management training provided on the same day as a medical encounter is not eligible for a separate encounter. If medical nutritional therapy or diabetes self-management training are the only medical service provided, a medical encounter may be claimed.

When submitting claims for more than one encounter for a Medicaid member on the same day at a single location, the facility must bill the correct revenue code for each encounter and include the appropriate diagnosis codes (when applicable) on each claim.

VACCINES

Refer to the Immunizations chapter or the Vaccine/Toxoid coding guideline for further information on Immunizations and immunization administration. The coding guidelines are available at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html.

ND Medicaid will cover injections and/or the administration of the injection if these services are billed alone using revenue code 771 (immunization alone) with an appropriate CPT code. These services cannot be billed with the revenue codes below or ND Medicaid will reimburse only the visit as the injection services are considered as part of the visit.

ND Medicaid will cover the immunization administration of vaccines within the scope of the Vaccine for Children (VFC) program. ND Medicaid will not cover the cost of pediatric vaccine materials.

Other vaccines currently covered by ND Medicaid, but outside the scope of the VFC program, will continue to be reimbursed according to the Medicaid fee schedule using the appropriate CPT codes.

PRIMARY CARE PROVIDER (PCP) DESIGNATION

A FQHC can be designated as a PCP; however, the facility cannot be used as a referring physician on claims. Referrals from these clinics must contain an authorization

of the referral (signature, initials) from a physician associated with the clinic or a supervising physician of the clinic.

For additional information on the Primary Care Case Management (PCCM) program, please see the PCCM chapter.

BILLING GUIDELINES

Claims must be submitted using the following *Revenue Codes* when billing for:

Revenue Code 0512	Dental Clinic
Revenue Code 0521	Clinic Visit by Member to RHC/FQHC
Revenue Code 0522	Home Visit by RHC/FQHC Practitioner
Revenue Code 0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility (SNF)
Revenue Code 0525	Visit by FQHC practitioner to a member in a SNF (not in a covered Part A stay) of NF or ICF/MR or other residential facility
Revenue Code 0529	Behavioral Health

FORENSIC EXAMINATIONS AND INTERVIEWS

ND Medicaid covers forensic services provided to children and adults who may have experienced physical or sexual abuse.

INITIAL FORENSIC MEDICAL EXAMINATION

Initial forensic medical examination performed on an alleged victim of child physical abuse completed by an enrolled practitioner of the healing arts under their scope of practice is a covered service and should be billed with the appropriate level E/M CPT® Code 99201-99215 appended with modifier 32 with one of the following ICD10-CM codes:

- T76.12xA – Child Physical Abuse, suspected, initial encounter
- Z04.72 – Encounter for examination and observation following alleged child physical abuse

FORENSIC INTERVIEW

A forensic interview is a single session, recorded interview designed to elicit unique information when there are concerns of possible physical or sexual abuse of a child. The forensic interview is conducted with a child in a supportive and non-leading manner by an ND Medicaid enrolled licensed mental health professional with specialized training in conducting forensic interviews.

Forensic Interviews should be reported with CPT® code 99499 appended with modifier 32 with one of the following ICD10-CM codes:

- T76.22xA - Child sexual abuse, suspected, initial encounter
- T76.12xA - Child physical abuse, suspected, initial encounter
- T76.52xA - Child sexual exploitation, suspected, initial encounter
- Z04.42 Encounter for examination and observation following alleged child rape
- Z04.72 Encounter for exam and observation following alleged child physical abuse

NONCOVERED SERVICES

Acute forensic medical examination performed on an alleged victim of criminal sexual conduct for the purpose of gathering evidence of an alleged crime are not covered by ND Medicaid and must be billed directly to the Attorney General's Office per N.D.C.C.12.1-34-07. Forensic medical examinations performed outside of the time restrictions established in N.D.C.C.12.1-34-07 are also not covered by ND Medicaid.

Child forensic medical examination performed on an alleged child victim of criminal sexual conduct for the purpose of gathering evidence of an alleged crime are not covered by ND Medicaid and must be billed directly to the Attorney General's Office per N.D.C.C.12.1-34-07.

Preliminary medical screening exam is conducted in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) before an acute forensic medical examination or child forensic medical examination may not be billed to a third party payor and must be billed directly to the Attorney General's Office per N.D.C.C.12.1-34-07.

EXCEPTION: A preliminary medical screening exam performed for an individual, eligible for North Dakota Medicaid, who is an alleged victim of criminal sexual conduct which allegedly occurred in a state other than North Dakota, is billable to North Dakota Medicaid. (NOTE: Acute forensic or child forensic exams are not billable to North Dakota Medicaid, even if the alleged criminal sexual conduct allegedly occurred in a state other than North Dakota.)

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

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

The federal guidelines for EPSDT are available at www.medicaid.gov.

OVERVIEW

ND Health Tracks is a comprehensive child health program intended to assure the availability and accessibility of required health care resources and help ND Medicaid members and their parents or guardians effectively use services.

Health Tracks includes a comprehensive child prevention and treatment system, to systematically:

- Identify eligible children and provide information about the benefits of prevention and the types of assistance available;
- Help children and their families use health resources;
- Assess the child's health needs through initial and periodic examinations; and
- Assure that health problems found are diagnosed and treated early, before they become complex and their treatment becomes more costly.

HEALTH TRACKS SERVICE REQUIREMENTS

All screening tools must be evidence-based. The Health Tracks benefits include the following:

- Screening services:
 - A comprehensive health and developmental history including assessment of both physical and mental health development, (see [Recommended Tools](#)).
 - A comprehensive unclothed physical exam,
 - Appropriate immunization – (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccine),
 - Laboratory tests (including Lead Toxicity screening*), and
 - Health Education – Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms

of the child’s development and to provide information about the benefits of health lifestyles and practices.

- Vision services including diagnosis and treatment for defects in vision.
- Dental services including relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.
- Hearing services including diagnosis and treatment for defects in hearing, including hearing aids.
- Other necessary health care services to diagnose and treat physical and behavioral health illnesses, defects and conditions discovered by the screening services.

***Lead Toxicity Screening** – All children are considered at risk and must be screened for lead poisoning. EPSDT program requirements dictate that all Medicaid-eligible children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 5 ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. A lead toxicity screening questionnaire can be utilized for children screened at ages outside the ranges noted above,

PERIODICITY SCHEDULE

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

Newborn	2-5 days	1 month	2 months	4 months
6 months	9 months	1 year	15 months	18 months
2 years	30 months	3 years	4 years	5 years
6 years	7 years	8 years	9 years	10 years
11 years	12 years	13 years	14 years	15 years
16 years	17 years	18 years	19 years	20 years

DIAGNOSIS

When a screening examination indicates the need for further evaluation of a child’s health, appropriate diagnostic services must be provided, and a referral should be made

without delay. Appropriate follow-up must also occur to make sure that the member receives a complete diagnostic evaluation.

TREATMENT

Health care services must be made available to treat, correct or ameliorate defects, physical and behavioral health illnesses, or conditions discovered by the screening services.

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

DOCUMENTATION REQUIREMENTS

Providers are encouraged to use the Bright Futures forms.

Documentation requirements can also be met using an internal form if it captures all the components listed above in Health Tracks Service Requirements. These documentation requirements include:

- Comprehensive health and developmental history, to include mental health screening;
- Health education/anticipatory guidance;
- Comprehensive unclothed physical examination;
- Immunizations received;
- Lead screening;
- Hearing screening;
- Vision screening;
- Dental screening; and
- Laboratory tests and results.

COVERED SERVICES

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

- Immunizations and administration (See Immunizations chapter),
- Laboratory tests, and
- Other necessary diagnostic and treatment services.

BILLING GUIDELINES

Provider Type	Revenue Code	Procedure Code
FQHC or RHC	0521	S0302
IHS	0519	S0302
LPHU	N/A	S0302
All other providers	N/A	S0302 or 9938x / 9939x

LIMITATIONS

ND Medicaid will not reimburse HCPCS code S0302 – EPSDT screening and CPT code 9938x/9939x – Preventive Medicine Services on the same date of service.

Per CPT –“If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.”

The provider’s electronic signature on the claim is the attestation of the medical necessity of both services, including an assurance that the following requirements are met.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

- Provider documentation must support billing of both services. Providers must create separate notes for each service rendered in order to document medical necessity.
- In deciding on appropriate E/M level of service rendered, only activity performed “above and beyond” that already performed during the Health Tracks visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.
- All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.

- The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph that clearly describes the specific condition requiring evaluation and management.
- The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

HOME HEALTH AND PRIVATE DUTY NURSING

ND Medicaid covers services provided by home health agencies that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

HOME HEALTH SERVICES

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

PRIVATE DUTY NURSING SERVICES

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

For skilled nursing needs that exceed four hours per day, ND Medicaid will review for medical necessity and determine an hourly fee with the home health agency or private duty nurse.

HOME HEALTH ELIGIBILITY REQUIREMENTS

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

- The member must need skilled nursing care on a part-time or intermittent basis, (at least one skilled nursing service every 60 days), or physical therapy or speech therapy or occupational therapy to qualify for home health services.
- The physician must certify that the member requires skilled nursing care in the home. Services must be medically necessary, and the member service is considered the most appropriate setting consistent with meeting the member's medical needs.
- Services must be provided at the member's place of residence. A residence may be the member's own dwelling, an apartment, a relative's home or temporary housing such as a motel/hotel room.

A face to face encounter for the initial ordering of home health services, which is related to the primary reason the member requires home health services, must occur no more than 90 days before or 30 days after the start of home health services. This face-to-face encounter may be performed by a physician, nurse practitioner, clinical nurse specialist

or physician assistant, all who must be working under the supervision of a physician. The practitioner performing the face-to-face must communicate the clinical findings of the encounter to the ordering physician. Communication between the practitioner conducting the face-to-face and the ordering physician is to be documented in the medical record.

Medical necessity for the home health services must be supported in the medical record. The visit may be performed via telehealth or in person; telephone encounter is not sufficient.

COVERED SERVICES

The home health agency must provide the following services:

- Skilled nursing by a registered nurse or licensed practical nurse under the supervision of a registered nurse.
- Home health aide under the direction of a registered nurse.
- Physical, occupational and speech therapy services provided by licensed therapists.

NONCOVERED SERVICES

Services that are not covered include:

- Individual procedures:
 - Eye drops or ointment instillations;
 - Routine glucose monitoring and insulin administration;
 - Routine foot care;
 - Stasis ulcer maintenance care;
 - Pediatric maintenance care;
 - Routine medication setup;
 - Other services that become self-care activities after the member or family members or others have been taught how to do the procedure(s) in a reasonable amount of time.
- Personal care services not directly related to the condition requiring skilled nursing care:
 - Light housekeeping
 - Transportation
 - Meal preparation
 - Laundry
 - Shopping
 - Childcare
 - Respite care

Respiratory therapy services (as a separate category of services). A registered nurse may provide respiratory therapy as a nursing service.

Observation and assessment by a skilled nurse are not reasonable and necessary to the treatment of the illness or injury when indications are that it is a long-standing pattern of the member's condition and no clinical progress is demonstrated.

REQUESTING HOME HEALTH SERVICES

Home health agency visits are limited to an initial 50 visits per member, per calendar year, for all covered home health services. These visits are not subject to prior approval. These visits do not apply to extended hour visits as these requests must be prior authorized by ND Medicaid.

Service authorization for services will be required where it is medically necessary for the member to exceed the home health visit limitation. ND Medicaid uses utilization review parameters for evaluating and determining medical necessity for the type of service(s) requested and the number of visits required to appropriately treat the member's condition.

Each service authorization is valid for 60 days. Requests for additional visits beyond the initial 50 visits must be submitted prior to the last visit of the 50-day limitation. Home health providers are required to track and request additional home health visits prior to the utilization of the 50-visit limit.

If the same level of care or a more intense level of care (i.e. more skilled nurse visits, addition of another service) is necessary beyond the initial 50 visits, the agency must submit a service authorization. Subsequent requests after the first 60-day period must also have service authorization.

Requests for additional visits must be submitted by the home health agency. The additional visits must substantiate medical necessity and be received by the ND Medicaid prior to the service being provided, or before the next 60-day period request. If the service authorization is not received by ND Medicaid prior to the 60-day time period, the visits will be denied. All requests for authorization of additional visits must be submitted with the following information:

- The service authorization (SFN 15);
- A legible copy of the current Home Health Certification and Plan of Treatment Form (CMS 485) or certified plan of treatment with the most recent 60-day summary or a copy of the original physician's order; and
- Any pertinent documentation to substantiate the need for additional visits.

The home health agency must keep on file copies of all documents submitted to ND Medicaid. Approved service authorizations are dependent on the member's eligibility during the approved service authorization period. If a member requires additional

services in an approved period, the home health agency is responsible for requesting a service authorization for the expanded services.

Facsimile copies will be accepted, and a response given in the same manner. Return fax numbers must accompany the request.

Payment to Home Health Agencies for covered services furnished to Medicaid patients is made per encounter. The term “encounter” is defined as a face-to-face visit between the patient and one or more home health professionals during which services are rendered. An encounter for each type services is defined as:

- Skilled Nursing Visit – An encounter is a continuous period of time not to exceed a two-hour period in which the nurse remains at the residence of a member for the purpose of providing ongoing skilled nursing services.
- Home Health Aide Visit – An encounter is a continuous period of time not to exceed a two-hour period in which the aide remains at the residence of the member for the purpose of providing necessary ongoing home health aide services.
- Therapy Services – All therapy services will be reimbursed per encounter.

Encounters with more than one home health professional and multiple encounters with the same home health professionals on the same day and at a single location constitute a single visit for each discipline.

Home Health Telemonitoring will be covered within the same limits noted above. Home Telemonitoring is not allowed for the initial Home Health evaluation visit or for the discharge visit. In addition, Home Health Telemonitoring is limited to no more than forty percent (40%) of the total visits during each certification period.

Telephonic encounters are not covered by ND Medicaid.

HOSPICE SERVICES

ND Medicaid covers services provided by hospice providers that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

HOSPICE ELECTION

A hospice election must be submitted for a member who is eligible for hospice care and who wishes to elect hospice.

HOSPICE CARE ELIGIBILITY REQUIREMENTS

A member must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill or until the member or representative revokes the election of hospice.

A member may live in a home in the community or in a long-term care facility while receiving hospice services. A long-term care facility is a nursing facility, swing bed facility or intermediate care facility for the intellectually disabled.

A dually eligible member must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

PHYSICIAN CERTIFICATION

A written certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the member's attending physician, if the member has one, should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated if a verbal certification was provided.

If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the member's medical prognosis is a life expectancy of six months or less.

COVERED SERVICES

The hospice must provide the services listed below. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

1. Core Services
 - a. Nursing services provided by or under the supervision of a registered nurse.
 - b. Social services provided by a social worker under the direction of a physician.
 - c. Services performed by a physician, dentist, optometrist or chiropractor.
 - d. Counseling services provided to the member and family members or other persons caring for the member at the member's home to assist in minimizing the stress and problems that arise from the terminal illness, related conditions and the dying process.
2. Supplemental Services
 - a. Inpatient hospice care including procedures necessary for pain control and acute or chronic symptom management.
 - b. Inpatient respite care.
 - c. Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the member's terminal illness must be provided by the hospice for use in the member's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the member's terminal illness.
 - d. Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the supervision of a registered nurse.
 - e. Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

INPATIENT HOSPICE CARE

A member may need care as an inpatient on a short-term basis during a period of crisis. To meet this need, the hospice or facility under contract to provide inpatient hospice care must provide 24-hour nursing services. Nursing services must be sufficient to meet the total nursing needs and be consistent with the member's plan of care. The inpatient facility must provide treatments, medications and diet as prescribed, and keep the member comfortable, clean, well-groomed and protected from accident, injury and infection. The inpatient facility must employ a registered nurse on each shift to provide nursing care.

INPATIENT RESPITE CARE

Inpatient respite care may be provided on an occasional basis to give the member's family or caregiver a break from the full-time responsibility of providing care. Payment

for inpatient respite care may not exceed five consecutive days of inpatient respite care at a time.

BEREAVEMENT COUNSELING

The hospice must make bereavement services available to the member's family for at least one year after the member's death. Family includes persons related to the member or those considered by the member to be family because of close association. No payment is made for bereavement counseling.

PAYMENT FOR PHYSICIAN SERVICES

The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and service, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a member's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR MEMBER IN LONG TERM CARE FACILITY

When hospice care is furnished to a member residing in a long-term care facility, payment to the long-term care facility by ND Medicaid is no longer available, and the hospice is responsible for paying for room and board furnished by the long-term care facility. The hospice is responsible for including the room and board charges on the claim for the amount equal to the Medicaid rate payable to the long-term care facility at the time the services are provided. The hospice may not negotiate a room and board rate with the long-term care facility except for payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates.

If a member has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the member. The hospice may make arrangements with the long-term care facility to collect the recipient liability. ND Medicaid will not reimburse the hospice for any uncollected recipient liability.

A hospice claim must be submitted for all members electing hospice who reside in a long-term care facility even if no payment is due from ND Medicaid and payment is made entirely by Medicare, insurance, or any other payment source.

PAYMENT

The hospice provider will be reimbursed at one of four predetermined rates for each day a member is under the care of the hospice. The four rates exclude payment for physician services that are separately paid.

The hospice provider will be reimbursed an amount applicable to the type and intensity of services provided each day to the member. The four levels of care into which each day of care is classified are:

- Routine Home Care – This level of care is used for each day the member is under the care of the hospice and the member is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
- Continuous Home Care – This level of care is used for each day the member receives nursing services on a continuous basis during a period of crisis in the member's home. The hospice is paid an hourly rate for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.
- Inpatient Respite Care – This level of care is for each day a member is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but, excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a member resides in a long-term care facility.
- General Inpatient Care – This level of care is for each day the member receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that can't be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the member is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the

resident's home; however, payment for general inpatient care can be made to another long-term care facility.

Payment for inpatient care days will be limited according to the number of days of inpatient care furnished to Medicaid members by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of days of hospice care provided to all Medicaid members by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate, and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to members diagnosed with acquired immunodeficiency syndrome (AIDS).

HOSPITAL SERVICES

ND Medicaid covers inpatient and outpatient services provided by hospitals that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

COVERED HOSPITAL SERVICES

Covered hospital services are subject to the following:

- Ambulance services are not payable to hospitals on an institutional claim and must be billed on a professional claim.
- Readmission to inpatient care on same day as discharge must be combined as one inpatient stay except when readmission is unrelated to original inpatient stay diagnosis and treatments.
- Outpatient services provided on the day of discharge may not be separately billed and must be included on the inpatient claim.
- Separate payments will be made for the mother and a newborn.
- Charges should reflect the usual and customary charge of the hospital. Only the patient due amount is subject to payment by Medicaid.
- Miscellaneous codes need a description and supporting documentation.

NONCOVERED SERVICES

An inpatient stay that is less than 24 hours is not payable by ND Medicaid.

The following items are noncovered services and must be identified as noncovered if billed on an institutional claim:

- | | |
|-------------------------|-----------------------------|
| • Admission Kits | • Nursing – Outpatient |
| • Ambulance Charges | • Patient Convenience Items |
| • Barber/Beauty | • Postage |
| • Biofeedback | • Private Room |
| • Books/Tapes | • Social Services |
| • Guest Tray | • Take Home Drugs |
| • Late Discharge | • Take Home Supplies |
| • Leave of Absence Room | • Tax |
| • Lifeline | • Technical Support Charges |
| • Linen | • Telemetry in ICU |
| • Non-Patient Room Rent | • TV/Telephone/Radio |

Refer to the Noncovered Medicaid Services chapter for further information.

BILLING GUIDELINES

Claims for dual-eligibles (Medicare and Medicaid) should be billed as follows:

- If the member has Part A Medicare, charges for an inpatient stay must be billed entirely on an institutional claim.
- If the member has only Medicare Part B and incurs charges during an inpatient stay, the Part B charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid on an institutional claim and include all charges for the inpatient stay. The institutional claim must include the Medicare Part B payment amount.
- If the member receives Medicare Part B services on an outpatient basis, the charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid and must be billed on an institutional claim.

IN-STATE PROSPECTIVE PAYMENT SYSTEM HOSPITALS

INPATIENT SERVICES

Payment to in-state acute prospective payment system (PPS) hospitals is based on All Patient Refined - Diagnosis Related Groups (APR-DRG) for inpatient services.

The APR-DRG system classifies patients into clinically consistent groups with similar length-of-stay (LOS) patterns and utilization of hospital resources. Payment for an acute hospital stay is based on these groups which are comprised of diagnosis and procedure codes reported by the provider.

Claims for services that will be reimbursed using APR-DRG cannot be submitted until the patient is discharged or transferred.

3-Day Payment Window

When a member is admitted to a short-term acute care hospital, the hospital must review up to three days prior to the inpatient admission to see if any related outpatient services, diagnostic and non-diagnostic, were provided to the member by the hospital and/or facility that is owned/operated by the hospital. If there were related outpatient services in the 3-day window, they are not covered as separate services and must be included on the inpatient claim along with other related services.

Outpatient Services

The Outpatient Prospective Payment System (OPPS) applies to PPS hospital outpatient departments.

Each HCPCS code billed that is reimbursed under the OPPS which is assigned to an ambulatory payment classification (APC). A hospital may receive several APC

payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting.

All outpatient services or visits occurring on same day for a member must be billed on one claim.

IN-STATE CRITICAL ACCESS HOSPITALS

Inpatient Services

Payment for inpatient services provided by in-state critical access hospitals (CAH) is made on a per diem rate.

- Claims must be submitted each calendar month on a separate claim form.
- Room and board (Revenue Codes 0100-0219) will be reimbursed on a per diem basis. The number of units billed for room and board Revenue Codes should include the date of discharge or death.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

Outpatient Services

Payment for outpatient services provided by a CAH is made on a percentage of charges.

ND Medicaid does not recognize Method II billing for CAH.

- Emergency room services should be billed as outpatient services on a separate claim form.
- Observation days and inpatient days cannot overlap.
- Physician services should be billed on a professional claim.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

OUT OF STATE HOSPITALS

An out of state hospital is defined as a hospital that is located in the United States and is more than 50 miles from a North Dakota border.

Payment to out of state hospitals is based on a percentage of charges for both inpatient and outpatient services.

Out of state services require prior approval from ND Medicaid. See Out of State Services chapter for additional information.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

REHABILITATION FACILITIES

Payment for inpatient services provided by a rehabilitation facility is made on a per diem basis. Payment for outpatient rehabilitation services is made on a percentage of charges. Inpatient rehabilitation stays are subject to a limit of 30 days per stay for patients 21 years of age and older.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

LONG TERM CARE HOSPITALS

Payment for services provided by a long-term care hospital (LTCH) is made based on a percentage of charges.

LTCH services require prior approval from ND Medicaid.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

PSYCHIATRIC HOSPITALS

Payment for inpatient services provided by a psychiatric hospital is made on a per diem basis.

ND Medicaid will cover inpatient psychiatric services for members under 21 years of age if the member meets certificate of need criteria.

Inpatient psychiatric services, in a free-standing psychiatric hospital of more than 16 beds, are not covered for members age 21 through 64.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.

- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

KIDNEY DIALYSIS SERVICES

Kidney dialysis claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 0634	Erythropoietin (OPE) < 10,000 units
Revenue Code 0771	Vaccine Administration
Revenue Code 0821	Hemodialysis Composite or Other Rate
Revenue Code 0831	Peritonea/Composite or Other Rate
Revenue Code 0841	CAPD/Composite or Other Rate
Revenue Code 0851	CCPD/Composite or Other Rate

IMMUNIZATIONS

COVERED SERVICES

North Dakota Medicaid covers immunizations for children and adults that are medically necessary and approved by the Federal Drug Administration (FDA). ND Medicaid also covers immunization administrations when the vaccine/toxoid is supplied by another entity.

Refer to the Vaccine/Toxoid coding guideline for further information on Immunizations and immunization administration. The coding guidelines are available at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html.

COVERAGE GUIDELINES

Vaccinations required for out-of-country travel are not covered by ND Medicaid as the travel is not considered medically necessary.

Vaccines for Children (VFC, state supplied) vaccines/toxoids supplied by the North Dakota Department of Health (NDDoH) must be used when administering a vaccine to ND Medicaid members, 0 through 18 years of age. Providers administering vaccines/toxoids to children in this age group must be enrolled in the NDDoH VFC program and receive the vaccines/toxoids at no charge.

VFC vaccines/toxoids and the administration of the vaccine are exempt from the Primary Care Case Management (PCCM) referral requirements.

The Vaccine Coverage table is available on the ND Department of Health's Immunization page at www.ndhealth.gov/immunize.

INDIAN HEALTH SERVICES AND TRIBALLY OPERATED 638 FACILITIES

Indian Health Service (IHS) facilities and tribally owned and operated 638 facilities meeting the state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, a Medicaid agency or state licensing authority may not consider an absence of licensure of any staff member of the facility.

COVERED SERVICES

ND Medicaid covers the same services for members who are enrolled in Medicaid and receiving services at IHS as those members who are enrolled in Medicaid only. Coverage and payment of services provided through telemedicine is on the same basis as those provided through face-to-face contact.

Payment to IHS facilities and tribally operated 638 facilities will be on an encounter basis and based on the approved all-inclusive rates published each year in the Federal Register by the Department of Health and Human Services.

Each encounter includes covered services by a health professional and related services and supplies.

Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single visit except when one of the following conditions exist:

- Multiple visits for different services on the same day with different diagnosis. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
- Multiple visits for different services on the same day with the same diagnosis. The diagnosis code may be the same on the claims, but the services provided must be distinctly different and occur within different units of the facility.
- Multiple visits for the same type of service on the same day with different diagnosis.

BILLING GUIDELINES

IHS claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 0100	In-House Medicaid Days
Revenue Code 0250	Pharmacy
Revenue Code 0490	Ambulatory Surgical Center
Revenue Code 0500	Outpatient
Revenue Code 0510	Vision
Revenue Code 0512	Dental
Revenue Code 0513	Mental Health (Psychiatrist/Psychologist)
Revenue Code 0519	EPSDT Screening
Revenue Code 0509	Telemedicine (clinic/physician)
Revenue Code 0900	Behavioral Health
Revenue Code 0961	Telemedicine (mental health)
Revenue Code 0987	Physician Inpatient Services

A procedure code must be billed with revenue codes that require a CPT/HCPC code according to NUBC guidelines.

INDIVIDUALIZED EDUCATION PROGRAM MEDICAID SERVICES BILLED BY SCHOOLS

Schools, for purposes of billing ND Medicaid for health services, means a public school district or special education unit.

The Department of Human Services (DHS), Medical Services Division (ND Medicaid) is responsible for the payment of services for Medicaid-eligible children who receive Medicaid covered health services that are described in the child's Individualized Education Program (IEP), per the Individuals with Disabilities Education Act (IDEA).

ND Medicaid will pay the school for services based on claims submitted by the school. Payment will be based on fee schedules developed by ND Medicaid.

To receive ND Medicaid payment, the services must be part of a special education program and otherwise covered by ND Medicaid. ND Medicaid will not directly pay private schools but can make payments to the public school district for IEP-related services for children in that district who are attending private educational facilities.

Medicaid-covered services must be provided by school personnel who meet ND Medicaid provider qualifications as well as all applicable state licensing standards and are enrolled as ND Medicaid providers. Personnel can be either an employee of or contracted through the school; however, all claims must be submitted by the school.

Qualified services must:

- Be provided to student who is eligible for Medicaid on the date of service;
- Be authorized or prescribed in the eligible Medicaid student's Individualized Education Program (IEP); o The IEP must be updated as Medicaid-eligible services are initiated or discontinued.
- Be rendered by an enrolled Medicaid provider who is either an employee of or contracted through a school;
 - Be a service covered under the North Dakota Medicaid State Plan;
 - Be documented appropriately; and
 - Be billed to Medicaid by the school.

COVERED SERVICES

Services must be medically necessary and outlined within an IEP that has been developed by the school's IEP team. Nursing services require a written order that

documents medical necessity. Other health-related services must be authorized by a licensed practitioner of the healing arts operating within their scope of practice:

- Therapies (physical therapy, occupational therapy and speech-language pathology)
- Audiology;
- Behavioral Health;
- Nursing Services that support the child's needs to access free appropriate public education provided by Registered Nurses to children with complex medical needs.
 - T1000 - Private duty / independent nursing service(s) – licensed, up to 15 minutes.
 - Written order can be from a physician, nurse practitioner or physician assistant.
- Transportation from school to IEP services provided at an offsite location, and transportation back to school. Inclusion of the service in the child's IEP is mandatory; and
- Applied behavior analysis for children with an Autism Spectrum Disorder (see Medicaid Applied Behavior Analysis policy for additional coverage and service authorization requirements at <http://www.nd.gov/dhs/autism/docs/autism-aba-service-policy-and-procedures.pdf>). NOTE: Service authorization must be received and approved prior to services being rendered.

TELEMEDICINE

Health Services billed by schools can be delivered via telemedicine; however, no originating site fee is allowed. See Services Rendered via Telemedicine chapter for additional information.

SCHOOL PSYCHOLOGISTS

The Centers for Medicare and Medicaid Services (CMS) has clarified that they would expect the Medicaid agency to ensure the practitioner qualifications for services furnished in all community locations, including schools, are minimally the same. Because School Psychologist qualifications are not minimally the same as Psychologists who are licensed by the Board of Psychological Examiners, North Dakota Medicaid is not able to recognize school psychologists as a Medicaid provider.

NONCOVERED SERVICES

Services that are not covered include:

- Services provided that are not documented in the Medicaid-eligible student's IEP.
- Services not authorized by the appropriate authorization or written order.

- Services that are not provided directly to the child such as attendance at staff meetings, IEP meetings, staff supervision, member screening, development and use of instructional text and treatment materials.
- Communications between the provider and child that is not face-to-face.
- Transportation to and from home to school.
- Population screenings such as lice checks.
- Services considered experimental or investigational.
- Services considered educational or instructional in nature.
- Medication administration.

FREE CARE AND THIRD PARTY LIABILITY

Services provided to Medicaid-eligible children that are part of an IEP are not subject to the same Medicaid Free Care and third party liability requirements. A 2014 State Medicaid Director Letter (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>) provided clarification to Medicaid agencies. The guidance clarifies that the Medicaid statute contains an exception at section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to services provided by schools to Medicaid-eligible children in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the IDEA. Public agencies (schools) with general responsibilities to ensure health and welfare are not considered liable third parties.

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

ND Medicaid covers services provided by Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that are certified, licensed and enrolled with ND Medicaid.

LEVEL OF CARE

ND Medicaid will not cover ICF/IID services unless the member meets ICF/IID level of care criteria.

LIMITS ON LEAVE DAYS

ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. The purpose of the hospital leave policy is to ensure that a bed is available when a member returns to the facility. A facility may not bill for hospital leave days if it is known that the member will not return to the facility.

Once the facility accepts payment for hospital leave on behalf of a Medicaid member, then the facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held; however, any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 30 therapeutic leave days per member per calendar year.

Once the facility accepts payment for therapeutic leave on behalf of a Medicaid member, then the facility must still bill ND Medicaid for therapeutic leave days beyond the beyond the 30th day that the resident's bed was held; however, any days exceeding the 30-day limit are noncovered days.

BILLING GUIDELINES

A member on medical or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of units billed must include the date of discharge or death.

ICF/IID claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Adult Licensed Facility

Revenue Code 0110	In-House Medicaid Days
Revenue Code 0180	Therapeutic Leave Days
Revenue Code 0182	Hospital Leave Days

Children's Licensed Facility

Revenue Code 0120	In-House Medicaid Days
Revenue Code 0183	Therapeutic Leave Days
Revenue Code 0185	Hospital Leave Days

A facility must submit a claim for every month a Medicaid member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make any payment for ICF/IID services to the ICF/IID provider if a member has elected hospice care. The hospice is paid the rate applicable to the member and is responsible for paying the facility for services provided to the member. Once a member has elected hospice benefits, the ICF/IID provider may not submit a claim for services provided while the member is on hospice.

LAB, RADIOLOGICAL, AND DIAGNOSTIC SERVICES

ND Medicaid covers services performed by a provider of (independent) laboratory services, (independent) x-ray services, or portable x-ray services, who are certified by Medicare and enrolled with ND Medicaid.

INDEPENDENT LABORATORIES, MEDICARE CERTIFIED

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

CODING GUIDELINES

ND Medicaid follows CMS National Coverage Determination (NCD) and specified Local Coverage Determination (LCD) guidelines for some laboratory, radiological and diagnostic procedures.

COMPONENTS OF AND BILLING FOR RADIOLOGIC SERVICES

Both professional and technical components may be billed to ND Medicaid. The professional component is applicable in any duration in which the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities. To bill for the professional component, use the applicable procedure code appended with modifier 26 in the appropriate modifier field of the CMS1500 claim form or the electronic equivalent. When more than one provider is involved with providing and billing the procedure the providers should establish a written agreement as to which component each provider will be billing. Providers found to be submitting duplicate claims will be referred to the Medicaid Program Integrity unit.

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

The technical component includes the charges for personnel, materials, including usual contrast media and drugs, film or xerograph, space, equipment and other facilities but excludes the cost of radioisotopes. (Technical components may be billed by providers

owning the equipment). To identify a charge for the technical component, enter the procedure code and append modifier TC in the appropriate modifier field.

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

LABORATORY SERVICES IN A PHYSICIAN'S OFFICE

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

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

CT SCAN / MRI

ND Medicaid will only cover medically necessary MRI and CT scans. MRI and CT scans can be used for the diagnosis of many medical conditions. Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis.

LOCAL PUBLIC HEALTH UNITS (LPHU)

COVERED SERVICES

ND Medicaid pays for medically necessary covered Medicaid services provided by local public health units.

Billed services must be based on a specific service provided to an eligible ND Medicaid member.

ND Medicaid will cover the following services provided by LPHUs:

HCPCS/ CPT Code	Description
D1206	Topical application of fluoride varnish (ages 6 months through 20 years only)
G0270	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
S0302	Completed EPSDT service (Health Tracks Screening)
S0390	Routine foot care
T1001	Nursing assessment / Evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1015	Clinic visit / encounter, all-inclusive service (OPOP visit)
T1030	Nursing care, in the home, by RN, per diem
T1031	Nursing care, in the home, by LPN, per diem
V5008	Hearing screening w/ report (cannot be reported with EPSDT service or nursing assessment or service.)
36415	Collection of blood by venipuncture
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)
69210	Removal impacted cerumen, on ear both ears
92567	Tympanometry (impedance testing)
94760	Non-invasive ear or pulse oximetry for oxygen saturation; single
95115	Professional service for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections
96110	Developmental screening
96127	Brief emotional or behavioral assessment
96161	Maternal Depression Screening

96372	Therapeutic, prophylactic or diagnostic injection (specify the material injected); subq or IM
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97804	Medical nutrition therapy, group (2 or more individuals), each 30 minutes
Laboratory Services	
G0432	Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv-1 and / or hiv-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (elisa) technique, hiv-1 and / or hiv-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, hiv-1 and / or hiv-2, screening
G0475	HIV antigen / antibody, combination assay, screening
80061	Lipid panel
81002	Urinalysis, non-automated, without microscopy
82270	Occult blood feces
82465	Assay blood serum cholesterol
82947	Assay glucose blood quantitative
82948	Blood glucose, reagent strip
83655	Assay of lead
85018	Hemoglobin
85610	Prothrombin time
86580	TB skin test
87430	Strep, group A
Vaccines / Toxoids	
Complete Vaccine / Toxoid coverage information can be found at http://www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html	

INDIVIDUALIZED EDUCATION PROGRAM (IEP) RELATED SERVICES

Services provided to Medicaid-eligible children in a school setting that are authorized or prescribed in the child's IEP must be billed to ND Medicaid by the school district. Refer to Individualized Education Program Medicaid Services Billed by Schools chapter.

NONCOVERED SERVICES

Services that are not covered include:

- Mass screenings i.e. lice checks, hearing screenings, scoliosis screenings.
- Medication administration (supervision of oral medication).

MEDICAID ELIGIBILITY OF MEMBER

Medicaid is authorized under Title XIX of the Social Security Act and provides health care coverage for low-income people. .

WHERE TO APPLY FOR MEDICAID BENEFITS

Applications for Medicaid benefits can be completed online, manually or by mail. Instructions are available at www.nd.gov/dhs/services/medicalserv/medicaid/apply.html.

WHO IS ELIGIBLE FOR MEDICAID?

Medicaid provides coverage to:

- Low-income individuals
- Children in foster care or subsidized adoption
- Former foster care children up to age 26, under certain circumstances
- Children with disabilities (birth to 19)
- Pregnant women
- Individuals with breast or cervical cancer or a pre-cancerous condition who are screened through a Center's for Disease Control Breast and Cervical Cancer Early Detection program
- Workers with disabilities
- Other blind and disabled individuals
- Low-income Medicare beneficiaries (Medicare Savings Programs)

More information on Medicaid eligibility requirements can be found at www.nd.gov/dhs/services/medicalserv/medicaid/eligible.html

MEDICAL NUTRITIONAL THERAPY

Medical nutrition therapy consists of counseling for individuals in relation to the nutritive and metabolic processes of the body. Medical nutrition therapy may be provided by licensed registered dietitians who are enrolled with ND Medicaid. Medical nutrition therapy may also be provided by a certified diabetes educator who is practicing under the supervision of a practitioner enrolled with ND Medicaid. If a licensed registered dietitian does not enroll with ND Medicaid, they may provide medical nutrition therapy under the supervision of a practitioner enrolled with ND Medicaid. Licensed registered dietitians or certified diabetes educators rendering medical nutrition therapy under the supervision of a practitioner must follow “incident to” requirements.

COVERAGE LIMITATIONS

To receive payment, a licensed registered dietitian must enroll as an independent Medicaid provider or be part of a clinic or FQHC. Certified diabetes educators may not enroll independently and must be part of a clinic or FQHC for services to be covered.

Nutritional services are allowed up to four (4) hours per calendar year without service authorization. Additional services may be authorized if determined to be medically necessary.

COVERED SERVICES

HCPCS/ CPT Code	Description
G0270	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97804	Medical nutrition therapy, group (2 or more individuals), each 30 minutes

NONCOVERED SERVICES

- Exercise classes
- Nutritional supplements for the purpose of weight reduction
- Instructional materials and books

MEDICARE COVERAGE

MEMBERS WITH MEDICARE

Medicaid members enrolled in the federally administered Medicare program are referred to as dual eligible. Medicare currently consists of three parts:

- **Medicare Part A** includes coverage for inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care;
- **Medicare Part B** includes coverage for doctor and other health care providers' services, outpatient care, durable medical equipment, home health care and some preventive services; and
- **Medicare Part D** is prescription drug coverage.

Medicare is the primary insurer for all dual eligible members. Medicaid may be required to pay some or all of the member's Medicare premium, deductible and coinsurance costs, depending if the member is eligible under one of the following types of Medicare Savings Programs:

- **Qualified Medicare Beneficiaries (QMB)** Medicaid will pay Part B premium and will make payments only toward Medicare coinsurance and deductibles.
- **Special Low-Income Medicare Beneficiaries (SLMB)** Medicaid will pay the Part B premium only.
- **Qualifying Individual (QI1)** Medicaid will pay Part B premium only. These individuals cannot be eligible for Medicaid.

NONCOVERED MEDICAID SERVICES

This list refers to services that are not covered by the ND Medicaid program. Please note: This is **not** an all-inclusive list.

- Abortions (exceptions are rape, incest or to save the life of the mother)
- Acupuncture
- Alcoholic beverages
- Artificial insemination
- Autopsies
- Body piercing
- Care Plan Oversight Services
- Dental implants
- Drugs that are not approved by the FDA
- Drug testing
- Equine therapy
- Experimental services and procedures
- Gender reassignment surgery
- Health services paid by another source i.e. Workers Compensation claims, eyeglasses covered by Fraternal Organization
- Health services which require service authorizations that were not obtained according to program policy and rules
- Health services that do not comply with guidelines and limitations
- Health services, other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian
- Health services for which a physician's order, a recommendation from a practitioner of the health arts, or a PCP referral are required but not obtained
- Health services not in the member's plan of care
- Health services not documented in the member's health/medical record
- Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers. (Providers of services, which are determined to be of low quality, must bear the cost of these services)
- Home modifications to accommodate mobility (example: wheelchair ramp, etc.)
- Hypnotherapy
- Infertility (testing, treatment, diagnostics or any related services)
- Interpreter services
- Massage therapy
- Missed appointments (providers may bill clients for missed appointments, if this is the normal practice for all patients)

- More than one office, hospital, long-term care facility, or home visit by the same provider, per member per day, except for an emergency
- Music therapy
- Non-CLIA certified lab services
- Non face-to-face services (i.e. telephone, email)
- Out of state services that were not prior approved
- Paternity testing
- Patient convenience (example: moving patient to facility closer to home)
- Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropic, analgesics or ADHD stimulant medications
- Reversal of sterilization
- Routine circumcisions
- Routine physical examination except for members in an ICF/IID
- Services for detoxification unless medically necessary to treat an emergency
- Services for members ages 21 through 64 in an Institution for Mental Disease (IMD)
- Services provided by Alcoholics Anonymous
- Services performed outside of the practitioner's scope of practice as defined by state laws
- Services that are not medically necessary
- Services received by a member on the Coordinated Services Program (CSP) that were not referred by the CSP provider
- Services rendered to a member without a Primary Care Provider (PCP) referral
- Services that were denied by a third party payer because third party requirements were not followed
- Tattoo or tattoo removal
- Transportation for non-medical appointments
- Weight loss programs and exercise programs
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP Medicaid services billed by schools

NON-EMERGENCY MEDICAL TRANSPORTATION (INCLUDING MEALS AND LODGING)

GENERAL REQUIREMENTS

Non-emergency medical transportation (NEMT) includes services provided by an individual, taxi, van, bus, airline, train or other commercial carrier. NEMT may also include lodging and meal reimbursement. Limitations on non-emergency medical transportation are addressed in North Dakota Administrative Code (NDAC) 75-02-02-13.1.

A NEMT provider must be enrolled in the ND Medicaid program and meet all applicable licensing requirements. ND Medicaid does not require vehicle insurance information to be submitted; however, it is the provider's responsibility to ensure that their insurance coverage is appropriate for the services they are providing. All providers including any hired drivers, are required to have a valid driver's license.

Human services zone or tribal offices authorized by ND Medicaid to approve and provide transportation must determine the most efficient, economical and appropriate means of transportation to meet the medical needs of the member. Except for transportation from a hospital (see below), other NEMT must be prior approved using either the Non-Emergency Medical Transportation Authorization (SFN 294) or Taxi Voucher (SFN 170). Human services zones and tribes are responsible for authorizing (approving) transportation and issuing the necessary reimbursement forms. A copy of the approved SFN 294 or SFN 170 must be provided to the transportation provider prior to transportation of the member.

Tribal offices are not required to obtain approval from a human services zone to transport members in state; however, tribal offices are required to obtain authorization from the human services zone for transportation, meals and lodging for a member receiving out of state services.

Only in extremely rare circumstances are friends, family or neighbors enrolled to provide non-emergency medical transportation. An individual who provides foster care, kinship or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a ND Medicaid eligible child to and from covered medical and dental appointments in situations in which the ND Medicaid eligible child's medical needs exceed ordinary, typical and routine levels. A court ordered guardian of a vulnerable adult may enroll as a transportation provider and is eligible for reimbursement to transport a ND Medicaid adult to and from covered medical and dental appointments.

A member may choose to obtain medical or dental services outside the member's community. If similar medical or dental services are available within the community and the member chooses to seek medical or dental services elsewhere, transportation expenses are not covered and are the responsibility of the member.

NONCOVERED SERVICES

Services that are not covered include:

- Transportation to a noncovered medical or dental service;
- Transportation of a member to a hospital or other site of health services that is ordered by a court or law enforcement agency;
- Charges for luggage, stair carry of the member or other airport, bus, or railroad terminal services;
- Transportation of a member to a noncovered provider or location (e.g. grocery store, health club, school, etc.); or
- Parking fees.

USUAL AND CUSTOMARY CHARGES

ND Medicaid requires providers to bill their usual and customary fee charged to their largest share of business other than Medicaid members. A transportation provider whose business includes riders in addition to Medicaid members cannot charge Medicaid more than the rate charged to its non-Medicaid business. If a transportation provider discounts multiple rider trips for non-Medicaid riders, the provider also must discount the amount billed for Medicaid riders, and must charge the same rates or offer free rides to Medicaid members. If a provider serves only Medicaid members, the rate charged for Medicaid member is the usual and customary fee.

TRANSPORTATION OF INDIVIDUALS WITH DISABILITY

Three criteria must be met for transportation of an individual with a disability via a wheelchair van or stretcher van:

- The member must have a mobility impairment of a severity that prevents the member from safely accessing and using a bus, taxi, private automobile, or other common carrier transportation;
- The trip must be to or from a ND Medicaid covered service; and
- The trip must be authorized by the human services zone or tribal office with a SFN 294.

TRANSPORTATION BY PRIVATE VEHICLE

Non-commercial/volunteer (private) vehicle mileage reimbursement will be according to the Medicaid fee schedule and requires a Non-Emergency Medical Transportation Authorization (SFN 294) from the appropriate human services zone or tribal office.

Providers may bill for only one member, regardless of the number of members being transported during a trip. Mileage is determined by map miles from the residence or community of the member to the medical facility. When necessary, to ensure volunteer drivers continue to provide transportation services to a member, the human services zone may request authorization from ND Medicaid to make payment for additional mileage. Private vehicle mileage may be billed to ND Medicaid only upon completion of the service. Private vehicle mileage may be allowed if the member or a household member does not have a vehicle that is in operable condition or if the health of the member or household member does not permit safe operation of the vehicle.

Transportation providers may only bill for distance travelled with the member in the vehicle (loaded miles). Providers may not bill for the distance travelled to pick up the member or the return trip to the provider's residence or business location after the member has been dropped off.

TRANSPORTATION BY TAXI

Transportation via Taxi must be prior approved using the Taxi Voucher (SFN 170). Members are expected to contact the human services zone or tribal office to determine if taxi transportation is the most appropriate and economical means of transportation for the member to their medical or dental appointment. The human services zone or tribal office may provide the approved Taxi Voucher (SFN 170) to the member or the taxi provider. The taxi provider is responsible for keeping the SFN 170 on file to support each claim submitted for reimbursement.

Taxi service will only be allowed from the member's home, school or work to their medical or dental appointment. The return trip from the medical or dental appointment will only be allowed to the member's home, school or work. Mileage is determined by map miles from the pickup location of the member to the medical or dental facility.

ND Medicaid allows exceptions when an emergency arises at another location other than those listed above, i.e. a member becomes ill while at a restaurant and needs medical attention, with no other means of transportation available. This exception must be documented by the taxi company for review by ND Medicaid.

URGENT TRANSPORTATION

In the event of an urgent medical situation, the NEMT provider is responsible for acquiring authorization via either the SFN 294 or SFN 170 from the appropriate human services zone or tribal office after the transportation has been provided. NEMT providers are required to request the authorization with 72 hours after providing urgent transportation. The human services zone or tribal office has five business days to provide the transportation provider with an approval or denial for the retrospective authorization. An approved retrospective authorization must include in the "Destination"

field if it was an ER or after-hours urgent care visit. The use of retrospective authorizations is limited to member's being transported on weekends, evenings or holidays when the human services zone or tribal office is not open.

NURSING FACILITY TRANSPORTATION

In-State Nursing Facilities

An in-state nursing facility may not bill ND Medicaid or charge a Medicaid eligible resident for transportation services provided by the facility.

ND Medicaid covers medically necessary transportation from a hospital to a nursing facility of the member's choice.

Minnesota Nursing Facilities

Non-emergency medical transportation of ND Medicaid members residing in Minnesota nursing facilities is covered by ND Medicaid and is paid separately from the daily rate paid to the nursing facility.

TRANSPORTATION FROM HOSPITAL

Upon discharge from an inpatient or outpatient service, hospitals may arrange and authorize the medically appropriate mode of transportation based on the member's medical condition. Hospital staff must complete the Medical Certificate of Transportation Services (SFN 249). A copy must be furnished to the NEMT provider and a copy kept in the member's medical record.

OUT OF STATE

Out of state transportation/meals/lodging to a provider located more than 50 statute miles from the nearest ND border requires a service authorization from ND Medicaid. If the out of state service is not authorized by ND Medicaid, any transportation expenses associated with the out of state service becomes the expense of the member.

MEALS AND LODGING

Payment for meals and lodging is allowed only when medical services or travel arrangements require a member to stay overnight. Payment will be made only to enrolled providers, according to the ND Medicaid fee schedule. Payment will not be made to the member.

Overnight travel is defined as pre-approved travel requiring an overnight stay. This may apply when the member must travel the day prior to an appointment to arrive on time or prepare for the appointment or upon completion of the appointment if, the return home is excessively burdensome or is not feasible for the member.

EXPENSES FOR DRIVER AND/OR ATTENDANT

Meal and lodging expenses may be authorized for a driver. Meal and lodging expenses may be authorized for an attendant only if the referring provider determines an attendant is medically necessary. Meal and lodging expenses may not be authorized for both a driver and an attendant unless the referring provider determines that one individual cannot function both as driver and attendant. Meal and lodging expenses are not allowed for a driver or attendant while the member is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area.

Meal and lodging expenses may be authorized for one parent to travel with a child who is under eighteen (18) years of age. Meal and lodging expenses will not be authorized for another driver, attendant, or parent unless the referring provider determines that another driver, attendant or parent's presence is necessary for the physical, or medical needs of the child.

PARENT/LEGAL GUARDIAN TRANSPORTED WITHOUT MEMBER

ND Medicaid allows the transportation, lodging and meals for one parent/legal guardian of a member under the age of 18 without the member present to travel to and from the medical facility for the purpose of providing support and care to the member.

CLAIMS SUBMISSION

Transportation, lodging and meal providers must bill for services via the North Dakota Web Portal using the electronic claims submission web pages. If a provider has a National Provider Identifier (NPI), they may bill on a professional claim.

BILLING GUIDELINES

Transportation services must be prior approved and authorized by the human services zone or tribe with a Non-Emergency Transportation Authorization (SFN 294) or Taxi Voucher (SFN 170); or by a hospital with a Medical Certificate of Transportation Services (SFN 249).

In addition, a Non-Emergency Transportation Trip Ticket (SFN 296) must be completed and submitted by providers that bill A0800, A0120, A0170, A0130, S0209, T2005 and T2049.

Transportation providers are responsible for keeping written records for each member that is transported to a covered service. In order to protect the privacy of members, records should not include the name of the provider that the member has the appointment with and should only include the facility name.

Failure to maintain the required documentation may result in a transportation provider being terminated and in ND Medicaid pursuing overpayment recoveries.

Documentation must be retained for five (5) years from the date of the last service provided.

Transportation providers must retain your records even if they stop providing transportation services. ND Medicaid and other federal and state agencies have the right to audit records and request supporting documentation for claims submitted for five (5) years from the date of service

Newly enrolled providers are placed on review for a period determined by ND Medicaid to ensure that procedures are followed, and correct documentation is submitted. During this review period NEMT providers are required to submit the applicable SFN 294, SFN 170, SFN 249 and/or SFN 296 with each claim.

FORMS

- <https://www.nd.gov/eforms/Doc/sfn00170.pdf>
- <https://www.nd.gov/eforms/Doc/sfn00249.pdf>
- <https://www.nd.gov/eforms/Doc/sfn00294.pdf>
- <https://www.nd.gov/eforms/Doc/sfn00296.pdf>

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

ND Medicaid covers medically necessary services provided by Nurses Practitioners (NP) and Physician Assistants (PA) enrolled with ND Medicaid.

NPs and PAs must receive an individual provider number even if they are a member of a group, clinic or employed by an outpatient hospital or other organized health care delivery system.

Medicaid billable services consist of services otherwise covered as a physician service that are within the scope of practice of the NP or PA license.

Nurse practitioners and physician assistants may serve as primary care providers (PCP) within the Primary Care Case Management (PCCM) program.

Nurse practitioners and physician assistants must enroll and obtain their own ND Medicaid provider number.

NURSING FACILITIES

ND Medicaid covers services provided by nursing facilities (NF) that are certified to participate in the Medicare program, licensed and enrolled with North Dakota (ND) Medicaid.

LEVEL OF CARE

ND Medicaid will not cover nursing facility services unless the member meets nursing facility level of care criteria.

LIMITS ON LEAVE DAYS

ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. The purpose of the hospital leave policy is to ensure that a bed is available when a resident returns to the nursing facility. A nursing facility may not bill for hospital leave days if it is known that the resident will not return to the facility.

Once the nursing facility accepts payment for hospital leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held; however, any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 24 therapeutic leave days per resident per rate year. The rate year begins January 1st for in-state long term care (LTC) nursing facilities.

Once the nursing facility accepts payment for therapeutic leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for therapeutic leave days beyond the 24th day that the resident's bed was held; however, any days exceeding the 24-day limit are noncovered days.

Hospital and therapeutic leave days, occurring immediately following a period when a resident received Medicare Part A benefits in the facility, are noncovered days.

The day of death is paid for in all instances except when a resident is in a Medicare benefit period, in which case the day of death is a noncovered day. The day of discharge to any location for a resident is a noncovered day.

BILLING GUIDELINES

A resident on hospital or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of units billed must include the date of discharge or death.

A separate claim line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed.

Claims must be submitted using the following *Revenue Codes* when billing for:

Revenue Code 0110	In-House Medicaid Days (private)
Revenue Code 0120	In-House Medicaid Days (semiprivate)
Revenue Code 0160	Medicare Full Benefit Period Days
Revenue Code 0169	Medicare Coinsurance Days
Revenue Code 0182	Medicare Noncovered Leave Days
Revenue Code 0183	Therapeutic Leave Days
Revenue Code 0185	Hospital Leave Days

A facility must submit a claim for every month a Medicaid member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make payment for nursing facility services to the nursing facility provider if a resident has elected hospice care. The hospice is paid the rate applicable to the resident and is responsible for paying the nursing facility for services provided to the resident. Recipient liability, if any, is applied to the hospice provider's claim. Once a resident has elected hospice benefits, the LTC nursing facility provider may not submit a claim for services provided while the resident is on hospice.

A hospice provider must submit a revocation of election form to ND Medicaid before payment can be made to a nursing facility for a resident who no longer is receiving hospice benefits. The facility should contact the hospice provider to ensure that a revocation notice has been filed with ND Medicaid prior to billing for nursing facility services.

IN-STATE NURSING FACILITIES

The rate established for in-state nursing facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the in-state nursing facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

OUT OF STATE NURSING FACILITIES

The rate for out of state nursing facilities is based on the rate established by the Medicaid agency in the state where the facility is located. The routine services included in the rate are determined by the rate established by that state's Medicaid agency, such as; supplies, therapies, nursing facility supplies, equipment, nonemergency transportation and non-legend drugs. Ancillary charges that are not included in the out of state nursing facility rate must be billed by the provider furnishing the service.

OCCUPATIONAL THERAPY

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

COVERED SERVICES

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

Occupational therapy services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge and skills of a qualified occupational therapist.

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

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

The following is a list of ND Medicaid covered CPT codes:

96110	Developmental screening
96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes
96127	Brief emotional or behavioral assessment
97039, 97139 & 97799	Unlisted modality, procedure or service These codes always require service authorization and will not be considered for services identified as noncovered in this chapter.
97165	Evaluation of occupational therapy, typically 30 minutes
97166	Evaluation of occupational therapy, typically 45 minutes
97167	Evaluation of occupational therapy established plan of care, typically 60 minutes
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
97010	Application of hot or cold packs to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes

PLAN OF CARE (TREATMENT PLAN)

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

or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

The plan of care/treatment plan shall contain, at minimum:

- Diagnosis;
- Long term treatment goals;
- Type, amount, duration and frequency of therapy services;
- A description of the member's functional status;
- The objectives of the occupational therapy service; and
- A description of the member's progress toward the objectives.

The plan of care (treatment plan) shall be consistent with the related evaluation and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

Occupational therapy services must:

- Be prescribed by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law; and
- Have a plan of care (treatment plan) that is signed within 45 days of the initiation of therapy, by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Recertification of the plan of care must occur within 60-days from the date of the initial evaluation or encounter. Subsequent recertification(s) must occur at 60-day intervals throughout the course of treatment.

Providers should follow their standard retention and documentation practices for the recertifications, which are subject to audit and review if procedures are billed to ND Medicaid for an eligible member.

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 20 visits per calendar year for members age 21 and over. ND Medicaid will not cover services in excess of the limit that are provided without a service authorization. The provider must

complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid, prior to the member's receipt of additional services. A copy of the plan of care recertification must be submitted with the service authorization. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed as part of the service authorization request:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals; and
- New long-term goals.

Upon receipt of the complete service authorization request, ND Medicaid will evaluate the plan of care/treatment plan for the following:

- Medical necessity;
- Accomplishment of prior goals;
- Progress;
- Reasonable new goals; and
- Maintenance care.

NONCOVERED SERVICES

Services that are not covered include:

- Occupational therapy that is provided without a prescription from a physician or licensed practitioner of the healing arts;
- Services for contracture that are not severe and do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care (treatment plan) or are specified in a plan of care (treatment plan) but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;

- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's Individualized Education Plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Occupational therapy services provided in a nursing facility or ICF/IID. Medicaid pays for those service through the rate established for the facility;
- Masseur or masseuse services;
- Services that are experimental or investigational;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization or any other visualization therapy;
- Dry needling;
- Kinesio Taping;
- Acupuncture;
- Maintenance therapy.

OPTOMETRIC AND EYEGLOSS SERVICES

ND Medicaid covers services provided by an ophthalmologist, optometrist or optician who is licensed and is enrolled with ND Medicaid. Services are covered when they are within the scope of the provider's practice and are also a covered service by ND Medicaid.

Providers seeking approval for optometric and eyeglass services requiring service authorization must submit a Request for Service Authorization for Vision Services (SFN 292) <https://www.nd.gov/eforms/Doc/sfn00292.pdf>

EYE EXAMS

Members ages 21 and over are limited to one eye examination and refraction every two years. Members ages 20 and under are limited to one eye examination and refraction every 365 days. ND Medicaid allows exceptions to these limits when one of the following conditions exists. Service authorization for an exception is required:

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

SERVICES FOR MEMBERS WITH LIMITED MEDICAID COVERAGE

Medicaid generally does not cover eye exams or eyeglasses for members with Qualified Medicare Beneficiary (QMB) coverage. Always check member eligibility before providing services. ND Medicaid may cover eye exams under the following conditions:

- Following cataract surgery: Members who have QMB only coverage are only eligible for eyeglasses following cataract surgery when Medicare approves the eyeglasses claim. ND Medicaid considers the Medicare coinsurance and deductible for this claim.
- Diabetic diagnosis: Members with basic Medicaid coverage, not QMB, who have a diabetic diagnosis (see following table). Eyeglasses are not covered for these members.
- Medically Necessary Eye Examinations: Eye exams for members with basic Medicaid coverage, not QMB, who have certain eye conditions (see following table). Eyeglasses are not covered for these members.

RETROACTIVE ELIGIBILITY

ND Medicaid does not cover eyeglasses for members who become eligible for Medicaid retroactively when the eyeglasses were purchased before retroactive eligibility was determined. However, eye exams are covered for members who become eligible retroactively. For example, a member had an eye exam and ordered eyeglasses on

July 15. On September 1, the member was determined eligible for Medicaid retroactive to July 1. ND Medicaid would cover the eye exam, but not the eyeglasses.

EYEGLASSES

Members ages 21 and older are eligible for eyeglasses every two years. Members ages 20 and under are eligible for eyeglasses every 365 days.

If the member has a diagnosed medical condition that prohibits the use of the pair of eyeglasses that has been dispensed to the ND Medicaid member, an exception may be made allowing eyeglasses to be dispensed outside of the limit requirement. Providers are required to submit a service authorization request and document the member's inability to use the eyeglasses that have been dispensed.

FRAME SERVICES

ND Medicaid will only cover lenses and frames purchased through ND Medicaid's eyeglasses contractor. The eyeglasses contractor will provide a list of Medicaid covered frames to dispensing providers.

Members have the option of using their “existing frames” and ND Medicaid will cover lenses. The existing frame is a frame that the member owns or purchases. When a member chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglasses contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglasses contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the member), ND Medicaid will pay for a frame covered under the eyeglasses contract, but not new lenses. The member can choose to pay privately for new lenses or choose a contract frame that the lenses will fit.

LENS ADD-ONS

Lens Feature	Covered for Children (Ages 20 and Under)	Covered for Adults (Ages 21 and Older)
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary with Service Authorization	Yes – if medically necessary with Service Authorization
Photochromic - Glass (i.e. photogray, photo-brown)	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization
Progressive	No	No
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes	Yes

	Yes	No
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)		
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization
Ultraviolet	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization
Slab-off and fresnell prism	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization

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

LENS STYLES AND MATERIALS

All lenses fabricated by the eyeglasses contractor for members 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.

ND Medicaid covers the following lens styles:

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

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

- Glass;
- CR-39;
- Polycarbonates.

REPAIR AND REFITTING

Services involving repair and refitting require service authorization.

REPLACEMENT LENSES AND FRAMES

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

If an adult (age 21 and older) loses or breaks his or her eyeglasses within the 2-year replacement timeframe, ND Medicaid will not cover another pair.

If a child (age 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, ND Medicaid will replace one pair of eyeglasses within the 365-day replacement timeframe. All replacement requests must be prior authorized.

ORDERING EYEGLASSES

Providers must order eyeglasses from the designated eyeglass contractor, Classic Optical. Eyeglasses orders can be submitted on-line at:

<https://www.classicoptical.com/Orders.asp>

DISPENSING SERVICES

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

CONTACT LENSES – SERVICE AUTHORIZATION AND INVOICE REQUIRED

Contact lenses and applicable dispensing fees require service authorization and are covered only when medically necessary and not for cosmetic reasons. 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.

ND Medicaid covers contact lenses when the member has one of the following conditions:

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

NONCOVERED SERVICES

Services that are not covered include:

- Services considered experimental or investigational.
- Dispensing fees for a member 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.

OUT OF STATE SERVICES

OUT OF STATE SERVICES

Out of state services are care or services rendered by a provider that is located more than fifty statute miles outside of North Dakota. An out of state provider may be an individual or a facility but may not be located outside the United States.

MEDICAID COVERED OUT OF STATE SERVICES

Out of state services provided to a ND Medicaid member must be covered ND Medicaid services, medically necessary, and rendered by a provider enrolled with ND Medicaid. In addition, out of state providers may receive payment for services rendered only under the following circumstances:

- The service has received service authorization from ND Medicaid; or
- The health service is provided in response to an emergency while a member is out of the state; or
- The health service is provided to a Non-Title IV-E child for whom North Dakota makes a state foster care payment or adoption assistance payment.

REQUESTING OUT OF STATE SERVICES

The member's North Dakota primary care provider and/or North Dakota specialty provider must submit a written request to ND Medicaid for authorization of each out of state service at least two weeks before scheduling an appointment.

Requests must include a Request for Service Authorization of Out of State Services (SFN 769), indicating:

- Member's name, date of birth and Medicaid number;
- Diagnosis;
- Reason for out of state care;
- The in-state primary care provider and/or specialist;
- The out of state physician and/or the facility being referred to;
- Current (within three months) medical information supporting the need for out of state services;
- A written second opinion from an appropriate in-state board certified specialist; and
- Assurance that the service is not available in North Dakota.

Upon receipt of the above information, ND Medicaid will determine if the request for out of state services meets requirements and will approve or deny the request in writing, which will be sent to the requesting in-state provider(s), member, out of state provider(s)

and human service zone office. The human service zone office is responsible for assisting members with travel, lodging and meal arrangements.

CHILDREN RECEIVING ADOPTION AND FOSTER CARE ASSISTANCE

Children residing out of state and receiving a state funded adoption subsidy (Non IV-E) may be eligible for Medicaid until the age of 18 and possibly to the age of 21 (if the resident state offers Medicaid to youth over the age of 18). The child may be eligible to receive Medicaid in his/her state of residence through the provisions of the Interstate Compact on Adoption and Medical Assistance (ICAMA). When moving out of state, the adoptive parent is to notify the human service zone office administering their subsidy payment. If the state of residence has facilitated joinder in the Interstate Compact and gives reciprocity to other member states, the child will qualify for Medicaid in the state of residence. The state of residence is then notified of the child's eligibility for Medicaid through the ICAMA notification process. This is done through the Children and Family Services Division of the Department of Human Services. If the state of residence has NOT facilitated joinder in the Interstate Compact and does NOT give reciprocity to other member states, the child will NOT qualify for Medicaid in the state of residence. In these situations, the child may continue to receive Medicaid through North Dakota. Many out of state providers are not enrolled with ND Medicaid and it is the responsibility of the adoptive parents to approach out of state providers about enrolling with ND Medicaid. Services provided to children with a state-funded subsidy, that are not covered by ND Medicaid, may be funded through the state funded adoption subsidy program.

Children in out of state placements with federal Title IV-E adoption subsidy or foster care payments are eligible for Medicaid in the state in which they reside. This includes temporary foster care placements.

Out of state providers that want to be reimbursed for covered services provided to children in foster care must enroll with ND Medicaid. Payment for services not covered by ND Medicaid may be the responsibility of a public agency and/or family.

OUT OF STATE EMERGENCY SERVICES

Emergency out of state services are allowable at the in-state physician's discretion but are subject to North Dakota Medicaid review. The transferring facility must notify North Dakota Medicaid within 48 hours of transfer. Documentation must include: a completed Request for Service Authorization for Out of State Services (SFN 769), date of transfer, mode of transportation and medical documentation, including the discharge summary. The in-state facility must provide medical evidence for the need for air ambulance whenever it is used.

When a member receives emergent medical or surgical care when traveling outside of North Dakota, the out of state facility must submit the admission history and physical

and discharge summary to North Dakota Medicaid for review to determine the medical necessity of the service.

URGENT OR EMERGENCY SERVICES FOR MEMBERS TEMPORARILY OUT OF THE STATE

In certain circumstances, ND Medicaid may cover urgent or emergency services for a member who is temporarily traveling outside of North Dakota. The out of state provider must enroll as a ND Medicaid provider and must submit supportive medical reports. Refer to the Out of State Provider section in the Provider Enrollment chapter of this manual.

ND Medicaid does not cover any services received outside of the United States.

SERVICES FOR INDIVIDUALS WITH A TRAUMATIC BRAIN INJURY (TBI)

Out of state services in a specialized facility/program for an individual with a traumatic brain injury requires service authorization. Requirements include:

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

The clinical information furnished by the referral source will be reviewed to determine if out of state placement is appropriate and medically necessary. If approval is granted, ND Medicaid will send an approval notice.

If the out of state facility is a Minnesota nursing facility specializing in services for individuals with a TBI, an out of state referral or approval is not required. However, the admitting Minnesota nursing facility must obtain a level of care determination from ND Medicaid's current contractor. Information regarding level of care procedures and screening forms are available at

www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html.

OUT OF STATE PSYCHIATRIC SERVICES FOR CHILDREN UNDER 21

Out of state psychiatric services for children under 21 require prior approval by ND Medicaid. A North Dakota agency requesting out of state psychiatric services for a child under 21 must ensure that appropriate in-state services are unavailable. The referring agency must be able to substantiate that:

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

- The child has been denied admission to available North Dakota facilities; or
- The program out of state is so unique that similar services are not available in North Dakota.

After ND Medicaid approval and prior to the child's admission, the out of state facility must complete an admission review with the ND Medicaid contractor to assure the child's cares and conditions meet North Dakota's certificate of need (CON) criteria. Additional information and CON forms are available in the manuals for psychiatric services for children under 21 located at

www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html

PARTIAL HOSPITALIZATION PSYCHIATRIC (PHP) SERVICES

ND Medicaid covers partial hospitalization psychiatric services provided to a member with an impairment resulting from a psychiatric, emotional or behavioral disorder. Services are provided by a multidisciplinary team of health care professionals, designed to stabilize the health of the member with the intent to avert inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization psychiatric services must be hospital based and under the supervision of a licensed physician.

Level A is an intense level of services by at least three licensed health care professionals for at least four hours and no more than eleven hours per day for at least three days per week.

Level B is an intermediate level of services by at least three licensed health care professionals for three hours per day for at least two days per week.

COVERAGE LIMITATIONS

The following limits have been established for partial hospitalization services.

Level A	45 days per calendar year per member
Level B	30 days per calendar year per member

Additional days may be authorized by ND Medicaid if determined to be medically necessary.

PHARMACY

ND Medicaid covers outpatient prescription drugs when prescribed by an enrolled prescriber and dispensed by an enrolled ND Medicaid provider.

See the Pharmacy Manual for specific billing and policy information at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html>.

PHYSICAL THERAPY

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

GENERAL INFORMATION

Physical therapy departments and their personnel must adhere to the “APTA Standards for Physical Therapy Services and Physical Therapy Practitioners”, the “North Dakota Physical Therapy Practice Act established in ND Century Code 43-26.1 and the NDPTA Guidelines for Physical Therapists”.

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

COVERED SERVICES

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

The services must be anticipated to progress toward or achieve the objectives in the member's treatment plan within a relatively short amount of time, not likely to exceed 90 days.

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

For individuals ages 21 and over, physical therapy is limited to 15 visits per calendar year. Service authorization is required for visits exceeding this limit.

The following is a list of ND Medicaid covered CPT codes:

96127	Brief emotional or behavioral assessment
97039, 97139 & 97799	Unlisted modality, procedure or service These codes always require service authorization and will not be considered for services identified as noncovered in this chapter.

97161	Evaluation of physical therapy, typically 20 minutes
97162	Evaluation of physical therapy, typically 30 minutes
97163	Evaluation of physical therapy, typically 45 minutes
97164	Re-evaluation of physical therapy, typically 20 minutes
97010	Application of hot or cold packs to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes

PLAN OF CARE (TREATMENT PLAN)

Physical therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

The plan of care/treatment plan shall contain, at minimum:

- Diagnosis;
- Long term treatment goals;
- Type, amount, duration and frequency of therapy services;
- A description of the member's functional status;
- The objectives of the physical therapy service; and
- A description of the member's progress toward the objectives.

The plan of care (treatment plan) shall be consistent with the related evaluation and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

Physical therapy services must:

- Be prescribed by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law; and
- Have a plan of care (treatment plan) that is signed within 45 days of the initiation of therapy, by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Recertification of the plan of care must occur within 60-days from the date of the initial evaluation or encounter. Subsequent recertification(s) must occur at 60-day intervals throughout the course of treatment.

Providers should follow their standard retention and documentation practices for the recertifications, which are subject to audit and review if procedures are billed to ND Medicaid for an eligible member.

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 15 visits per calendar year for members age 21 and over. ND Medicaid will not cover services in excess of the limit that are provided without a service authorization. The provider must complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid, prior to the member's receipt of additional services. A copy of the plan of care recertification must be submitted with the service authorization. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed as part of the service authorization request:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals; and
- New long-term goals.

Upon receipt of the complete service authorization request, ND Medicaid will evaluate the plan of care/treatment plan for the following:

- Medical necessity;
- Accomplishment of prior goals;
- Progress;
- Reasonable new goals; and
- Maintenance care.

NONCOVERED SERVICES

Services that are not covered include:

- Physical therapy that is provided without a prescription from a physician or licensed practitioner of the healing arts;
- Services for contracture that are not severe and do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care (treatment plan), or are specified in a plan of care (treatment plan) but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's individualized education plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Masseur or masseuse services;
- Services that are experimental or investigational;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization or any other visualization therapy;
- Dry needling;
- Kinesio Taping;

- Acupuncture;
- Maintenance therapy.

PHYSICIAN SERVICES

ND Medicaid covers medically necessary services provided by physicians enrolled with ND Medicaid. Physicians must receive an individual provider number even if the physician is a member of a group, clinic or is employed by an outpatient hospital or other organized health care delivery system that employs physicians.

SERVICES

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

Refer to the Lab, Radiological and Diagnostic Services chapter for specific information.

Only medically necessary services are covered, which is demonstrated by:

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

PREVENTATIVE HEALTH SERVICES

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

- The service is provided face-to-face to the member;
- The service affects the member's health condition rather than the member's physical environment;
- The service is not otherwise available to the member without cost as part of another preventive health program funded by a government or private agency;
- The service is not part of another covered service;
- The service minimizes an illness, infection or disability that will respond to treatment;
- The service is generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness;

- The service is ordered in writing by a physician and included in the plan of care approved by the physician.

Services that are not covered as preventive health services:

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

INCIDENTAL SURGICAL PROCEDURES

Incidental surgical procedures performed at the same time as other major surgery is not a billable item and ND Medicaid will not pay separately for these procedures.

Organ removal from a non-Medicaid eligible living donor and provided to a Medicaid-eligible member is considered part of the transplant procedure.

Costs associated with organ removal from a Medicaid-eligible member living donor and provided to another individual is the responsibility of the entity covering the organ transplant surgery.

ADDITIONAL SURGICAL PROCEDURES

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

The medical reason for the surgery must be substantiated with an ICD-10-CM code supported with documentation in the member's medical record.

CONCURRENT CARE

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

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

ND Medicaid will not pay for concurrent care when:

- The physician makes routine calls at the request of the member or member's family or as a matter of personal preference; or
- Available information does not support the medical necessity or concurrent care.

PROLONGED CARE

ND Medicaid covers prolonged services involving direct (face-to-face) patient contact. ND Medicaid does not cover prolonged services that do not involve providing direct (face-to-face) care.

Operative standby services are only covered in the case of a documented existing risk or distress, such as documented fetal distress.

TELEMEDICINE

See Telemedicine chapter for additional information.

ONCOLOGY DRUG TRIALS

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

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

NONCOVERED SERVICES

Services that are not covered include:

- Care plan oversight services;
- Team conference without patient present;
- Telephone calls, including telephone consultations;
- Preventative medicine counseling;
- Removal of healthy tissue or organs;
- Advance care planning.

PRIMARY CARE CASE MANAGEMENT (PCCM)

DEFINITIONS

- *Auto-Assignment*: The process by which ND Medicaid utilizes a default assignment of a Medicaid member to a PCP when a member does not select a PCP within a given time period, as defined by ND Medicaid.
- *Emergency Care*: Those services provided in response to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- *Primary Care*: All health care services, and laboratory services customarily furnished by or through a physician or advanced practice nurse working in the areas of general practice, family medicine, internal medicine, obstetrics/gynecology, adult health or pediatrics, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.
- *Primary Care Case Management (PCCM)*: Care coordination provided by a primary care provider that includes locating, providing, coordinating and monitoring health care services provided to Medicaid members.
- *Primary Care Provider (PCP)*: One provider chosen by the member or assigned by North Dakota Medicaid to provide primary care and case management services. The Primary Care Provider serves as an entry point into the medical and health care system and provides primary, preventive and routine health care services. PCPs are advocates for the member in coordinating and managing the use of the entire health care system to benefit the member.
- *Substitute PCP*: A provider within the same facility (same facility is defined as a facility that is associated with the Primary Care Provider's facility by having the same Medicaid Provider Identification number as the PCP's facility when submitting a claim) and with a type and specialty that may serve as a PCP or a provider with a type and specialty that may serve as a PCP that is located outside the facility but has a referral from the PCP to provide the necessary medical care to the PCP's designated Medicaid members until the PCP is able to resume care. Referrals must be documented and placed in the member's medical record at both the PCP and Referred to Provider's offices.

GENERAL INFORMATION

The PCCM program requires most Medicaid members to choose a Primary Care Provider (PCP) to help manage their health care needs and provide referrals for specialty services as needed.

Members are exempt from PCCM requirements during any period of Medicaid retroactive eligibility.

SELECTING A PRIMARY CARE PROVIDER (PCP)

Members required to enroll in PCCM must select a PCP within 14 days of their approval for Medicaid eligibility. Members that do not select a PCP within this time period are assigned a PCP by ND Medicaid. Once a PCP is selected or assigned, a member must follow the requirements of the PCCM program.

Selecting a PCP will facilitate a patient-provider relationship through which the PCP will carry out their PCCM program responsibilities of: (1) providing primary, preventive and routine health care services, (2) managing and coordinating the member's health care services, and (3) acting as an entry point into the health care system(4) providing referrals to other providers as needed.

Members can select either an individual provider or an entity to be their PCP. A physician, nurse practitioner, or physician assistant can be selected a PCP with one of the following a specialty areas:

- Family practice;
- Internal medicine;
- Obstetrics/gynecology;
- Pediatrics;
- Adult Health;
- General practice;

The following entities may be selected as a primary care provider:

- Rural Health Clinic (RHC);
- Federally Qualified Health Center (FQHC); or
- Indian Health Services (IHS) clinic or tribally operated 638 facility.

Providers enrolled with ND Medicaid who have one of the specialties noted above must complete the Contract to Provide Primary Care Case Management Services (SFN 1296) and become available as a PCP selection for potential members. The SFN 1296 includes the requirements for providing PCCM services, including prohibitions, sanctions and termination from participation. Providers who do not want to act as a PCP can make a request through via email to dhsmci@nd.gov.

VERIFICATION OF MEMBER ELIGIBILITY

It is the responsibility of the "referred to provider" to verify a member's Medicaid eligibility status and PCCM enrollment prior to providing services to the member. If the

member is enrolled in PCCM, the provider must assure necessary referrals from the member's designated PCP are in place prior to any services received by the member to receive consideration of payment by ND.

REFERRALS

The PCP is responsible for making referrals for services received by a member that require PCP authorizations. The table of covered services in the Medicaid Covered Services chapter of this manual provides information on those services which require a PCP referral.

Referral may be made via any of the following:

- North Dakota Medicaid PCCM Program Referral (SFN 708)
- <https://www.nd.gov/eforms/Doc/sfn00708.pdf>
- A provider-customized referral form or other insurance form;
- A statement in a member's medical records dictated and recorded by the designated PCP;
- A telephone call which is documented in the member's medical record; or
- A referral letter signed by the designated PCP.

Referrals may be electronically signed and must be documented in the member's medical record at both the PCP and the "referred to provider" offices.

The following items must be included in each PCP referral:

- Date of referral;
- PCP name and signature;
- PCP National Provider Identifier (NPI) number;
- Member's name and Medicaid ID number;
- Referred services provider's name ("referred to" provider);
- Diagnosis and/or reason for the referral;
- Requested services; and
- Scope and duration of the referral.

IHS/Tribal 638 facilities, RHCs and FQHCs can be designated as a PCP; however, referrals from these facilities must contain an individual provider's signature authorizing the referral. The referring provider must be affiliated with the IHS/Tribal 638 facility, RHC, or FQHC and claims submitted must contain an individual provider's NPI as the referring provider.

Primary care provided by a PCP substitute, who is a colleague/associate of the member's PCP (during a PCP's absence or inability to see a member), does not require a referral from the PCP if the PCP substitute is affiliated with at least one of the same

provider groups as the PCP. This affiliation is defined by both the PCP and the PCP substitute having an active PCP type of affiliation with one or more of the same group providers. Group providers can log into MMIS, click on the “Affiliations/Service Locations” link on the left side of the page to display their affiliations. Any provider that has an active “M-Ind2GrpPCP” type of affiliation on the date of service, that matches one of the member’s PCP affiliations can fill in as a PCP substitute.

The services requested by the PCP through a referral must indicate the scope and duration of the referral. For example, a referral stating, “evaluation only” is valid for services specific to the evaluation; whereas, a referral stating, “evaluation and treatment” is valid for service related to both evaluation and treatment.

Walk-in/urgent care clinics are “exempt” from PCP referrals only when both of the following conditions are met:

- The walk-in/urgent care clinic must be associated with the PCP’s provider group by having the same Medicaid Provider number as the PCP’s clinic when submitting a claim; and
- The walk-in/urgent care clinic has an electronic health record system in which the walk-in clinic provider can access the member’s medical records immediately upon assessing the member.

All other walk-in clinics are allowed 15 working days from the date of the service to obtain a referral for all services provided.

A referral is also valid for secondary referrals for related services. For example, a PCP refers a member with possible lung cancer to an oncologist for “evaluation and treatment” (primary referral). The oncologist refers the member to a surgeon for surgical resection of the lung (secondary referral). Because the referral indicated “evaluation and treatment”, the original referral from the PCP covers the secondary referral for surgery.

It is ND Medicaid policy that referrals be effective for no more than one year. Retroactive referrals are not allowed except for services received in a walk-in/urgent care clinic as described above.

PCP REQUEST FOR DISENROLLMENT FROM A MEMBER

A PCP may request disenrollment from a member when there is a good cause. Good cause includes:

- The member has committed acts of physical or verbal abuse that pose a threat to providers or other patients;
- The member has violated rules of the PCCM program as stated under Rights and

responsibilities in the Primary Care Case Management Program Member Handbook

<https://www.nd.gov/dhs/services/medicalserv/medicaid/managedcare.html>

- The member is unable to establish or maintain a satisfactory relationship with the PCP. Disenrollment of a member for this reason is permitted only if it has been demonstrated that the PCP: 1) made a reasonable effort to assist the member to establish a satisfactory relationship, 2) provided the member the opportunity to select an alternative PCP, and 3) informed the member that the member may file a grievance regarding the disenrollment.

A PCP may not request disenrollment from a member because of a change in health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs, except where continued enrollment seriously impairs the PCP's ability to furnish services to the member or other patients.

In order to disenroll from a member, the PCP must provide written notice to the member and to ND Medicaid at least 30 days prior to the date of disenrollment. The written notice must provide the reasons for the disenrollment and will be reviewed by ND Medicaid to ensure requirements have been met.

MEMBER REQUEST FOR TRANSFER OR DISENROLLMENT

Under certain circumstances, members are permitted to change PCPs by making an oral or written request to their local human service zone office.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

ND Medicaid covers services provided by Psychiatric Residential Treatment Facilities (PRTFs) that are licensed and enrolled with North Dakota (ND) Medicaid.

CERTIFICATE OF NEED

ND Medicaid will only cover PRTF services if the member meets certificate of need criteria. The admitting facility must complete an admission review with ND Medicaid's contractor to assure the child's cares and conditions meet North Dakota's certificate of need (CON) criteria. Additional information and CON forms are available in the manual for psychiatric services for children under 21 located at www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html

See Out of State Psychiatric Services for Children Under 21 in the Out of State Services chapter for additional requirements.

RATES FOR IN-STATE PRTFs

The rate established for in-state PRTFs is an all-inclusive rate for routine services. Routine services include supplies, therapies, personal supplies, equipment, transportation and non-legend drugs. Separate billings for these items will not be paid. Enter only the room and board charges. Do not enter ancillary charges.

RATES FOR OUT OF STATE PRTFs

The rate for out of state PRTFs is based on the rate for comparable services established by the Medicaid agency in the state where the facility is located.

BILLING GUIDELINES

Claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 0110	In-House Medicaid Days
Revenue Code 0183	Leave Days

Leave days are noncovered days. Payment is not available for any day that a member does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

A facility must submit a claim for every month a Medicaid member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

REHABILITATIVE SERVICES

Rehabilitative services are designed to provide a group of needed mental health services to Medicaid members in order to restore them to their highest possible functioning level for maximum reduction of physical or mental disability. Rehabilitative services are limited to individuals in families that are in crisis with risk of major disruption, to individuals who are at risk of entering or reentering a mental health or hospital facility, services provided to individuals who have discharged from inpatient psychiatric treatment and services provided by Human Service Center (HSC) staff, that are not otherwise other licensed practitioners, in settings outside the HSC.

COVERED SERVICES

Rehabilitative services include behavioral intervention services that consist of developing and implementing a regimen that will reduce, modify or eliminate undesirable behaviors and/or introducing new methods to induce alternative positive behaviors and management including improving life skills. Specific services are outlined in the table below.

Service Name	Definition of Services	Who Provides
Screening, Triage, and Referral Leading to Assessment	This service includes the brief assessment of an individual’s need for services to determine whether there are sufficient indications of behavioral health issues to warrant further evaluation. This service also includes the initial gathering of information to identify the urgency of need. This information must be collected through a face-to-face interview with the individual and may also include a telephonic interview with the family/guardian as necessary. This service includes the process of obtaining cursory historical, social, functional, psychiatric, developmental, or other information from the individual and/or family seeking services in order to determine whether or not a behavioral health issue is likely to exist and the urgency of the need. Services are available 24 hours per day, seven days per week. This service also includes the provision of appropriate triage and referrals to needed services based on the individual’s presentation and preferences as identified in the screening process.	Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Exempt Psychologist, Licensed Professional Counselor (LPC), Behavior Modification Specialist
Behavioral Assessment	Interview with the individual, family, staff or other caregivers, and observation of the individual in the environment to assess identified behavioral excesses or deficits. This service involves operationally defining a behavior, identifying environmental, antecedent and consequent events, and making a hypothesis regarding the likely function or purpose of the behavior as well as formulation of therapeutic recommendations/intervention regimen.	Licensed Exempt Psychologist, Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC)

Service Name	Definition of Services	Who Provides
	<p>The assessment may be conducted over a period of a few days, depending on the individual's needs and what is being assessed. The assessment should only be billed after it has been completed. This service is limited to two per calendar year. If additional services are medically necessary, the provider may request and receive service authorization from ND Medicaid.</p>	
Crisis Intervention	<p>Emergency behavioral health therapeutic intervention intended to assist in a crisis situation. Crisis situations may be defined as an individual's perception or experience of an event or situation that exceeds the individual's current resources or coping mechanisms. Crisis intervention seeks to stabilize the individual's mental state and prevent immediate harm to the individual or others in contact with that individual.</p> <p>Providers rendering crisis intervention services must be available 24 hours per day, 7 days per week, in the event that the individual needs further follow up services.</p>	Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), Behavior Modification Specialist
Nursing Assessment and Evaluation	<p>This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out an order from a licensed practitioner within their scope of practice. This service must be inclusive of all of the following items:</p> <ol style="list-style-type: none"> 1. Assessment to observe, monitor, and care for the physical, nutritional and psychological issues, problems or crises manifested in the course of an individual's treatment; 2. Assessing and monitoring the individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual for a medication; 3. Assessing and monitoring the individual's medical and other health issues that are either directly related to the mental health disorder, or to the treatment of the disorder; and 4. Consulting with the individual's family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health disorder. 	Registered Nurse (RN)
Behavioral Health Counseling and Therapy	<p>Behavioral health counseling and therapy provides individual or group counseling by a clinician for children in foster care receiving services through a residential child care facility or in a therapeutic foster care home. Clinicians must be employed by or contracted through the residential child care facility or the therapeutic foster care agency.</p> <p>This service is limited to one hour per child per day of individual counseling and one hour per child per day of group counseling and must be within each practitioner's scope of practice in accordance with licensure and certification. If additional services are</p>	Licensed Addiction Counselor (LAC), Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC)

Service Name	Definition of Services	Who Provides
	medically necessary, the provider may request service authorization from ND Medicaid.	
Individual Counseling	Individual counseling is a process through which an individual works one-on-one with a trained therapist in a safe, caring, and confidential environment to explore their feelings, beliefs, or behaviors, work through challenging or influential memories, identify aspects of their lives that they would like to change, better understand themselves and others, set personal goals, and work toward desired change.	Licensed Master Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC)
Intensive in-home for Children	<p>This service provides families, who are at risk of one or more children being placed in out-of-home care, with intensive in-home crisis intervention and family education. The service must be directed to the Medicaid-eligible child through work with families in their own homes. Providers are on call 24 hours a day, seven days a week. Services are time-limited and providers carry a limited caseload.</p> <p>A child is at risk if the referring agency documents the child is at risk of out-of-home placement and one or more of the following criteria is present:</p> <ul style="list-style-type: none"> • Court determination for need of placement; • Temporary custody transferred from parents with reunification as the plan; • History of significant law violation, physical or sexual abuse and/or neglect, incorrigibility, delinquency, substance abuse, severe mental health issues, etc.; • A referral from the child and family team process; • Prior placement of any child from within the family unit; • Prior placement history of child identified in the referral; • Prevent adoption disruption; • Child protection assessment resulting in a “Services Required”; and/or • Earlier intervention before court order involvement to prevent placement outside the home. <p>Situations not covered above will be reviewed by ND Medicaid per a recommendation and proposed care plan from Intensive In-Home Service provider and the referring agency.</p> <p>This service must take place in the home where the child resides. Parents/guardians must be physically present while the service is being delivered.</p> <p>The length of service is brief, solution-focused and outcome-based. The average length of service is usually two to six months. Services provided beyond</p>	Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC)

Service Name	Definition of Services	Who Provides
	<p>six months will require thorough documentation in the child's plan of care and are subject to audit.</p>	
<p>Skills Restoration</p>	<p>Time limited skills restoration provides an individual with needed and desired skills such as daily living/independent living skills to improve their functional impairments affected by the individual's behavioral health diagnoses and symptoms to meet rehabilitation goals. Skills restorations is a systematic series of instructional activities, which include a mixture of education, confirmation and demonstration of learned skills and capacity for observed learning over time to ensure lasting results that translate to the living environment.</p> <ul style="list-style-type: none"> • Functional impairment must be severe enough to meet medical necessity. • Example skill areas affected by behavioral health diagnoses and symptoms: <ul style="list-style-type: none"> ○ Behavioral health illness symptom management; ○ Harm reduction techniques; ○ Coping skills; ○ Decision and problem solving; ○ Self-awareness; ○ Emotional regulation skills; ○ Communication skills; ○ Household management; ○ Budgeting skills; ○ Learning skills for financial self-support; ○ Housing stability and maintenance skills; ○ Meal prep and cooking skills; ○ Laundry; ○ Self-care; ○ Personal hygiene grooming; ○ Bathing and dressing; ○ Toilet hygiene; ○ Self-management of taking medications. <p>Skills restoration technique and interventions used should be evidence based practice.</p> <p>Individuals must score at "moderate" or above according to the WHODAS 2.0.</p> <p>Skills restoration is considered an individual service and if provided in a group setting, must be billed with the appropriate modifiers.</p>	<p>Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), Behavior Modification Specialist, Registered Nurse (RN)</p>
<p>Behavioral Intervention</p>	<p>A service to identify responsive actions by an individual to stimuli and to develop and facilitate the implementation of an intervention regimen that will reduce, modify, or eliminate undesirable responses. This intervention is a comprehensive rehabilitative service that braids developing daily living skills, interpersonal skills, and behavior management skills into a defined individualized strategy to enable an individual to manage symptoms and regain lost</p>	<p>Licensed Exempt Psychologist, Behavior Modification Specialist</p>

Service Name	Definition of Services	Who Provides
	<p>functioning due to mental illness, substance abuse, and/or co-occurring disorders.</p> <p>This service includes the assessment of the individual and the development a Behavioral Intervention Plan. The plan is to be reviewed and modified as needed to ensure the individual receives appropriate interventions.</p>	
Forensic Interview	<p>A single interview session performed by an accredited children’s advocacy center. The single interview session must be recorded and is designed to elicit a child’s unique information when there are concerns of possible abuse.</p>	<p>Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC)</p>
Skills Integration	<p>A service designed to support an individual in the community in their efforts to apply and integrate those life skills that have been learned in their therapy programs. The individual typically requires support for cueing/modeling of appropriate behavioral and life skills in order to maximize their skills and prevent need for higher levels of care.</p> <p>For example, behavior management assistance helps an individual to stabilize, reduce, or eliminate undesirable behaviors which put them at risk of being served in restrictive settings. Role modeling helps an individual learn and observe appropriate behavioral and emotional responses to various situations which can trigger their medical symptoms.</p> <p>The service reduces disability and restores an individual to previous functional levels by assisting the individual in ongoing utilization and application of learned skills in normalized living situations. This strengthens the skill development that has occurred, and promotes skill integration in various life roles.</p> <p>Services are limited to four hours per day and must be within each practitioner’s scope of practice in accordance with licensure and certification. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.</p> <p>Skills integration is considered an individual service and if provided in a group setting, must be billed with the appropriate modifiers.</p>	<p>Mental Health Technician, Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC), Behavior Modification Specialist</p>
Substance Use Disorder Treatment	<p>Substance Use Disorder Treatment means ambulatory services provided to an individual with an impairment resulting from a substance use disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for</p>	<p>Licensed addiction counselors and licensed addiction programs may enroll as Medicaid providers for American Society of Addiction</p>

Service Name	Definition of Services	Who Provides
	<p>treatment of substance use disorder may be hospital-based or non-hospital-based.</p> <p>Limitations:</p> <ol style="list-style-type: none"> 1. Coverage for American Society of Addiction Medicine 2.1 services is limited to thirty days per calendar year per individual. 2. Coverage for American Society of Addiction Medicine 2.5 services is limited to forty-five days per calendar year per individual. 3. Coverage for American Society of Addiction Medicine 3.5 services is limited to forty-five days per calendar year per individual. 4. The North Dakota Medicaid Program may authorize additional days if determined to be medically necessary. <p>Licensed addiction counselors, operating within their scope of practice, performing American Society of Addiction Medicine 1, and practicing within a recognized Indian reservation in North Dakota, are not required to have licensure prescribed in North Dakota Administrative Code chapter 75-09.1 for Medicaid American Society of Addiction Medicine 1 billed services provided within a recognized Indian reservation in North Dakota.</p> <p>Licensed addiction counselors include licensed clinical addiction counselors, licensed master addiction counselors and practitioners possessing a similar license in a border state and operating within their scope of practice in that state. Licensed addiction programs operating in a border state must provide documentation to the North Dakota Medicaid Program of their state's approval for the operation of the addiction program.</p>	<p>Medicine levels of care 1, 2.1, 2.5, 3.1 and 3.5, as prescribed in North Dakota Administrative Code chapter 75-09.1.</p>

Services rendered must be within the enrolled practitioner's scope of practice. Providers enrolled to render rehabilitative services are not allowed to bill service codes outside of those noted above. Providers interested in seeking the ND Medicaid's approval for additional codes must submit a Technology/Procedure Assessment (SFN 905) <http://www.nd.gov/eforms/Doc/sfn00905.pdf>

Medicaid-eligible children under EPSDT are able to receive these and all other medically necessary services.

Rehabilitative services must be provided to, or directed exclusively toward, the treatment of the Medicaid member.

There is no duplication of billed services.

Rehabilitative services do not include:

- Room and board;
- Services provided to residents of institutions for mental disease;
- Services that are covered elsewhere in the State Medicaid plan;
- Educational, vocational and job training services;
- Recreational and social activities;
- Habilitation services; or
- Services provided to inmates of public institutions;
- Services rendered in schools as part of a child's Individualized Education Program.

MEMBER ELIGIBILITY FOR SERVICES

The following requirements must be met before rehabilitative services can be provided through the Medicaid program:

- The member must be eligible for the Medicaid program.
- Other than *Screening, Triage, and Referral Leading to Assessment, Behavioral Assessment, Crisis Intervention* and *Forensic Interview*, the service must be recommended by a practitioner of the healing arts within the scope of their practice under state law.
- The member must need mental health or behavioral intervention services that are provided by qualified entities.
- The member must have a mental health disorder, and must:
 - Be at risk of entering or reentering a mental health facility or hospital and demonstrate a score of moderate or above based on the WHODAS 2.0; or
 - Be from a household that is in crisis and at risk of major dysfunction that could lead to disruption of the current family makeup; or
 - Be in family that has experienced dysfunction that has resulted in disruption of the family.

PLAN OF CARE

Each member should have a primary point of contact at the entity. The primary point of contact should be delineated and easily identifiable in the member's plan of care. The minimum contents for the plan of care are:

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of member

- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners that are providing care/services to the member
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

PROVIDER QUALIFICATIONS

Individual practitioners must meet the qualifications in the Provider Qualifications table and must be employed by an entity that has a provider agreement with ND Medicaid. The practitioner is responsible for ensuring services can be provided within their scope of practice and is responsible for maintaining the individual qualifications outlined in the table below.

Provider Types	Licensure/ Certification Authority	Education/ Degree Required	Position requires Supervision Y/N	Position Supervises others Y/N
Licensed Addiction Counselor, Clinical Addiction Counselor, or Master Addiction Counselor (only for Behavioral Health Counseling and Therapy)	Requires licensure as an Addiction Counselor, Clinical Addiction Counselor, or Master Addiction Counselor by the ND Board of Addiction Counseling Examiners.		Supervision requirements dictated by ND Board of Addiction Counseling Examiners.	Supervision requirements dictated by ND Board of Addiction Counseling Examiners.
Licensed Exempt Psychologist	Eligibility for licensure exemptions as determined by the ND Board of Psychologist Examiners.		Yes-supervision is provided by a Licensed Clinical Psychologist	No
Behavior Modification Specialist		Master’s degree in psychology, social work, counseling, education, child development and	Supervised by Licensed Clinical Psychologist, or a clinician in	No

Provider Types	Licensure/ Certification Authority	Education/ Degree Required	Position requires Supervision Y/N	Position Supervises others Y/N
		family science or communication disorders. Or a bachelors' degree in one of the above fields and two years of work experience in the respective discipline.	one of the identified eligible professions in the preceding column with at least two years' experience.	
Licensed Baccalaureate Social Worker enrolled prior to November 1, 2018. After November 1, 2018, only enrolled to provide Behavioral Health Counseling and Therapy and Skills Integration.	Licensure as LBSW by the ND Board of Social Work Examiners.		The LBSW is supervised by an LCSW, LMSW or LPCC.	No
Licensed Master Social Worker	Licensure as LMSW by ND Board of Social Work Examiners.		No	Yes. May supervise LBSW.
Registered Nurse	Licensure as a Registered Nurse by the ND Board of Nursing.		No	Yes. The RN may supervise Mental Health Technicians.
Licensed Professional Counselor	Licensure as LPC by the North Dakota Board of Counselor Examiners.		No	May supervise less experienced LPCs.
Licensed Associate Professional Counselor, if enrolled prior to November 1, 2018. After November 1, 2018, will only enroll to provide Forensic Interview, Behavioral Health Counseling and Therapy and Intensive In-Home for Children.	Licensure as LAPC by the ND Board of Counselor Examiners.		No	No

<p>Mental Health Technicians</p>	<p>Certification as a Mental Health Technician.</p>	<p>Requires a high school degree or general equivalency diploma (GED).</p>	<p>Requires supervision by a licensed practitioner within their scope of practice.</p>	<p>No</p>
----------------------------------	---	--	--	-----------

RECIPIENT LIABILITY

Medicaid has various eligibility categories based on income and other factors, such as disability or pregnancy. Some people qualify for Medicaid without any cost sharing while others may be responsible for a part of their medical bills. This is called recipient liability or client share.

Recipient liability is the monthly amount a Medicaid member must pay toward the cost of medical services before the Medicaid program will pay for services received. It works like a monthly deductible.

The recipient liability amount is based on the difference between a member's or household's monthly income and the Medicaid income limits.

Certain medical expenses such as health insurance or Medicare premiums, can be used to lower a member's monthly recipient liability if he or she submits proof of the expenses to their human service zone eligibility worker.

Each month, ND Medicaid applies a member's recipient liability amount to claims submitted based on the order in which the claims are submitted and processed. The recipient liability may be applied to one or more claim(s). Once the entire monthly recipient liability amount is applied to a claim(s), ND Medicaid pays for other covered services received during the month.

When recipient liability is applied to a claim, ND Medicaid sends a notice to the member showing the provider's name, date of service, and the amount of recipient liability owed to the provider. The member is responsible for paying the recipient liability to the provider(s) listed on the notice.

Providers are notified via the remittance advice of the amount of recipient liability owed from a member. Providers (except for Point of Sale Pharmacy) may not collect RL at the time of service.

REVIEW BY QUALITY HEALTH ASSOCIATES

OVERVIEW

ND Medicaid contracts with Quality Health Associates (QHA) to perform reviews and service authorizations of services provided by hospitals to ND Medicaid members. These include hospitals enrolled with ND Medicaid located within 50 statute miles of the North Dakota border.

ND Medicaid requires a service authorization and a retrospective review of various procedures as part of its utilization and quality control measures.

PREAUTHORIZATION PROCESS

The following procedures require service authorization:

- Breast reconstruction;
- Cosmetic surgery;
- Ear procedures;
- Eye procedures;
- Facial procedures;
- Nose procedures;
- Obesity procedures.

QHA will also review all of the above procedures (principal or secondary) retrospectively on an inpatient or outpatient basis.

Preadmission and pre-procedure review are a responsibility of QHA and the practicing physicians of North Dakota. The areas of required review listed above are identified to the state and will not be paid unless the claim denotes review has been performed and the admission is necessary and the setting is appropriate. The primary responsibility of initiating preadmission review rests with the admitting physician or his/her designee.

- Physicians or their designees are encouraged to review and be familiar with the required areas of review. When a physician decides to schedule a procedure/admission either inpatient or outpatient, which is within the identified areas of review, he/she or other designated personnel should mail the required information to QHA. Minimal information to include for QHA review consists of:
 - Patient information (Medicaid ID, Name, Address, Age)
 - Dates of Service (Admission/Procedure dates)
 - Contact person (Name, Phone Number)
 - Procedure to be performed (complete narrative of the procedure and CPT/ICD-10-CM code if available)

- Physician name, North Dakota license number and NPI
- Provider name and number of the facility where procedure is being performed
- Criteria (Utilize criteria in QHA's manual)
- Supportive documentation which must consist of medical history, previous treatment, and present treatment.
- QHA cannot approve an admission or procedure if the data is incomplete. QHA recommends that the information be submitted prior to the scheduled admission or surgery date. A request for cosmetic surgery must be submitted two weeks prior to the surgical procedure and four weeks must be allowed for obesity procedures.
- The QHA case review coordinator (CRC) needs the necessary patient, physician, outpatient, or hospital information and will require medical indications for the admission or surgical procedure as appropriate. When the CRC is able to determine that the criteria is met based on the information received, the following will occur:
 - The admission is authorized for payment. The admitting physician will need to wait for the QHA preadmission authorization form to admit the patient or perform the procedure.
 - A computer-generated form identified as a "Request for Preadmission/ Pre-procedure Review" is then completed by the CRC and copies are mailed to the admitting physician and hospital or hospital outpatient department within one business day.
 - Upon receipt of the authorization form, the hospital or hospital outpatient department should maintain the document with the medical record. The QHA authorization number must be included on the institutional claim or professional claim to assure payment. The QHA authorization number is verified, and if not valid, the claim will be denied until corrected, and/or retrospectively reviewed by QHA.
- When the CRC is unable to approve the admission or procedure, the CRC contacts the Physician Reviewer (PR) to discuss the case. The PR subsequently contacts the admitting physician and provides an opportunity to discuss the case. If the PR approves the case, the CRC is informed and the review is completed.
- If the PR, after consultation with the admitting physician, determines that the admission or procedure is inappropriate or not medically indicated, or is not at the appropriate level, the admitting physician will be informed in writing that the proposed admission or procedure is not authorized and a letter of adverse determination will be issued. The admitting or attending physician may then:
 - Perform the procedure in an outpatient setting if the PR determined that the procedure could be safely performed on an outpatient basis;

- Cancel the procedure if medical necessity was not determined. If the attending or admitting physician chooses to proceed, he/she may admit the patient or perform the procedure. Upon receipt of denial for payment, the admitting or attending physician may request a reconsideration from QHA.

RURAL HEALTH CLINICS (RHC)

ND Medicaid covers services provided by Rural Health Clinics (RHCs) that are certificated from the Center for Medicare and Medicaid Services and enrolled with ND Medicaid.

COVERED SERVICES

Payment to RHCs for covered services furnished to ND Medicaid members is an all-inclusive rate for each encounter. For RHCs, the term “encounter” is defined as a face-to-face visit with the member during which a RHC service is rendered. Each encounter includes covered services by a medical professional as well as related services and supplies. See Telemedicine chapter for additional information on services rendered via telemedicine.

A **medical encounter** may occur with the following practitioners:

- Physician
- Physician Assistant
- Nurse Midwife
- Visiting Nurse
- Nurse Practitioner

A **mental health encounter** may occur with the following practitioners:

- Clinical (Licensed) Psychologist
- Licensed Clinical Social Worker

Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single encounter, except when one of the following conditions exist:

- After the first encounter, the member suffers an illness or injury requiring additional diagnosis or treatment; or
- The member has a medical visit and mental health visit.

When submitting claims for more than one encounter for a Medicaid member on the same day at a single location, the RHC must bill the correct revenue code for each encounter and include the appropriate diagnosis codes (when applicable) on each claim.

VACCINES

Refer to the Immunizations chapter or the Vaccine/Toxoid coding guideline for further information on Immunizations and immunization administration. The coding guidelines are available at www.nd.gov/dhs/services/medicalserv/medicaid/cpt.html.

ND Medicaid will cover injections and/or the administration of the injection if these services are billed alone using revenue code 771 (immunization alone) with an appropriate CPT code. These services cannot be billed with the revenue codes below or ND Medicaid will reimburse only the visit as the injection services are considered as part of the visit.

ND Medicaid will cover the immunization administration of vaccines within the scope of the Vaccine for Children (VFC) program. ND Medicaid will not cover the cost of pediatric vaccine materials.

Other vaccines currently covered by ND Medicaid, but outside the scope of the VFC program, will continue to be reimbursed according to the Medicaid fee schedule using the appropriate CPT codes.

PRIMARY CARE PROVIDER (PCP) DESIGNATION

A RHC can be designated as a PCP; however, the clinic may not be used as a referring provider on claims. Referrals from RHCs must contain an authorization of the referral (signature, initials) from a provider associated with the clinic or a supervising physician of the clinic.

For additional information on the Primary Care Case Management (PCCM) program, see the PCCM chapter.

BILLING GUIDELINES

Claims must be submitted using the following *Revenue Codes* when billing for:

Revenue Code 0521	Clinic Visit by Member to RHC/FQHC
Revenue Code 0522	Home Visit by RHC/FQHC Practitioner
Revenue Code 0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility (SNF)
Revenue Code 0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) of NF or ICF/MR or other residential facility

SPEECH-LANGUAGE PATHOLOGY

A speech-language pathologist is an individual possessing a master's degree or its equivalent in the area of speech-language pathology or audiology and is licensed to practice in the state in which the individual provides services. The speech-language pathologist must adhere to applicable state requirements established for speech-language pathology.

COVERED SERVICES

Speech-language pathology includes diagnostic, screening, preventative, consultative or corrective services provided by or under the directions of a speech-language pathologist.

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

- Diagnosis;
- Long term treatment goals;
- Type, amount, duration and frequency of therapy services;
- A description of the member's functional status;
- The objectives of the speech-language pathology service; and
- A description of the member's progress toward the objectives.

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

Speech-language pathology includes services necessary for the diagnosis and treatment of speech, hearing and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphasia) regardless of the presence of a communication disability.

The following is a list of ND Medicaid covered CPT codes for speech-language pathology services.

92507	Treatment of speech, language, voice, communication, and/or hearing processing disorder
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92610	Evaluation of swallowing function
92611	Fluoroscopic and video recorded motion evaluation of swallowing function

92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92607	Evaluation of patient with prescription of speech-generating and alternative communication device
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing and/or oral feeding function
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

PLAN OF CARE (TREATMENT PLAN)

Speech-language pathology services must relate directly and specifically to a written treatment plan established by the physician, after any needed consultation with the qualified Speech-Language Pathologist, or by the Speech-Language Pathologist providing services.

The plan of care/treatment plan shall contain, at minimum:

- Diagnoses;
- Long term treatment goals;
- Type, amount, duration and frequency of therapy services;
- A description of the member's functional status;
- The objectives of the speech-language pathology service; and
- A description of the member's progress toward the objectives.

The plan of care (treatment plan) shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

Speech Language Pathology services must be:

- Prescribed by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law; and
- The plan of care (treatment plan) must be signed, within 45 days of the initiation of therapy, by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Recertification of the plan of care must occur within 60-days from the date of the initial evaluation or encounter. Subsequent recertification(s) must occur at 60-day intervals throughout the course of treatment.

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 30 visits per calendar year for members age 21 and over. ND Medicaid will not cover services in excess of the limit that are provided without a service authorization. The provider must complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid, prior to the member's receipt of additional services. A copy of the plan of care recertification must be submitted with the service authorization. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed as part of the service authorization request:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals; and
- New long-term goals.

Upon receipt of the complete service authorization request, ND Medicaid will evaluate the plan of care/treatment plan for the following:

- Medical necessity;
- Accomplishment of prior goals;
- Progress;
- Reasonable new goals; and
- Maintenance care.

ND Medicaid requires a copy of the recertification when the provider is requesting encounters which are over the service limits.

NONCOVERED SERVICES

Services that are not covered include:

- Speech-language pathology that is provided without a prescription from a physician or licensed practitioner of the healing arts;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care (treatment plan), or are specified in a plan of care (treatment plan) but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's individualized education plan;
- Speech-language pathology services provided in a nursing facility or ICF/IID. ND Medicaid pays for those services through the rate established for the facility;
- Maintenance therapy.

STERILIZATION AND HYSTERECTOMY

This chapter covers Sterilizations (Elective and Non-Elective)

ELECTIVE STERILIZATIONS

Elective sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing including tubal ligation, removal, occlusion or vasectomy.

Providers that perform elective sterilization procedures for the primary purpose of permanent birth control must obtain consent prior to the procedure being performed.

ND Medicaid will cover sterilization procedures performed for the purpose of permanent birth control if the member provides voluntary informed consent, is at least twenty-one years of age at the time consent is obtained, is mentally competent, and is not institutionalized. The person obtaining the consent must give the member:

- An opportunity to ask questions about the sterilization procedure;
- A copy of the consent form;
- A thorough oral explanation about the procedure and any discomforts, procedural risks, and possible anesthetic effects. The oral explanation shall include:
 - Advice that the member may withdraw or withhold consent without affecting their right to future care or benefits;
 - A description of the available alternative family planning and birth control methods;
 - Advice that the sterilization procedure is considered irreversible;
 - A full description of the benefits or advantages that may be expected as a result of the sterilization; and
 - Advice that the sterilization will not be performed for at least 30 days, except in the case of premature delivery or emergency abdominal surgery.

A member may **not** consent to sterilization when:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion;
- Under the influence of alcohol or other substances that affect the member's state of awareness.

WRITTEN CONSENT FORM

For consent initiated on or after July 1, 2019, ND Medicaid will only accept

the Federal HHS Consent for Sterilization form:

http://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated_0_remediated.pdf

No other forms will be accepted.

Shortly before the sterilization, the physician who will perform the procedure must explain the requirements for informed consent that are listed on the consent form.

An interpreter or other arrangements must be provided to ensure that information regarding the sterilization is communicated effectively to a member with a disability that necessitates other means of communication or to a non-English speaking member.

The consent form must be signed and dated by all the following or ND Medicaid will deny claims submitted:

- The individual to be sterilized. An informed consent is valid only if at least 30 days have passed, but not more than 180 days have passed from the date of signature, except in cases of premature delivery or emergency abdominal surgery. If a member is sterilized at the time of a premature delivery or emergency abdominal surgery, payment will be made if at least 72 hours have passed since the patient gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been signed at least 30 days before the expected delivery date. A caesarean section can be considered premature delivery but is not emergency abdominal surgery.
- The interpreter, if one was provided. The interpreter must sign and date the form after the member signs it but before the day of the surgery.
- The person who obtained the consent. The person obtaining consent also must sign and date the form after the member signs it but before the day of surgery.
- The physician who performed the sterilization procedure. The physician must sign the form the day of surgery, or after the surgery.

The member may not be billed if the provider fails to follow the informed consent process or accurately complete the consent form.

STANDARDS FOR RETROACTIVE ELIGIBILITY

The Sterilization consent form requirements cannot be met retroactively. Providers may want to complete a consent form and allow for the 30-day waiting period when individuals without financial resources or health care coverage request sterilization and indicate that they are considering application or have applied for ND Medicaid. An alternative approach would be to inform the individual, preferably in writing, that

retroactive eligibility does not apply to sterilization procedures unless a consent form is signed and the 30-day waiting period adhered to.

BILLING GUIDELINES

If the claim is submitted electronically the consent form must be received within 30 days or the claim will be denied.

Charges related to a sterilization procedure during an inpatient hospitalization that are billed electronically must be entered in the Notes/Remarks section on the Web Portal or billing notes section for EDI transactions.

Charges related to a sterilization procedure during an inpatient hospitalization must be entered in Form Locator 80 when billing on a paper UB04 claim form.

NONELECTIVE STERILIZATION

ND Medicaid covers medically necessary sterilization by hysterectomy unless it is performed for the primary purpose of rendering the individual permanently incapable of reproducing. The member and their representative, if applicable, must sign an acknowledgment of receipt of both oral and written information that the hysterectomy surgical procedure would make the member permanently incapable of reproducing children. The Physician Certification for Medically Necessary Hysterectomy and Member Acknowledgement of Sterility (SFN 614) and instructions for completing are available at

www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Do not use the Physician Certification for Medically Necessary Hysterectomy and Member Acknowledgement of Sterility (SFN 614) for elective sterilization procedures.

The Physician Certification for Medically Necessary Hysterectomy and Member Acknowledgement of Sterility (SFN 614), when signed by the member or their representative indicates that the provider informed the member (and their guardian if applicable), that the procedure would cause sterility.

The member or member's representative may sign the Physician Certification for Medically Necessary Hysterectomy and Member Acknowledgement of Sterility (SFN 614) before or after the hysterectomy. A representative/guardian must sign the form for a member who is not mentally competent. A member residing in an institution may sign the acknowledgment for themselves unless they have been found incompetent by a court.

Oophorectomy and Orchiectomy are medically necessary and are not performed for the purpose of sterilization; therefore, these procedures do not fall under Medicaid written consent/sterilization requirements. Practitioners and facilities must follow their standard consent and documentation practices which are subject to audit and review if procedures are billed to ND Medicaid for an eligible member.

BILLING GUIDELINES

If the claim is submitted electronically, the Physician Certification for Medically Necessary Hysterectomy and Member Acknowledgement of Sterility (SFN 614) must be received within 30 days or the claim will be denied.

SUBSTANCE USE DISORDER TREATMENT SERVICES

ND Medicaid covers substance use disorder treatment services when rendered by an enrolled ND Medicaid provider.

See the Rehabilitative Services chapter of this manual for specific coverage and policy information.

SURVEILLANCE UTILIZATION REVIEW SECTION (SURS)

THE FUNCTION OF SURS

The Surveillance/Utilization Review Section (SURS) is dedicated to carrying out program integrity functions and is a federally mandated program that conducts reviews to safeguard against unnecessary and inappropriate use of Medicaid services. The Code of Federal Regulations 42 CFR § 456.3 stipulates that each state Medicaid agency utilize a surveillance and review process to protect the integrity of the program. The purpose of this requirement is to avoid unnecessary costs to the program due to fraud, waste or abuse and assure that eligible members receive quality and cost-effective medical care.

TYPES OF REVIEWS

The SURS staff conducts preliminary studies which may include ad hoc reviews, member or provider analysis, focused quarterly reviews, compliance reviews and investigations in instances of suspected fraud, waste or abuse.

Provider and member reviews are a necessary and routine function conducted by SURS. While the methods for reviews may vary, the desired outcome is always to identify areas that may warrant more attention.

Reviews and/or investigations may lead to sanctions, recoupments, referral to law enforcement or other penalties per North Dakota Century Code 50-24.1-36 and NDAC 75-02-05.

Some reviews may reveal an error caused by an unknown billing system issue or human error with the provider. These types of situations generally reveal no intent to defraud the Medicaid program.

Claims submitted to ND Medicaid are processed electronically and usually are not reviewed by medical experts to determine if the services provided were medically necessary and billed appropriately prior to ND Medicaid issuing payment.

Although the claims payment system detects and denies most erroneous claims, the system cannot detect the medical necessity of the service or detect all potential errors. For this reason, payment of a claim does not mean that the service was medically necessary, correctly billed, or the payment made was correct.

Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment.

If a claim is paid and ND Medicaid later discovers that the services were paid in error, ND Medicaid is required by federal regulations to recover any overpayment regardless of whether the incorrect payment was the result of ND Medicaid error, provider error, or other cause.

KEY POINTS

- The provider is ultimately responsible for documentation and accurate billing of services which includes diagnosis codes, healthcare common procedure coding system (HCPCS), current procedural terminology (CPT) and procedure coding system (PCS).
- SURS is entitled to recover payments made to providers when a claim was paid incorrectly for any reason.
- Reviews may be subject to five years of claims history except in instance of a credible allegation of fraud in which there is no limitation on reviews.
- SURS may withhold payment, suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid provider agreement, federal and state laws, regulations and policies.
- A service authorization does not guarantee payment; a claim may be denied or a payment may be recovered even if a service authorization was obtained.

SWING BED FACILITIES

ND Medicaid covers services provided by swing bed facilities who are licensed and enrolled with ND Medicaid.

LEVEL OF CARE

ND Medicaid will only cover swing bed facility services if the member meets nursing facility level of care criteria.

ALL-INCLUSIVE RATE

The daily rate established for swing bed facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate claims for these items will be denied. Only the room and board charges should be submitted on the claim, do not enter ancillary charges. Ancillary charges that are not included in the swing bed rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

BILLING GUIDELINES

Leave days are noncovered days. Leave day status is determined at midnight. Payment is not available for any period that a member does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

Swing bed claims must be submitted to ND Medicaid using the following *Revenue Codes*:

Revenue Code 0110	In-House Medicaid Days (private)
Revenue Code 0120	In-House Medicaid Days (semiprivate)
Revenue Code 0160	Medicare Full Benefit Period Days
Revenue Code 0169	Medicare Coinsurance Days
Revenue Code 0183	Leave Days

A facility must submit a claim for every month a Medicaid member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make payment for swing bed services to the swing bed provider for a member who is receiving hospice care. The hospice provider is paid a daily rate and is responsible for paying the swing bed services provided to a Medicaid member. Once

a member has elected hospice benefits, the swing bed provider may not submit a claim for services provided while the member is on hospice.

TELEMEDICINE

Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. Telemedicine involves two collaborating provider sites: an “originating site” and a “distant site”. The client/patient is located at the originating site and the practitioner is located at the distant site and provides those professional services allowed/reimbursed by ND Medicaid.

The totality of the communication of the information exchanged between the physician or other qualified healthcare professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

COVERED SERVICES

Qualified services for telemedicine must:

- Maintain actual visual contact (face-to-face) between the practitioner and patient.
- Be medically appropriate and necessary with supporting documentation included in the patient’s clinical medical record.
- Be provided via secure and appropriate equipment to ensure confidentiality and quality in the deliver of the service. The service must be provided using a HIPAA compliant platform.
- Use appropriate coding as noted in the following table:

Applicable Modifier(s)	GT; and 95	Via interactive audio and video telecommunication systems
Applicable Revenue Codes(s)	0780	Telemedicine – facility charges related to the use of telemedicine
HCPCS Code(s)	Q3014	Telehealth originating site facility fee
Place of Service	02	Telehealth - the location where health services and health related services are provided or received, through a telecommunication system

PAYMENT LIMITATIONS

Payment will be made only to the distant practitioner during the telemedicine session. No payment is allowed to a practitioner at the originating site if his/her sole purpose is the presentation of the patient to the practitioner at the distant site.

Payment will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional payment for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Payment is made for services provided by licensed professionals enrolled with ND Medicaid and within the scope of practice per their licensure only. All service limits set by ND Medicaid apply to telemedicine services.

Except for noncovered services noted below, telemedicine can be used for services covered by Medicaid, and otherwise allowed, per CPT, to be rendered via telemedicine.

INDIAN HEALTH SERVICES AND TRIBAL 638 FACILITIES

Telemedicine services provided by an Indian Health Service (IHS) facility or a Tribal 638 Clinic functioning as the distant site, are reimbursed at the All-Inclusive Rate (AIR), regardless whether the originating site is outside the “four walls” of the facility or clinic.

NONCOVERED SERVICES

Services that are not covered include:

- Therapies provided in a group setting
- Store and Forward
- Targeted Case Management for High Risk Pregnant Women and Infants
- Targeted Case Management for Individuals in need of Long-Term Care Services

REFERENCE CITATIONS

42 CFR 410.78 - Telehealth services

<https://www.law.cornell.edu/cfr/text/42/410.78>

Telemedicine coverage from Medicaid.gov

<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>

THIRD PARTY LIABILITY (TPL)

Federal Medicaid statute and regulations require state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid.

Providers must obtain information about a member's health care coverage from the member, the member's representative, the human service zone office, or through the information provided by the Medicaid remittance advice on the explanation of benefits. Providers may also obtain an assignment of benefits from the member to ensure direct payment from the third party payer.

For Medicaid purposes, health care coverage is defined as any third party resource available to the eligible Medicaid members for health care and related services.

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS

Providers and Medicaid members are required to follow the third party payer's policies and procedures to maximize the available benefit. ND Medicaid may refuse payment for any covered service or procedure provided to an individual eligible for both Medicaid and third party coverage if the third party coverage denies payment because of the failure of the provider or member to comply with the requirements of the third party coverage. If the third party payer does not pay anything on the claim because policy and procedures were not followed, ND Medicaid will not pay the claim.

Providers must seek payment from third party payers prior to billing ND Medicaid for the service. With few exceptions, Medicaid is the payer of last resort and can only be billed after the third party has paid its legal liability.

Specific preventive pediatric care services billed to ND Medicaid within 90 days after the date the provider of these services has initially submitted a claim to the third party payer will be denied.

Services for which payment has been denied by the third party payer for reasons other than noncompliance may be eligible for ND Medicaid payment. An explanation of benefits (EOB) or other documentation must accompany the claim.

Workers Compensation, Personal Injury Protection (PIP)/No Fault, Homeowners or Business Liability insurance coverage are primary to Medicaid. If a claim against one of these policy types is established, ND Medicaid must be notified. Payment information

received from these coverages must be included on the claim submitted to ND Medicaid. Documentation to support the payment must be included with the claim.

If the provider has third party information that is not recorded with ND Medicaid, the provider must advise ND Medicaid by sending an EOB from the third party payer. The provider must adequately identify the EOB by writing the provider number, member's name and Medicaid ID number on the EOB. The EOB can be sent via FAX to (701) 328-1544, attention TPL Unit. Additionally, if a member's third party coverage is terminated the provider may fax a copy of the third party EOB showing the coverage termed to the TPL Unit, which will help ensure claims are not denied for third party coverage that is no longer available to the member.

If ND Medicaid has third party information that the provider is not aware of, ND Medicaid will supply the provider with adequate information to bill the third party.

Providers are not allowed to bill the member for any balances after payment is received from the third party and ND Medicaid. Medicaid payment is considered payment in full, even if payment is zero.

If a member is paid directly by a third party payer, a provider may bill a member to recover the amount paid by the payer.

Providers cannot refuse services to a Medicaid member because the member has third party coverage. Providers cannot demand payment and require the member to bill the third party, unless specific terms of the third party require that benefits be paid to the member. ND Medicaid may be billed only to the extent there is a legal obligation for the member to pay for services.

MEMBER COOPERATION WITH TPL BILLING

If a Medicaid member is non-cooperative or fails to cooperate with the third party payer, the provider may contact the applicable human service zone office or the TPL Unit at 701-328-2347 or medicaidtpl@nd.gov for assistance.