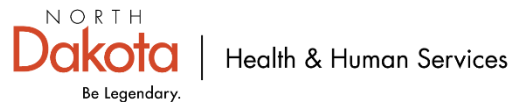


GENERAL INFORMATION FOR PROVIDERS

NORTH DAKOTA MEDICAID AND OTHER MEDICAL ASSISTANCE PROGRAMS



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SUMMARY OF CHANGES

The January 2023 ND Medicaid provider manual updates contain various changes that are detailed below. While providers should review chapters that are specific to their specialty, all enrolled Medicaid providers are responsible to understand and comply with program requirements contained in generic chapters such as provider enrollment, provider information, Medicaid eligibility of a member, noncovered Medicaid services, and primary care case management.

Providers should carefully review the following chapters for substantive updates:

1. Ambulance
2. Non-Covered Services
3. Telehealth

KEY CONTACTS

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

Provider Enrollment

(701) 277-6999
(701) 433-5956 (fax)

Send written inquiries to:
Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

or e-mail inquiries to:
NDMedicaidEnrollment@noridian.com

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

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 Health and Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

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

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 BCBS ND

(833) 777-5779

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

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

Send written inquiries to:
Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Health and Human Services
Dept 325
600 E Boulevard Ave
Bismarck ND 58505-0250

Or e-mail inquiries to:
medicaidfraud@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)
Ascend (Long Term Care and Inpatient Psych Services for Members Under 21	(877) 431-1388
1915(i) Services	nd1915i@nd.gov

Kepro is contracted with ND Department of Health and Human Services to perform service authorization review of certain requests for services and supplies for members effective January 1, 2021. Kepro uses InterQual® criteria for determining medical necessity for services requiring authorization. More information can be found at <https://nddhs.kepro.com>

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
- Claims Status
- Service Authorization Inquiry

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. Providers who have an NPI that is associated with more than one Medicaid ID number must use the PIN number assigned to the Medicaid ID number used to access AVRS.

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 • 1915(i) Eligibility
<p>Option 2: Payment Inquiry</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

AM I ELIGIBLE TO ENROLL AS A PROVIDER?

To be eligible for enrollment, a provider must:

- Supply a covered service(s) to at least one ND Medicaid eligible member.
- Meet the conditions in this chapter and conditions of the ND Medicaid provider agreement (SFN 615).
- 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.
- Be free of any exclusions from a federally funded program including the List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM) or a state Medicaid agency.

DO I NEED TO ENROLL?

Eligible providers may not bill for services under a supervising or peer provider's NPI. All eligible providers must enroll and bill with their own NPI. A list of provider types eligible to enroll with ND Medicaid is located under Taxonomy Codes at <https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-provider-enrollment-information>.

PHYSICIANS IN RESIDENCY

You must enroll with Medicaid to bill for services rendered to members if you have:

- A license to practice medicine in North Dakota by the ND Board of Medical Examiners, or
- A temporary special license for foreign medical school graduates as outlined in the Medical Practices Act of ND ([N.D.C.C. § 43-17-18\(4\)](#)).

You cannot bill using a supervising physician's NPI.

OUT OF STATE PROVIDERS

Out of state providers may enroll with ND Medicaid. "Out of state provider" means a provider who is located more than fifty (50) miles from a North Dakota border. 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 to receive payment. Out of state providers may apply for a retroactive enrollment date for the date of covered services provided to a member (see below section "What is an Enrollment Effective Date?").

WHAT DO I NEED TO ENROLL?

Providers need to send:

- A [completed online application](#), and
- [Completed packet of supporting documentation](#) (see Required Documents under Enrollment). Supported documentation can be submitted by:
 - Fax to 701-433-5956 Attn: Provider Enrollment; or

- Secure email. Request access to a secure link by sending an email to NDMedicaidEnrollment@noridian.com. You will be sent a link to a secure site to submit your supporting documentation.
- An Out of State Enrollment Clarification form (SFN 509) if you are an out of state provider. The form is available at www.nd.gov/eforms.

Your application processing does not begin until both your online application is completed and submitted and your completed packet of supporting documentation is received.

WHAT IS AN ENROLLMENT EFFECTIVE DATE?

You will be able select an enrollment effective date on your application. An enrollment effective date is the date your enrollment will be made effective. It is limited to no more than ninety (90) days prior to the date your complete application packet is received. If you do not select an enrollment effective date, your enrollment will become effective on the date that your application is approved.

Providers who request a retroactive effective enrollment date may supply covered services prior to receipt of all required enrollment documents if the provider meets all eligibility requirements at the time the service is provided and only if appropriate documentation of the services supplied is maintained.

ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety (90) days for situations involving emergent care provided to a member. If the application involves an emergency service, a copy of the claim and medical notes must be sent with the application packet. If you do not submit this information a date beyond ninety (90) days of receipt of a completed application will not be approved.

Retroactive enrollment is not applicable to the 1915(i) program.

WHAT HAPPENS WHEN MY APPLICATION IS APPROVED?

You will need a 7-digit Medicaid ID number. You will receive this in one of two ways. If you completed the security information section during your enrollment process, you will receive a letter via the United States Postal Service with enrollment information that includes your 7-digit Medicaid ID number and login information to access the web portal. If you did not complete the security section during the enrollment process, you can register for web access using the Provider Registration section on the home page of the MMIS Web Portal once your application is approved. To register for web access, click the "Register" link, enter your 7-digit Medicaid ID and Social Security Number (for individual providers) or Employer Identification Number (for billing groups).

DO I NEED TO REVALIDATE MY ENROLLMENT?

Yes, you will need to revalidate your enrollment at least once every five (5) years. Your revalidation date is in your online provider portal. ND Medicaid will also send notifications to the email address(es) associated with your enrollment record. A revalidation roster is updated and published on the ND Medicaid website that lists

Provider Revalidation Dates that are due within 90 days of the published date. <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-revalidations-dates.xlsx>. Past due revalidations are also posted online at <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-revalidations-past-due.xlsx>.

WHAT IF THERE IS A CHANGE IN MY ENROLLMENT?

It's your responsibility to update your enrollment information. Changes that cannot be updated through the provider web portal may be sent via email to NDMedicaidEnrollment@noridian.com. Changes that include sensitive information such as social security numbers, dates of birth, etc., may be sent via secure fax at 701-433-5956 Attn: Provider Enrollment or via secure email. Please email NDMedicaidEnrollment@noridian.com and request a secure link to send updated information. You will be sent a secure link to send your required information.

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

WHAT IF THERE IS A CHANGE IN OWNERSHIP?

You have thirty-five (35) days to send changes of ownership for owners who have 5% or more ownership interest. Refer to [42 C.F.R. § 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 may result in payment suspensions for enrolled providers.

PROVIDER UPDATES

Provider updates such as affiliations, terminations, EFT, taxonomy, address, name, etc., must be sent to Provider Enrollment for Processing. Please see the [Provider Enrollment](#) section of the ND HHS website for more information on how to request these updates.

TERMINATING MEDICAID ENROLLMENT

Send your notice of termination via email to NDMedicaidEnrollment@noridian.com or fax to 701-433-5956 Attn: Provider Enrollment. Include name, national provider identifier (NPI) if applicable, ND Medicaid number, and the termination date. Notice of termination without cause must be sent in writing and requires 30 days' advance notice. ND Medicaid may also end enrollment under the following circumstances:

- Breach of the provider agreement;
- Demonstrated inability to perform under the terms of the provider agreement;
- Failure to follow applicable North Dakota and United States laws; or
- Failure to follow regulations and policies of the North Dakota Department of Health and Human Services or the ND Medicaid program.

See [N.D. Administrative Code § 75-02-05](#) for more information.

PROVIDER REQUIREMENTS

Your signature on the Medicaid provider agreement for North Dakota Medicaid means you agree to follow the conditions of participation in the provider agreement. The Medicaid Program Provider Agreement (SFN 615) is available at www.nd.gov/eforms. More requirements may apply based on the provider type or specialty. Conditions include:

- You may not abandon a member in a way that would violate professional ethics.
- You may not refuse to serve a member because of race, color, national origin, age, or disability.
- You must advise members in advance if you are accepting them only on a private pay basis. This shall be in writing and signed by the member.
- When a provider arranges ancillary services for a member through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the member and they may not bill the member directly.

PROVIDER OBLIGATIONS

You must ensure services are ordered or rendered within the scope of your practice according to state law and release information needed to support services billed to ND Medicaid, as appropriate.

SCOPE OF PRACTICE AND LICENSURE

ND Medicaid realizes there are other professional sources that define the relationship between the member and provider; including certain CPT© code definitions, current CDT© definitions, American Dental Association Guidelines and Dental Evidence, the American Academy of Pediatric Dentistry Oral Health Policies and Recommendations (the Reference Manual of Pediatric Dentistry), the ASAM Criteria: Treatment of Addictive, Substance-Related, and Co-Occurring Conditions (most current version), The Diagnostic and Statistical Manual of Mental Disorders (5th ed, DSM-5), current HCPCS codes, ethical standards of practice, accepted professional standards of practice, and current evidence-based practice guidelines. Providers are responsible for maintaining the qualification for their licensure and are not eligible to order or render services during any periods in which there is a lapse in their license.

RELEASE OF INFORMATION

You agree to release, upon reasonable request, information needed to support the services billed to ND Medicaid as a condition of your participation in the program. Medicaid is a covered entity under HIPAA and is acting within its authority to request documentation. Supplying the requested documentation is not a HIPAA violation. Laws applicable to supplying documentation are:

[45 C.F.R. § 164.506](#) - uses and disclosures to carry out treatment, payment, or health care operations.

[45 C.F.R. § 164.512\(d\)](#) - allows the disclosure of protected health information to a health oversight agency (which includes ND Medicaid as a government benefit program).

[42 C.F.R. § 456.23](#) - ND Medicaid's authority to conduct a post-payment review.

[North Dakota Administrative Code § 75-02-05-04\(2\)](#) – provider responsibilities, including supplying documentation upon request.

[42 C.F.R. § 431.107\(b\)\(2\)](#) – requiring providers to submit information regarding Medicaid payments for furnishing services.

ELECTRONIC CLAIMS SUBMISSIONS

Medicaid claims sent electronically experience fewer errors and quicker payment. Electronic service claims must be in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. More information on the format and data requirements is available at <https://www.hhs.nd.gov/human-services/medicaid/provider/mmis-nd-health-enterprise-medicare-management-information-system>.

Providers sending claims for non-medical services are exempt from sending HIPAA compliant claims. These services include home and community-based services, waiver services, and non-emergent transportation/meals/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 (U.S.C.) 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 Health and Human Services; and
- All state laws and rules governing provider licensure and certification, as well as the standards and ethics of their business or profession.

Providers must be familiar with all current rules and regulations governing the ND Medicaid program. Provider manuals are to help providers in billing ND Medicaid; they do not have all ND Medicaid programs rules and regulations. Any rule citations in the manual are for reference and are not a summary of the entire rule.

MEMBER PARITY

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

DOCUMENTATION GUIDELINES FOR MEDICAID SERVICES

Your documentation records must:

- Thoroughly document the extent of services rendered and billed. These records are used to decide medical necessity and correct billing.
- Be in their original or legally reproduced form. This may be electronic.
- Support the time spent rendering a service for all time-based codes.
- Be kept for a minimum of seven (7) years from the date of their creation or the date when they were last in effect, whichever is later. Note: state law may require a longer retention period for some provider types.
- Be signed by the ND Medicaid-enrolled provider rendering the service. Claims selected for an audit that don't have signed records shall be denied.
- Be legible, promptly completed, dated and time, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy. Signatures must follow [Medicare requirements](#).
- Be kept confidential.

WHAT DOES DOCUMENTATION INCLUDE?

Documentation includes:

1. 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 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.

HOW DO I HANDLE CONFIDENTIALITY AND RECORDS ACCESS?

All member and applicant information and related medical records are confidential and must be protected subject to applicable laws. ND Medicaid personnel and authorized agents are permitted access to information concerning any services that may be covered by Medicaid. This access does not require authorization by the member because disclosure to carry out treatment, payment, or healthcare operations are allowed under HIPAA. See [C.F.R. § 164.506](#). This includes health plans contracting with ND Medicaid for information relating to Medicaid services reimbursed by the health plan.

Providers must make available for examination and photocopying, upon request from authorized agents of the state or federal government, 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 records available may result in the provider's suspension and/or termination from Medicaid.

Release of records to other individuals may only happen if there is a signed release from the member authorizing access to the records or if the disclosure is for a permitted purpose under applicable confidentiality laws.

REQUIREMENTS FOR ORDERING, REFERRING AND PRESCRIBING PROVIDERS

ND Medicaid requires ordering, referring, or prescribing providers to enroll as a participating provider. ND Medicaid cannot pay for ND Medicaid-covered services requiring a referral, order, or prescription from a physician or other licensed practitioner of the healing arts unless the referring, ordering, or prescribing provider is enrolled.

PAYMENT FOR SERVICES

Medicaid payment for covered services will be made to providers when the following conditions are met:

- Provider is enrolled with ND Medicaid.
- Services are rendered by practitioners licensed and operating within the scope of their practice as defined by law.
- Member is eligible for Medicaid.
 - It is the provider's responsibility to verify a member's eligibility status and PCCM enrollment prior to supplying services to the member. If the member is enrolled in PCCM, you must assure referrals from the member's designated PCP are in place for any services received by the member to receive consideration of payment by ND.
- Service is medically necessary.
 - ND Medicaid may review medical necessity at any time before or after payment.
- Service is covered by ND Medicaid and is not considered experimental or investigational.
- Service authorization requirements are met where applicable.
- Medicaid and/or third-party payers are billed according to rules and instructions as described in this manual, the most current Provider Bulletin, and the ND Medicaid website.
- Billed charges are usual and customary.
 - Usual and customary charge" refers to the amount the provider charges the 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 fee schedule amount 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.

- Payment to providers from Medicaid and all other payers do 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 meet timely filing requirements.

SERVICE AUTHORIZATIONS

Service authorizations (SA) are required for certain procedures, services, and items before being initiated, supplied, or performed. Please refer to specific service chapters or manuals as appropriate for more SA-related guidance. Failure to obtain an SA will result in the denial of the service or supply.

All claims are subject to post-payment review or audit. Any service or supply paid without an approved SA is subject to recoupment. Approved service authorizations are service, supply, and provider-specific and are non-transferrable. An approved SA can only be modified by a written request from a provider at the department's discretion. Web-based authorizations cannot be altered by the department and require resubmission.

Before submitting SA documentation, please:

- Ensure forms are complete and accurate.
- Include pertinent SA documentation. You may expedite the review process by highlighting documentation that specifically supports the SA's medical necessity.
 - Documents must include:
 - Matching requested date spans on all forms and documents.
 - Order/referral dates that are related to the SA requested dates.

Requests not meeting these criteria could be returned, denied, or rejected as incomplete.

RETROACTIVE SERVICE AUTHORIZATIONS

Retroactive service authorizations may be submitted for consideration up to 90 days from the date of service with good cause i.e., urgent/emergent medical conditions, retrospective eligibility. They should not be used on a routine basis.

Retroactive authorization requests are reviewed and decided internally on a case-by-case basis.

The Department will only consider timely, retroactive, or extension SA requests if all required forms and supporting information are submitted. Submissions that are incomplete or missing information will be returned or denied. Any re-submissions will need to be updated for dates, documentation, and orders so that they are current and complete based on the type of SA being submitted. The Department will not keep documentation from earlier submissions. Decisions will be based on the newest date of submission, not an earlier submission date.

Please see page 7 of this manual for a complete listing of service authorization contacts if further information is required.

WHAT IF THE MEMBER HAS OTHER INSURANCE?

Do not send claims to Medicaid until the charges are processed by the primary payer for members also covered by Medicare, other insurance, or when another third-party is responsible for the cost of the member's health care. See Third Party Liability chapter for more information.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

ND Medicaid follows the National Correct Coding Initiative (NCCI) Edits. The Centers for Medicare and Medicaid Services (CMS) developed these edits 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 www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.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 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; Medicaid payment is payment in full.
- 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
1915(i) Services	No	Yes	Yes, see 1915(i) chapter	Yes
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 Kepro	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	No	No	No
Certified nurse midwife services	No	No	No	No
Chiropractic services	No	20 manipulations per year; x-rays 2 per year	Yes, after limits are met	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
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 if 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, through age 20.
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	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
Medication Therapy Management	No	Some limits apply. See ND Medicaid Medication Therapy Manual	Service Authorization recommended. See ND Medicaid Medication Therapy Manual	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
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	30 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	Yes, through age 20.
Partial hospitalization program	No	No	No	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	30 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
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	No	Yes	Yes	No

Service	Referral Required from Primary Care Provider	Limits	Service Authorization Required	Age Restrictions
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 Behavioral Health Services Manual	Some services require SA. See Behavioral Health Services Manual	Some services are restricted to certain ages. See Behavioral Health Services Manual
Rural health clinics (RHC)	No, if 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	No	No	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. 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 supplied documentation meets ND Medicaid guidelines, payment will be approved. The claim will be denied payment if documentation does not meet these guidelines.

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 reports 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 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 Century Code defines the crime of "incest." [N.D.C.C. § 12.1-20-11](#). North Dakota statutes do not define 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 refine 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 performed 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.
- If a second trip occurs on the same day, modifier 76 must be appended to the HCPC code.
- The date of service on the claim should be the date that the ambulance departs the point of pickup with the member on board.

AIR AMBULANCE

Transportation by air ambulance is a covered Medicaid service if the member has a potentially life-threatening medical condition that prevents 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 when medically necessary in these situations:

- Transportation between two long term care facilities when the member's plan of care requires a health service not available at the long-term care facility where the member resides.
- Transportation between two hospitals when a necessary service is not available at the hospital where the member is located when medical necessity is determined.
- Transportation between a hospital and long-term care.

MULTIPLE PATIENTS ON ONE TRIP

Ambulance providers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one patient onboard must use the "GM" modifier ("Multiple Patients on One Ambulance Trip") for each service line item. In addition, ambulance providers are required to submit documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the Medicaid recipient identifiers for each Medicaid recipient.

If two patients are transported to the same destination simultaneously, for each Medicaid member, Medicaid will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that member plus 50 percent of the total mileage payment allowance for the entire trip. If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicaid member (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard. This policy applies to both ground and air transports.

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 covered under the North Dakota Medicaid State Plan.

A member's death is recognized when pronounced by a legally authorized individual in 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

Noncovered services 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 pronounced dead prior to the time the ambulance was called or dispatched.

AMBULATORY SURGICAL CENTER SERVICES

An ambulatory surgical center (ASC) must meet Medicare's Conditions for Coverage (CFCs) and be enrolled with ND Medicaid as an ASC. Evidence of meeting Medicare's CFCs can be either the ASC being enrolled with Medicare or certification from The Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities, Inc (AAAASF) or the Health Care Facilities Accrediting Program (HFAP) of the ASC meeting Medicare's CFCs. An ASC may be independent or operated by a hospital.

COVERED SERVICES

Procedures listed on the ND Medicaid ASC fee schedule are covered within an ASC. Members may receive ASC-covered services within applicable lifetime limits, etc. A procedure may require service authorization. Reference *Codes Requiring Service Authorization* at: <https://www.hhs.nd.gov/human-services/medicaid/provider>

An ASC is only paid the facility fee for the surgical procedure. An ASC may not bill any other services. The following services and supplies are included in the ASC facility fee and may not be billed or paid separately:

- Use of facility (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 technician services provided by ASC employees (e.g., nurses, technicians, orderlies).
- Drugs, biologicals, surgical dressings, supplies, splints, casts appliances, and equipment commonly furnished by the ASC in connection with surgical procedures. Drugs and biologicals are limited to those that cannot be self-administered.
- Urinary supplies, such as collection devices, indwelling and external catheters, drainage bags, leg straps, external urethral clamps, irrigation supplies (bulbs, syringes, tubing, sterile saline, or water), insertion trays, and perianal fecal collection pouches.
- Administrative, record keeping, and housekeeping services necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).
- Blood, blood plasma, and platelets.
- Anesthetic and any supplies, whether disposable or reusable, necessary for its administration.

SEPARATELY COVERED SERVICES

The following services and supplies are not included in the ASC facility fee and may be billed separately by an enrolled provider other than the ASC.

- Professional services: physician, anesthesiologist (administration or supervision of the administration of anesthesia), and certified registered nurse anesthetists (CRNA) services;
- Laboratory, x-ray, or diagnostic procedures other than those directly related to the performance of the surgical procedure;
- Prosthetic devices;
- Ambulance services;
- Durable medical equipment for use in the member's home; and
- Pathology services.

ANESTHESIA SERVICES

ND Medicaid covers services provided by enrolled anesthesiologists or licensed certified registered nurse anesthetists (CRNA).

COVERED SERVICES

Anesthesia services personally furnished by an anesthesiologist or CRNA 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 a qualified individual performs any procedures in the anesthesia plan that they do not perform;
- Monitors the course of anesthetic administration at frequent intervals;
- Remains physically present and available for immediate evaluation and treatment of emergencies;
- Provides indicated post-anesthesia care; and
- Complies with federal requirements when administering an anesthetic during sterilization procedures.

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

OTHER ANESTHESIA SERVICES

Pre-anesthetic Evaluations and Post-operative Visits: ND Medicaid reimbursement for anesthesia services includes pre- 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. If an anesthetic is not administered due to a surgery cancellation, the anesthesiologist or CRNA may bill an Evaluation and Management (E/M) CPT code that demonstrates the level of service performed. No separate payment is allowed for the post-operative visit.

Intrathecal and Epidural Catheter: Placement of an intrathecal or epidural catheter is paid separately. The correct unmodified CPT surgical code must be used to bill the catheter placement.

Pain Management: 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 Anesthesia for Vaginal or Cesarean Section: 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 anesthesiologist or CRNA is physically present with the member must be recorded in the unit's box. ND Medicaid payment for CPT 01967 will be capped at a maximum of 75 minutes.

Moderate (Conscious) Sedation: Moderate conscious sedation procedure codes are eligible for separate reimbursement, in accordance with current CPT and NCCI coding guidelines. Moderate conscious sedation codes are time-based procedure codes. Time must be clearly documented to support the reported codes and units. Moderate conscious sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care, these procedures should be reported under 00100-01999.

BILLING GUIDELINES

ND Medicaid requires the use of specific CPT/HCPCS anesthesia codes with the appropriate modifier for anesthesia services.

- The claim must include the exact number of minutes beginning when the anesthesiologist or CRNA prepares the member for induction and ending when the anesthesiologist or CRNA is no longer in personal attendance and the patient can be safely placed under postoperative supervision.
- Qualifying Circumstances for Anesthesia (99100-99140) are considered bundled and will not be separately reimbursed.
- The CPT/HCPCS code must be accompanied by 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 anesthetic to one patient, with or without the assistance of a CRNA).
 - AD = Medical supervision by a physician: more than four concurrent anesthesia procedures.
 - QK = Medical direction by a physician of two, three, or four concurrent anesthesia procedures.
 - QX = CRNA services with medical direction by a physician.
 - QY = Medical direction of one qualified non-physician anesthetist by an anesthesiologist.
 - QZ = CRNA services without medical direction by a physician.

BASIC CARE FACILITIES

ND Medicaid covers services provided by licensed and enrolled basic care.

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.

ND Medicaid 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 ND Medicaid.

LIMITS ON LEAVE DAYS

MEDICAL CARE LEAVE

ND Medicaid will cover a maximum of 30 days per occurrence for medical care leave. The medical care leave policy ensures that a bed is available when the 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. Any days exceeding the 30-day limit are noncovered.

THERAPEUTIC LEAVE

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. Any days exceeding the 28-day limit are noncovered days.

BILLING GUIDELINES

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

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

The day of a resident's death is a covered day. The day of a resident's discharge is a noncovered day.

Basic care facility services must have separate lines for personal care and room and board 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 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:
www.hhs.nd.gov/health/women/womens-way

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 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 provided by a cardiac rehabilitation program approved by and enrolled with Medicare.

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 patient 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, 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

Noncovered services 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 non-cardiac diagnosis requiring such therapy.

CHIROPRACTIC SERVICES

ND Medicaid covers chiropractic services provided by an enrolled doctor of chiropractic licensed under state law.

COVERED SERVICES

Chiropractic manipulation coverage extends only to 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. Evaluation and Management (E/M) services and x-rays are also covered, per the limits described below.

Refer to the Chiropractic Services coding guideline for further information. The coding guidelines are available at www.hhs.nd.gov/human-services/medicaid/provider

COVERAGE LIMITATIONS

Manual manipulation of the spine is limited to one manipulation per day and may not exceed 20 manipulations per calendar year without a service authorization.

New Patient Evaluation and Management (E/M) services (99202 or 99203) are covered 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.

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 region.

NONCOVERED SERVICES

- Chiropractic maintenance therapy is not covered. (Maintenance therapy is defined as a plan of care 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.)
- Any joint manipulation outside of the spine.

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 performed 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
- Medical necessity for treatment is clearly documented.

SERVICES THAT ARE NOT MEDICALLY NECESSARY

- Continued chiropractic treatment after the initial two weeks, if no improvement is documented, unless the chiropractic treatment is modified.
- Continued chiropractic treatment if no improvement is documented within 30 days even with a modification of chiropractic treatment.
- Continued chiropractic treatment once the maximum therapeutic benefit has been achieved.
- Chiropractic manipulation of a member who is asymptomatic or is without an identifiable clinical condition.
- Chiropractic care of a member, whose condition is neither regressing nor improving.
- Manipulation of infants for non-neuromusculoskeletal indications.
- Chiropractic manipulation 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 for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, breech or other malpresentations, scoliosis, dysmenorrhea, otitis media, asthma, epilepsy, etc.).

SERVICE AUTHORIZATIONS AND BILLING GUIDELINES

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

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

COORDINATED SERVICES PROGRAM (CSP)

ND Medicaid uses the CSP 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 a physician, nurse practitioner, or physician assistant with a specialty of family practice, general practice, or internal medicine. 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. The member may also be required to select one dentist of their choice based on the usage of dental services.

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

The requirement for coordinated services is made by ND Medicaid upon recommendation of medical professionals who identify utilization patterns indicating the member may benefit from the CSP.

A review of services may be initiated by:

- A member audit of medical and pharmacy services;
- A recommendation from a medical professional; or
- 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 more information about CSP members and pharmacy transactions. <https://www.hhs.nd.gov/medicaid-pharmacy-providers>

SERVICES OBTAINED FROM A NON-DESIGNATED PROVIDER

ND Medicaid will not pay 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 upon CSP provider referral and approval 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 sent 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 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 sent to:

- Fax: (701) 328-1544
- Mail: Department of Health and 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 www.hhs.nd.gov/nd-medicaid-provider-information/medicaid-provider-manuals-and-guidelines.

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 www.hhs.nd.gov/medicaid-provider-information/medicaid-durable-medical-equipment-providers.

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 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;
- Hysterectomies for the purpose of sterilization; or

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

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

COVERED SERVICES

Services are covered when rendered in a FQHC, or other outpatient setting, including the member's residence. Services rendered in an inpatient or outpatient department of a hospital, including a critical access hospital, are not covered.

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

If the only services rendered during a visit are "incident to" services, the visit does not qualify for claiming of an encounter. Services provided "incident to" are included in the encounter and cannot be billed separately (e.g. laboratory services, x-rays, and procedures performed during the visit).

For FQHCs, the term "encounter" is defined as a face-to-face visit with the member during which a qualifying encounter service is rendered. FQHCs may furnish services that qualify as a medical, dental or behavior health encounter.

A **medical encounter** can only be claimed for services rendered face-to-face by one of the following practitioners compensated by a FQHC for the services provided:

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

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

- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Professional Clinical Counselor

- Licensed Marriage and Family Therapist
- Licensed Psychologist
- Nurse Practitioner
- Licensed Addiction Counselor
- Licensed Addiction Program

Dental services are reimbursed at an all-inclusive rate for each **dental encounter**. The dental encounter includes covered services and supplies.

Face-to-face services with more than one health professional and/or multiple services 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 receives more than one type of service: medical, behavioral health, or dental.

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 is the only medical service provided, a medical encounter may be claimed.

See the Telehealth chapter for additional information on services rendered via telehealth.

VACCINES

Refer to the Immunizations chapter for additional information on immunizations and immunization administration.

Vaccines administered in conjunction with a medical encounter are considered incident to the medical encounter and neither the vaccine nor the vaccine administration can be billed in addition to a medical encounter.

When the only service provided is a vaccine:

- The vaccine administration can be billed, but an encounter cannot be billed. The vaccine administration must be billed using Revenue Code 0771 (Vaccine administration) along with the appropriate CPT code.
- If the vaccine is supplied by the Vaccine for Children (VFC) program, ND Medicaid will not make payment for the vaccine. ND Medicaid will only make payment for the vaccine administration; however, the claim must include

Revenue Code 0636 (Drugs requiring detailed coding) and the appropriate CPT code for the vaccine. If the vaccine is not supplied by the VFC program and is currently covered by ND Medicaid, the vaccine will be reimbursed according to the Medicaid fee schedule using Revenue Code 0636 (Drugs requiring detailed coding) and the appropriate CPT code.

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, see the PCCM chapter.

BILLING GUIDELINES

When billing for more than one encounter for a member on the same day at a single location, the facility must bill each encounter separately using the correct revenue code and the appropriate diagnosis codes on each claim.

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 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 a North Dakota Medicaid-eligible individual 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.)

GENDER AFFIRMING CARE AND SERVICES

ND Medicaid covers medically necessary gender affirming care and services provided to members:

- Who have a clinic diagnosis of gender dysphoria; and
- Who have provided informed consent* which indicates understanding of procedure/process, risks and outcomes expected.

*If a member is under 19 years of age, a parent or legal guardian must provide informed consent.

COVERED SERVICES

A prerequisite for gender affirming care and services is for contraindicated medical and behavioral health conditions to be addressed and well-controlled.

Hormone Therapy Services

Gonadotropin-Releasing Hormone (GnRH) Therapy delays the onset of puberty and/or continued pubertal development. GnRH therapy should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of GnRH therapy adolescents must:

- Have a comprehensive mental health evaluation,
- Be evaluated by an endocrinologist, and
- Be referred to a licensed behavioral health provider for concurrent counseling.

GnRH therapy must be rendered under the direction of an endocrinologist and concurrent with behavioral health counseling. Medical assessments are to be performed at a frequency determined by the endocrinologist.

Cross-Sex Hormone Therapy

Cross Sex-Hormone Therapy is a course of hormone replacement therapy intended to induce or change secondary sex characteristics.

- Behavioral health counseling is required for the first twelve (12) months at a frequency determined to be clinically appropriate by the licensed behavioral health provider.
- Individual must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

Surgical Procedures

Gender Confirmation Surgery (also known as gender affirmation surgery or sex reassignment surgery) means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. To be considered for gender confirmation surgery, a member must:

- Be at least 18 years of age;
- Have lived in the desired gender role for twelve (12) continuous months;
- Be evaluated by a licensed behavioral health provider within the past sixty (60) days; and
- Have completed twelve (12) continuous months of hormone therapy, unless medically contraindicated.

Medical records must be retained and include a signed statement from a licensed behavioral health provider with whom the member has an established and ongoing relationship.

Prior to surgery, a post-operative plan of care must be in place which includes behavioral health counseling, appropriate physical care, and hormone replacement therapy.

Covered Surgical Procedures

Clitoroplasty	Phalloplasty
Erectile prosthesis (One per lifetime)	Prostatectomy
Hysterectomy	Salpingo-oophorectomy
Labiaplasty	Scrotoplasty
Mammoplasty – after twenty-four (24) continuous months of hormone therapy.	Testicular prostheses
Mastectomy	Urethroplasty
Ochiectomy	Vaginectomy
Ovariectomy/oophorectomy	Vaginoplasty
Penectomy	Vulvectomy
Permanent hair removal to treat surgical tissue donor sites only	Vulvoplasty
Please see Codes Requiring Service Authorization for complete listing of CPT® codes.	

Revisions to surgeries for the treatment of gender dysphoria are only covered in cases where the revision is required to address complications of the surgery (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.)

SERVICE AUTHORIZATION

Surgical services for gender affirmation require service authorization **prior** to services being rendered. Please visit <https://nddhs.kepro.com/> for further information.

NONCOVERED SERVICES

Reversal of any surgical procedure listed in this chapter.

Revisions are not for cosmetic issues (e.g. laser hair removal from sites other than surgical grafting sites, chondrolaryngoplasty, and facial feminization, liposuction, gluteal implants, hydrogel and silicone injections.)

Services to reverse effects of hormone induced changes.

Maintenance of fertility, cryopreservation of ova or sperm, infertility treatment.

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

Health Tracks is the name of North Dakota Medicaid's EPSDT benefit. EPSDT is Medicaid's federally required comprehensive and preventative health benefit, for individuals through age 20.

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

OVERVIEW

The ND Health Tracks/Well-Child Checks benefit focuses on early prevention and treatment, assures the availability and accessibility of required health care resources, and helps members and their parents or guardians effectively use services.

Health Tracks/Well-Child Checks benefit 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 check-ups; and
- Assure that health problems found are diagnosed and treated early, before they become complex, and their treatment becomes more costly.

HEALTH TRACKS/WELL-CHILD CHECKS SERVICE REQUIREMENTS

All screening tools must be evidence-based. The Health Tracks/Well-Child Checks benefit includes the following:

- Screening/Examination services:
 - A comprehensive health and developmental history including assessment of both physical and mental health development (see [Bright Futures Commonly Used Screening Tools](#)),
 - A comprehensive unclothed physical exam,
 - Appropriate immunization – (according to the [schedule](#) established by the Advisory Committee on Immunization Practices (ACIP) for vaccines),
 - Laboratory tests (including Lead Toxicity screening*), and
 - Health Education – Health education is a required component of screening/examination services and includes anticipatory guidance. At the outset, the physical and/or dental check-up 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 healthy lifestyles and practices.

- Vision services including evaluation and treatment for defects in vision.
- Dental services including fluoride varnish, sealants, relief of pain and infections, restoration of teeth, and maintenance of oral health. Dental services may not be limited to emergency services.
- Hearing services including evaluation 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 through a check-up.

***Lead Toxicity Screening** – The Centers for Disease Control and Prevention (CDC) recommends testing blood for lead exposure. All children are considered at risk and must be screened for lead toxicity. EPSDT benefit requirements dictate that all children eligible for Medicaid have a screening blood lead test completed at 12 months and 24 months of age. Medicaid-eligible children between the ages of 36 months and 72 months of age must have a blood lead test if they have not been previously screened for lead toxicity. The CDC recommends health care providers use either a capillary or venous sample for the initial blood level. If the capillary results are equal to or greater than 3.5 ug/dl, a venous sample should be collected. All blood lead level results are included in the mandatory reportable conditions per [ND Administrative Code § 33-06-01-01](#) Reportable Conditions. The [Childhood Lead Poisoning Evaluation Questionnaire](#) (SFN 59322) can be utilized for children screened at ages outside the ranges noted above. Additional information [Blood Lead Levels in Children | Lead | CDC](#).

PERIODICITY SCHEUDULE

The recommended frequency of Health Tracks/Well Child Check assessments is according to the following schedule. Consult the [Bright Futures Well Child Periodicity Schedule](#) for a description of visits.

Recommended EPSDT Periodicity Schedule:

Newborn	2 months	9 months	18 months	Age 3 through
3-5 days	4 months	12 months	24 months	age 20,
1 month	6 months	15 months	30 months	annually

ND Medicaid allows Health Tracks screenings/Well-Child Checks as often as considered medically necessary. Inter-periodic checkups (check-ups outside the periodicity schedule) should be billed the same as a periodic check-up

DIAGNOSIS

When a check-up 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 through the check-up.

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 must use the Bright Futures guidelines.

Documentation requirements can also be met using an internal form or within your Electronic Health Record, if it captures all the components included in the Bright Futures guidelines. These documentation requirements include:

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

Please see Documentation Guidelines for Medicaid Services under the Provider Information chapter in this manual.

COVERED SERVICES

Vision, hearing, and dental screenings are part of a Health Tracks/Well-Child Check and cannot be billed separately. The following may be billed separately using the appropriate CPT code:

- Immunizations and administration (See Immunizations chapter in this manual),
- Fluoride Varnish,
- Developmental Screenings,
- Maternal Depression Screenings,
- Laboratory tests, and

- Other necessary diagnostic and treatment services.

BILLING GUIDELINES

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

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.

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.

HOME HEALTH AND PRIVATE DUTY NURSING

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

HOME HEALTH SERVICES

Home health services are skilled nursing services, as defined in the [North Dakota Nurse Practice Act](#) (N.D.C.C. § 43-12.1), 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 the member's 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 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, must occur no more than 90 days before or 30 days after the start of home health services. Face-to face encounters:

- Must be related to the primary reason the member requires home health services, It
- May be performed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
- May be performed via telehealth or in-person, telephone encounters are insufficient.

Clinical findings of the encounter must be communicated by the performing practitioner to the ordering physician. This communication must be documented in the medical record along with medical necessity for the home health services.

COVERED SERVICES

Home health agencies 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

Uncovered services 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 50 visits per member per calendar year, for all covered home health services. These visits are not subject to prior approval and do not apply to extended hour visits. Extended hour visit requests must be prior authorized by ND Medicaid.

SERVICE AUTHORIZATION TO EXCEED HOME HEALTH VISIT LIMITATION

Service authorization is required when it is medically necessary for the member to exceed the home health visit limitation. 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 home health agency must submit a service authorization. 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.

Requests for additional visits beyond the initial 50 visits must be submitted prior to the last visit of the 50-day limitation and prior to the additional service being provided. 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.

Each service authorization is valid for 60 days. Subsequent requests after the first 60-day period must be medically necessary, have a service authorization, and be received by ND Medicaid prior to the service being provided or before the next 60-day period. If the service authorization is not received prior to the 60-day time period, the visits will be denied.

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 FOR COVERED SERVICES

Payment to Home Health Agencies for covered services provided 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 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

For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director or the hospice or physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

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 below services. 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 Medicaid payment is made for bereavement counseling.

PAYMENT FOR PHYSICIAN SERVICES

Daily hospice care rates 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 plans of care, supervision of care and service, periodic review and updating plans of care, 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

The hospice is responsible for paying room and board for when providing care for a member residing in a long-term care facility. In this situation, payment to the long-term care facility by ND Medicaid is no longer available. 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 arrange 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 discharged is 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 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 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. Newborn and mother's charges must be billed on separate claims for each member.
- 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

ND Medicaid does not reimburse revenue codes 510-519 for hospital-based clinic services.

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.

Effective January 1, 2023, North Dakota Medicaid will require a valid HCPCS code for Revenue Code 0250 on all outpatient services. A NDC must also be submitted if the HCPCS code requires it.

**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 noncovered for members ages 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

Effective for dates of service on or after March 1, 2021, HCPCS code A4657 – Syringe, with or without needle, will not be paid separately and considered incidental to the dialysis service performed on that day.

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.hhs.nd.gov/human-services/medicaid/provider.

COVERAGE GUIDELINES

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

Vaccines for Children (VFC, state supplied) vaccines/toxoids supplied by North Dakota Department of Health and Human Services (NDHHS) must be used when administering a vaccine to members, 0 through 18 years of age. Providers administering vaccines/toxoids to children in this age group must be enrolled in the NDHHS 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 NDHHS Immunization page at www.hhs.nd.gov/public-health-information/diseases-conditions-and-immunization/immunizations.

VACCINE COUNSELING

Effective July 1, 2022, ND Medicaid will cover stand-alone vaccine counseling visits related to all pediatric vaccines, including the COVID-19 vaccine to all members under the age of twenty-one, when provided by a physician or other qualified health care professional including Local Public Health clinics. Vaccine counseling for members aged 21 and over will not be covered.

- G0312 Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of

service for ages under 21, 5 to 15 mins time. (This code is used for Medicaid billing purposes.)

G0313 Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time. (This code is used for Medicaid billing purposes.)

G0314 Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time. (This code is used for the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT).

G0315 Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time. (This code is used for the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT).

This service will not be separately reimbursed when provided in conjunction with preventative medicine codes 99381-99397, or vaccine administration provided on the same calendar date by the same provider of service.

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 telehealth 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 using 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 0900	Behavioral Health
Revenue Code 0987	Physician Inpatient Services

Reference the Telehealth chapter of this manual for specific billing instruction related to services rendered via telehealth.

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 Health and Human Services (ND HHS), 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);
 - 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 Services including Rehabilitative Services. The student must meet the eligibility requirements for rehabilitative services and all other rehabilitative services guidelines apply. See Rehabilitative Services chapter of the [Behavioral Health Services Manual](#) for more information;
- 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 www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/autism-aba-service-policy-and-procedures.pdf). NOTE: Service authorization must be received and approved prior to services being rendered.

TELEHEALTH

Health Services billed by schools can be delivered via telehealth; however, no originating site fee is allowed. See Telehealth 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

Noncovered services 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 are 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 when it is known that the member will not return to the facility.

Once the facility accepts payment for hospital leave on behalf of a member, then the facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held. 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 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. 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 billed units 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:

Revenue Code 0110	In-House Medicaid Days
Revenue Code 0180	Therapeutic Leave Days
Revenue Code 0185	Hospital Leave Days

A facility must submit a claim for every month a 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, RADIOLOGY AND DIAGNOSTIC SERVICES

ND Medicaid covers laboratory services, regardless of setting, performed by a laboratory with a current Clinical Laboratory Improvement Amendments (CLIA) certificate and enrolled with ND Medicaid.

COVERED LAB SERVICES

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.

CODING GUIDELINES

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

LABORATORY BILLING GUIDELINES

Providers eligible for payment of laboratory services in an office setting are those providers allowed to order laboratory services within their scope of practice in the state in which services are ordered.

Providers rendering services in an office setting may also send laboratory specimens to independent or outpatient hospital laboratories. The independent or outpatient hospital laboratory must submit the laboratory billing in these situations.

All laboratory claims must include the valid NPI number of the ordering, prescribing, or referring provider for services requiring an order.

DIAGNOSTIC RADIOLOGY BILLING GUIDELINES

Both professional and technical components of a diagnostic radiology service may be billed to ND Medicaid. 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.

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

To bill for the technical component, enter the procedure code and append modifier TC in the appropriate modifier field. The technical component encompasses the charges for personnel and materials, which includes, film or xerography, space, equipment, and other facilities but excludes the cost of radioisotopes. Radiopharmaceuticals / contrast media shall be reported on the same claim as the diagnostic service with the appropriate HCPCS code and NDC combination for the product administered. (Technical components shall be billed by providers owning the equipment).

Unmodified CPT codes are intended to describe both the professional and technical components of a service. The professional and technical components together are referred to as a “global service”. It is never appropriate for the professional and technical components to be unbundled and reported separately under the same rendering NPI (whether on separate line items of a single claim or separate claims).

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 member.

ND Medicaid will cover the following services provided by LPHUs:

HCPCS/ CPT Code	Description
99188	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
T1013	Sign language or oral interpretive services, per 15 minutes
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)
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

HCPCS/ CPT Code	Description
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	
Please see the Vaccine/Toxoid Medicaid Coding Guideline for full coverage and coding information at www.hhs.nd.gov/human-services/medicaid/provider	

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.hhs.nd.gov/medicaid-expansion-and-childrens-health-insurance-program-chip/apply-medicaid.

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.hhs.nd.gov/eligibility-and-how-apply

MEDICAID SERVICES RENDERED IN SCHOOLS

This chapter is intended to provide direction to providers who are rendering Medicaid covered services in schools.

This chapter does not cover services that are part of a Medicaid-eligible student's Individualized Education Program (IEP). For information on Medicaid and IEP services, see the IEP Medicaid Services Billed by Schools chapter for additional information.

COVERED SERVICES

Services that are otherwise covered by ND Medicaid may be rendered in a school. Services are subject to the same service authorization requirements and limits as (non-IEP) services rendered outside of the school.

Medicaid covered services provided in a school must be rendered by practitioners who are enrolled as a ND Medicaid provider and meet ND Medicaid provider qualifications. This is consistent with services rendered in other places of service.

Reimbursement is available for services provided when all the following conditions are met:

- The student is eligible for Medicaid on the date of service;
- The rendering practitioner is an enrolled Medicaid provider and operating within their scope of practice;
- The service is covered under the North Dakota Medicaid State Plan;
- The practitioner maintains documentation to support the service rendered; and
- Third Party Liability requirements are met.

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.

SCHOOL NURSES

Except as noted in the following paragraph, ND Medicaid does not enroll school nurses:

ND Medicaid enrolls registered nurses to provide nursing services to Medicaid-eligible children (under the age of 21) who have complex medical needs and an

approved IEP that documents medical necessity for nursing services that support the child's needs to access free appropriate public education.

SCHOOL APPROVAL TO PROVIDE SERVICES

Practitioners not employed by the school who render services to Medicaid-eligible individuals in the school, must secure the necessary approvals from the local school to render services within the school. Nothing in this chapter is intended to supersede local school control.

THIRD PARTY LIABILITY

Services rendered in schools for non-IEP services are subject to Medicaid Third Party liability requirements; therefore, providers must bill all non-IEP services rendered in schools to liable third parties. Medicaid is the payer of last resort. See the Third-Party Liability chapter for additional information.

TELEHEALTH

Services rendered in schools may be delivered via telehealth. See the Telehealth chapter for additional information on services rendered via telehealth.

NONCOVERED SERVICES

- Services rendered without the appropriate service authorization
- Services that exceed Medicaid limitations
- Services authorized or prescribed in the Medicaid eligible student's IEP
- Communications between the provider and Medicaid member that do not maintain actual visual contact
- Transportation to and from home to school
- Services considered experimental or investigational
- Services considered educational or instructional in nature
- Administration of prescriptions and over the counter medications

BILLING GUIDELINES

Services rendered in a school must be billed with place of service (POS) 03 (school); unless the provider agency or practitioner leases space in the school, in which case POS 11 (office) must be billed.

In order to ensure correct accounting of funding for services, if a school employs practitioners who render IEP services and non-IEP services, the school must obtain a separate ND Medicaid provider number to bill ND Medicaid for the non-IEP services. It is the school's responsibility to bill IEP and non-IEP services under the correct provider number.

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 Medicaid-enrolled licensed registered dietitians. 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 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.

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

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 on 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.

MEDICATION ASSISTED TREATMENT (MAT)

DEFINITION

MAT is the use of medications approved by the US Food and Drug Administration (FDA), in combination with behavioral therapies and support services, to provide a whole-patient approach to the treatment of alcohol and opioid use disorders. This chapter pertains to the following MAT program providers:

- Opioid Treatment Program (OTP)- an accredited treatment program with SAMHSA certification and Drug Enforcement Administration (DEA) registration to administer and dispense opioid agonist medications, including Methadone, that are approved by the FDA to treat opioid addiction. OTPs must provide medical, counseling, vocational, educational, and other assessment and treatment services, either onsite or by referral to an outside agency or practitioner through a formal agreement, as identified in the member's behavioral health individual treatment plan (ITP); or
- Office-based Opioid Treatment (OBOT),- an organization that employs or contracts with a provider who holds a current waiver with SAMHSA and has been assigned a DEA identification number for buprenorphine prescribing for opioid use disorders. OBOTs may only provide buprenorphine opioid treatment. OBOTs must provide medical, counseling, vocational, educational, and other assessment, and treatment services, either onsite, or by referral to an outside agency or practitioner through a formal agreement, as identified in the member's behavioral health ITP.

PROVIDER REQUIREMENTS

Services must be provided by a practitioner who has a current DEA-X number or by a practitioner affiliated with a MAT program accredited by a SAMHSA-Approved Opioid Treatment Program Accrediting Body.

The billing provider must be enrolled with a specialty of 509 – Methadone.

CRITERIA FOR COVERAGE

Member must:

- have a diagnosed moderate or severe opioid use disorder;
- be determined clinically appropriate for MAT; and
- agree to initiate MAT and receive other services identified in the member's behavioral health ITP.

The member must require at least one face-to-face or telehealth check-in per month for prescribing or dispensing OBOT/OTP medication. For those receiving buprenorphine-

based treatment, the Data Waived prescriber has deemed it medically necessary to treat the member's opioid addiction with buprenorphine products.

SERVICE REQUIREMENTS

A MAT provider must present the member with the following information as evidenced by signature of the member:

- all relevant facts concerning the use of MAT that is clearly and adequately explained;
- other treatment options and detoxification rights;
- a written estimate of expenditure including the amount expected to be covered by insurance and/or other payment sources and out of pocket expenditures for the member;
- written program participation expectations and a list of incidents that require termination of program participation;
- written procedures for non-compliance and discharge including administrative medication withdrawal; and
- education pertaining to their prescription.

The provider must:

- review the PDMP for the member's past and current use of Category II and III prescriptions prior to the induction of MAT.
- review the PDMP to determine if the member is receiving opioid or tramadol prescriptions concurrently with MAT services.
- offer behavioral health counseling services to the member, if clinically appropriate, and document it in the member's behavioral health ITP. base services on a comprehensive physical, exam, screening, and assessment and documented in the member's behavioral health ITP.
- complete an initial behavioral health ITP within seven days of enrollment into MAT, update it at least every two months, and include the following medication addiction treatment services:
 - plans for behavioral health services;
 - care coordination services to address identified medical, social, SUD, and mental health issues; and
 - signature of the member and the staff who prepared the behavioral health ITP.

Provider documentation must include:

- medication prescribing and adjustment by prescribing professional;
- nursing assessment and medication tolerance and vital signs;
- lab test outcomes and treatment progress with MAT; and

- medication distribution.

Telehealth must be provided in accordance with applicable federal and state laws and policies and follow the Controlled Substances Act (CSA) ([28 USC Part 802](#)) for prescribing and administration of controlled substances.

COVERED SERVICES

Members must be assessed at intake for the MAT program by an enrolled Medicaid provider.

The following MAT services are bundled services and must be billed using the appropriate reimbursement codes for:

- MAT Intake; and
- MAT Established.

MAT INTAKE

MAT Intake, which may be reimbursed for the first week of the member's enrollment into the MAT program, includes:

- a face-to-face assessment by a physician, psychiatrist, nurse practitioner or physician assistant;
- behavioral health assessment by a licensed addiction counselor;
- drug testing;
- pregnancy test for HCG (if clinically appropriate);
- any other labs or tests performed as part of clinic protocols for their addiction treatment members; and
- induction of medication.

MAT Intake reimbursement limitations:

- No more than once every twelve months for a member with the same provider clinic.
- If the member has seen a practitioner at the provider clinic within the last twelve months reimbursement will be denied.

MAT ESTABLISHED

MAT Established, which may be reimbursed beginning week two and weekly thereafter, as clinically indicated, must include the following:

- The member received their MAT medication for the week being billed;

- For OTPs, a clinical assessment that meets the requirements in 42 CFR § 8.12(f)(4) must be conducted, face to face or by telehealth, as clinically appropriate, at least once every three months for the first year of continuous treatment, and at least once every six months for each subsequent year;
- For OBOTs, a visit with the prescriber every three months for the first year of continuous treatment, and at least once every six months for each subsequent year;
- pregnancy tests for HCG, when clinically appropriate;
- drug testing, when clinically appropriate;
- any other labs or tests performed as part of clinic protocols for their addiction treatment members; and
- update of the behavioral health ITP at least every two months.

ADDITIONAL BILLING INFORMATION

- Medication can only be billed in conjunction with receiving MAT Intake or MAT Established weekly bundled services.
- Medication (except medication used during induction) is not included within the bundled rate and may be reimbursed outside of the bundled rate.
- Buprenorphine (oral or implant) may be reimbursed outside of the bundled rate.
- Insertion and/or removal of Buprenorphine implant may be reimbursed outside of the bundled rate.
- Clinically appropriate screening and laboratory services associated with the provision of MAT may not be billed separately.

SERVICE AUTHORIZATION

Service Authorization is not required.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

The codes identified in the Billing Guidelines may not be billed by FQHCs. FQHCs must follow the Criteria for Coverage and Service Requirement sections of this policy.

BILLING GUIDELINES

Meeting the requirements for covered services outlined above allows the provider to bill the weekly bundled rate and medication. For instance, when an ITP is updated, the provider can bill for the subsequent two months, and when an established patient in their second year has a visit for their required six-month clinical assessment, the provider can then bill for the subsequent six months.

The following HCPCS© Codes and modifiers must be used when billing for MAT weekly bundled services.

HCPCS® Code	Modifier	Service	Frequency	Rate
H0016	U7	MAT Intake	Weekly	\$308.54
H0016		MAT Established	Weekly	\$92.32
H0020		Methadone & Administration at OTP setting	Daily as provided	\$3.30
H2010		Medication & Take-Home Packaging	Daily as provided	\$3.30
Applicable code		Buprenorphine	Based on code	NDC pricing
Applicable CPT code		Insertion or removal of implant	Based on procedure	Fee Schedule

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
- Advance care planning
- Alcoholic beverages
- Autopsies
- Body piercing
- Dental implants
- Drugs that are not approved by the FDA, including regimens when all medications in the regimen do not have FDA approval
- Drug testing that is not medically indicated
- Equine therapy
- Experimental and investigational service, procedure, or products (this includes if the member has primary insurance, and the primary insurance denies the service, procedure, or product as experimental.)
- Health services paid by another source i.e. Workers Compensation claims, eyeglasses covered by a Fraternal Organization
- Health services for obtaining or maintaining a medical marijuana registry identification card
- Health services which require service authorizations that were not obtained according to program policy and rules
- Health services not in compliance 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 or a referral from a practitioner of the healing arts or PCP are required but not obtained
- Health services not documented in the member's medical record or plan of care
- 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 (diagnostic, medical, surgical, or pharmaceutical services related to infertility)
- 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, unless medically necessary
- Music therapy
- Non-CLIA certified lab services
- Non-face-to-face services, except for services listed in the Telehealth chapter of this manual
- Out of state services that were not prior approved
- Paternity testing
- Patient convenience (example: moving patient to facility closer to home)
- Payment for a private room in a nursing facility or basic care facility
- Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropic, analgesics, or ADHD stimulant medications
- Plan of care oversight activities
- Preventative medicine counseling
- Removal of health tissue or organs
- Reversal of sterilization
- Routine circumcisions
- Routine physical examination except for members in an ICF/IID
- Services not documented in the member's health care record
- 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 denied by a third-party payer because third-party requirements were not followed
- Tattoo or tattoo removal
- Team conference without patient present
- 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 § 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. 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 member's medical needs. 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 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. 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 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 eligible 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

Noncovered services 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. A transportation provider whose business includes riders in addition to members cannot charge Medicaid more than the rate charged to its non-Medicaid riders. If a transportation provider discounts multiple rider trips for non-Medicaid riders, the provider also must discount the amount billed for members and must charge the same rates (including free rides) to members. If a provider serves only members, the rate charged to Medicaid is the usual and customary fee.

TRANSPORTATION OF INDIVIDUALS WITH A DISABILITY

The below 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 must 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 within 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 retroactive authorization. An approved retroactive authorization must include in the "Destination" field if it was an ER or after-hours urgent care visit. The use of retroactive 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

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

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

Minnesota Nursing Facilities

Non-emergency medical transportation of 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 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 and 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 eighteen (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 A0100, A0800, A0120, A0170, A0130, S0209, S0215 T2005 and T2049.

Transportation providers are responsible for keeping written records for each member who is transported to a covered service. The record must include the provider Medicaid ID number, member name, member Medicaid ID number, time of the pick-up and drop off, address of pick-up, address of drop off, trip date, and mileage. 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 and address.

Failure to maintain the required documentation may result in a transportation provider being terminated and 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

These forms are available at www.nd.gov/eforms.

- SFN 170
- SFN 249
- SFN 294
- SFN 296

NURSE PRACTITIONERS, CERTIFIED NURSE MID-WIVES, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS

ND Medicaid covers medically necessary services provided by Nurses Practitioners (NP), Certified Nurse Mid-Wives (CNM), Clinical Nurse Specialists (CNS), and Physician Assistants (PA) who are licensed to practice in the state in which the services are provided and enrolled with ND Medicaid.

NPs, CNMs, CNSs, 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, CNM, CNS, or PA license.

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

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

The hospital leave policy ensures that a bed is available when a resident returns to the nursing facility. ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. 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. 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. 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 a resident's discharge to any location 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 billed units 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 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. Included routine services 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 not included in the out of state nursing facility rate must be billed by the provider furnishing the service.

OCCUPATIONAL THERAPY

ND Medicaid covers occupational therapy provided to a member by an occupational therapist enrolled with ND Medicaid and licensed to practice occupational therapy in the state in which the services are provided.

COVERED SERVICES

Occupational therapy requires an order (prescription) from a physician or practitioner of the healing arts allowed to prescribe under their scope of practice according to state law. Occupational therapy must also have a referral from the member's primary care provider, which includes a referral for "evaluation and treatment".

Occupational therapy includes services that address an individual's deficits in occupational performance, 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 an occupational therapist.

Occupational therapy provided on an ongoing basis for members who have experienced trauma, have a chronic condition, or have a condition due to congenital abnormality, deprivation, or disease that interrupts or delays the sequence and rate of normal growth, development, and maturation is covered if provided to maximize the member's functional level.

Occupational therapy services provided to a resident in a nursing facility or ICF/IID are not separately billable. ND Medicaid pays for occupational therapy through the rate established for these facilities.

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.
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
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
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes

PLAN OF CARE

Occupational therapy services must be provided in accordance with the documented plan of care that is dated and signed by the occupational therapist responsible for oversight of the plan. The occupational therapy must be ordered by a physician or other licensed practitioner of the healing arts.

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

- Diagnosis;
- A description of the member's functional status;
- The objectives of the occupational therapy service;
- Short-term treatment goals;

- Long-term treatment goals; and
- Type, amount, duration, and frequency of therapy services;

The plan of care shall be consistent with the related evaluation, which is considered part of the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a relatively short amount of time, generally not to exceed 90 days. 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.

The occupational therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the physician or other licensed practitioner of the healing arts who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment since initial or previous plan of care update;
- New, modified or carried-over short-term goals; and
- New, modified or carried-over long-term goals.

LIMITATIONS

Occupational therapy evaluations are limited to one per calendar year. Occupational therapy is limited to 30 visits per calendar year for members age 21 and over.

SERVICE AUTHORIZATIONS

A service authorization is required for additional evaluations and re-evaluations for members of any age and for therapy visits that exceed the limit of 30 visits per calendar year for members aged 21 and over. ND Medicaid will not cover services in excess of the limit that are provided without a service authorization. The occupational therapist 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 current

plan of care and relevant progress notes must be submitted with the service authorization.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress toward goal attainment;
- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified, or carried-over goals.

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The occupational therapy provider must demonstrate good cause for the failure to secure the required prior service authorization request.

NONCOVERED SERVICES

- Occupational therapy provided without an order from a physician or licensed practitioner of the healing arts;
- Services for contracture that 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 without participation of the member;
- Arts and crafts activities for the purpose of recreation;
- Services that are not part of the member's plan of care or are specified in a plan of care but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or prevent the digression of the functional status of a member;
- 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;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization, or any other visualization therapy;
- Dry needling;

- Kinesio Taping;
- Acupuncture; and
- Maintenance therapy.

OPTOMETRIC AND EYEGLASS SERVICES

ND Medicaid covers services provided by an ophthalmologist, optometrist, or optician who is licensed and is enrolled with ND Medicaid. ND Medicaid covered services must be within the scope of the provider's practice.

Providers seeking approval for optometric and eyeglass services requiring service authorization must submit a Request for Service Authorization for Vision Services (SFN 292) The form is available at www.nd.gov/eforms.

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. 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. 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 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 eyeglass contractor must secure an order (prescription) from the ordering practitioner and include the NPI, taxonomy and name of the ordering practitioner on the claim to ND Medicaid. 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)
Blue Blocking Lenses	Yes – if medically necessary with Service Authorization	Yes – If medically necessary with Service Authorization
Photochromic – plastic (i.e. Transition)	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization
Photochromic – Glass (i.e. photo gray, photo-brown)	Yes - if medically necessary with Service Authorization	Yes - if medically necessary with Service Authorization
Progressive	No	No

Lens Feature	Covered for Children (Ages 20 and Under)	Covered for Adults (Ages 21 and Older)
Blue Blocking Lenses	Yes – if medically necessary with Service Authorization	Yes – If medically necessary with Service Authorization
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes	Yes
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	Yes
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 Fresnel 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 eyeglass 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 their 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. Eyeglass orders can be submitted on-line at:

www.classicoptical.com/Orders.asp

DISPENSING SERVICES

Ophthalmologists, optometrists, and opticians may provide dispensing services.

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. The provider dispensing the contact lenses must secure an order (prescription) from the ordering practitioner and include the NPI and taxonomy of the ordering practitioner on the claim to ND Medicaid.

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

Noncovered services include:

- 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 50 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 member must be covered ND Medicaid services 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 practitioner 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 their 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 Health and 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 ND Medicaid review. The transferring facility must notify ND 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 ND 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.hhs.nd.gov/nd-medicaid-provider-information/medicaid-provider-manuals-and-guidelines.

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, or 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.hhs.nd.gov/nd-medicaid-provider-information/medicaid-provider-manuals-and-guidelines

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 www.hhs.nd.gov/medicaid-pharmacy-providers.

PHYSICAL THERAPY

ND Medicaid covers physical therapy provided to a member by a physical therapist enrolled with ND Medicaid and licensed to practice physical therapy in the state in which the services are provided.

COVERED SERVICES

Physical therapy requires an order (prescription) from a physician or practitioner of the healing arts allowed to prescribe under their scope of practice according to state law. Physical therapy must also have a referral from the member's primary care provider, which includes a referral for "evaluation and treatment".

Physical therapy includes services that address an individual's deficits in physical performance, motor skills, cognitive skills, sensory integrative skills, preventive skills, therapeutic adaptations, and activities of daily living.

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 physical therapist.

Physical therapy provided on an ongoing basis for members who have experienced a trauma, have a chronic condition, or have a condition due to congenital abnormality, deprivation, or disease that interrupts or delays the sequence and rate of normal growth, development, and maturation is covered if provided to maximize the member's functional status.

Physical therapy services provided to a resident in a nursing facility are not separately billable. ND Medicaid pays for physical therapy through the rate established for these facilities.

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.
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
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
97542	Wheelchair management, each 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes

PLAN OF CARE

Physical therapy services must be provided in accordance with a documented plan of care that is dated and signed by the physical therapist responsible for oversight of the plan. The therapy must be ordered by a physician or other licensed practitioner of the healing arts.

The initial plan of care shall contain, at minimum:

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

The plan of care shall be consistent with the related evaluation which is considered incorporated into the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a relatively short amount of time, generally not to exceed 90 days. 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.

The physical therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the physician or other licensed practitioner of the healing arts who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment since initial or previous plan of care update;
- New, modified, or carried-over short-term goals; and
- New, modified, or carried-over long-term goals.

LIMITATIONS

Physical therapy evaluations are limited to one per calendar year. Physical therapy is limited to 30 visits per calendar year for members age 21 and over.

SERVICE AUTHORIZATIONS

A service authorization is required for additional evaluations or re-evaluations for members of any age and for therapy visits that exceed 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 provided without a service authorization. The physical therapist 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 current plan of care and relevant progress notes must be submitted with the service authorization request. The form is available at www.nd.gov/eforms.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress toward goal attainment;

- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified or carried-over goals.

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The physical therapy provider must demonstrate good cause for the failure to secure the required prior service authorization request.

NONCOVERED SERVICES

- Physical therapy provided without an order from a physician or licensed practitioner of the healing arts;
- Services for contracture that 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 part of the member's plan of care or are specified in a plan of care but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or to prevent the digression of 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;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization, or any other visualization therapy;
- Dry needling;
- Kinesio Taping;
- Acupuncture; and
- Maintenance therapy.

PHYSICIAN SERVICES

ND Medicaid covers services provided by a physician who is licensed to practice in the state in which the services are provided and 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.

COVERED 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 clinic, a 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 ND Medicaid Professional Fee Schedule to determine if specific services are covered: www.hhs.nd.gov/nd-medicaid-provider-information/medicaid-provider-fee-schedules

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.

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.

TELEHEALTH

See Telehealth 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.

PROLONGED E&M SERVICES

HCPCS code G2212 must be used when billing for prolonged Evaluation and Management (E/M) services which exceed the maximum time for a level five (99205, 99215) office/outpatient E/M visit by at least 15 minutes on the date of service. Effective January 1, 2021, CPT codes 99417, 99358 and 99359 will not be accepted with 99202 - 99215. See [MLN Matters MM12071](#) for further information.

SPORTS PHYSICALS

Effective January 1, 2023, sports physicals should be coded as CPT® code 99429-unlisted preventive service along with ICD-10-CM code Z02.5. If a well-child visit and a sports physical occur at the same visit the provider should bill the well-child visit only.

PRIMARY CARE CASE MANAGEMENT (PCCM)

DEFINITIONS

- "Auto-Assignment" means the process by which ND Medicaid utilizes a default assignment of a member to a PCP when a member does not select a PCP within a given time period, as defined by ND Medicaid.
- "Emergency Care" means 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", means 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 where the practitioner furnishes them.
- "Primary Care Case Management" (PCCM) means care coordination provided by a primary care provider that includes locating, providing, coordinating, and monitoring health care services provided to members.
- "Primary Care Provider" (PCP) means one provider chosen by the member or assigned by ND 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" means 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 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 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, and (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); or
- 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 above noted the specialties 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 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 which 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);
- The form is available at www.nd.gov/eforms;
- 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 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.

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 www.hhs.nd.gov/nd-medicaid-provider-information/primary-care-case-management-program

- 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

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

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 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 they submit 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.

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 (CMS) and enrolled with ND Medicaid.

COVERED SERVICES

Payment to RHCs for covered services furnished to 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 plus related services and supplies. See Telehealth chapter for additional information on services rendered via telehealth.

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 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 for additional information on immunizations and immunization administration.

Vaccines administered in conjunction with a medical encounter are considered incident to the medical encounter and neither the vaccine nor the vaccine administration can be billed in addition to a medical encounter.

When the only service provided is a vaccine:

- The vaccine administration can be billed, but an encounter cannot be billed. The vaccine administration must be billed using Revenue Code 0771 (Vaccine administration) along with the appropriate CPT code.

If the vaccine is supplied by the Vaccine for Children (VFC) program, ND Medicaid will not make payment for the vaccine. ND Medicaid will only make payment for the vaccine administration; however, the claim must include Revenue Code 0636 (Drugs requiring detailed coding) and the appropriate CPT code for the vaccine. If the vaccine is not supplied by the VFC program and is currently covered by ND Medicaid, the vaccine will be reimbursed according to the Medicaid fee schedule using Revenue Code 0636 (Drugs requiring detailed coding) and the appropriate CPT code.

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

SIGN AND ORAL LANGUAGE INTERPRETER SERVICES

ND Medicaid covers sign and oral language interpreter services for assistance in providing covered services to a member who has limited English proficiency or who has hearing loss.

COVERED SERVICES

ND Medicaid reimbursement for interpreter services is available when provided to members to facilitate access to ND Medicaid covered services.

COVERAGE GUIDELINES

Interpreters are not able to enroll as a Medicaid provider; however, interpreter services are eligible for reimbursement when rendered in conjunction with a ND Medicaid covered service and when billed by professional service provider types such as: physicians, podiatrists, optometrists, nurse practitioners, dentists, office-based practitioners, public health units, and behavioral health providers.

Interpreters may be employed by or contracted with the billing provider. If a member comes to an appointment with an interpreter, the provider is not required to use that interpreter. Three people must be present for the service to be covered: the provider, the patient, and the interpreter.

Staff members at the provider's office who are qualified in American Sign Language (ASL) or competent in spoken language interpretation may interpret the medical service; however, the interpretive service is not billable if the staff member is also providing another service. For example, a bilingual staff nurse may interpret during an appointment, but may not perform the duties of a nurse while interpreting; only one service (either interpreting or the medical service) is billable to North Dakota Medicaid. If the provider renders a medical service while communicating in the member's language, it is not interpreting and not separately billable as an interpreter service.

Location, type of interpretation provided, name of interpreter, date and time of interpretation, agency, service duration (time in & time out), and the cost of providing the service (agency invoice) should be documented in the patient's records.

Interpreters shall adhere to national standards developed by the National Council on Interpreting in Healthcare (NCIHC), to include accuracy, confidentiality, impartiality, role boundaries, professionalism, professional development, and advocacy.

All sign and oral language interpreters must:

- Be qualified and competent;
- Demonstrate proficiency in both English and the targeted language (sign or spoken) including any specialized health care terms or concepts; Use the appropriate mode of interpreting given the situation (for example, consecutive, simultaneous, summarization, or sight translation); Have received appropriate interpreter training that includes instruction in the skills and ethics of interpreting, and rules of confidentiality and data privacy; Understand their role as interpreters without deviating into other roles, such as counselor or legal advisor; and be sensitive to the patient's culture.

NONCOVERED SERVICES

ND Medicaid will not reimburse interpreter services in conjunction with the following services:

- Inpatient or outpatient hospital services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Day treatment
- Nursing Facilities
- Basic Care Facilities
- Indian Health Service (IHS) or Tribal 638 for services reimbursed through an encounter rate
- Psychiatric Residential Treatment Facilities (PRTF)
- Federally Qualified Health Centers (FQHCs) for services reimbursed through an encounter rate
- Rural Health Clinics (RHCs) for services reimbursed through an encounter rate
- Home Health Agencies
- Emergency and non-emergency medical transportation.

ND Medicaid does not cover interpreter services:

- Provided in conjunction with a non-covered service
- Provided by a family member (parent, spouse, sibling, or child), friend or volunteer
- Time and expense for the interpreter to travel to and from the location of the rendered service
- To compensate for wait time (includes waiting in a lobby, exam room, or any office space when a medical service is not being delivered)
- For administrative tasks such as scheduling or cancelling appointments or making reminder calls
- For no shows or cancelled appointments

BILLING GUIDELINES

Interpreter services must be billed by the provider billing the service rendered in conjunction with the interpretive service. Providers should bill both the office visit and

the interpreter service on the same claim form. If a ND Medicaid covered service is not billed in conjunction with the interpretive service, the entire claim will deny.

Non-dental providers must bill for the interpretive services using Healthcare Common Procedure Coding System (HCPCS) code "T1013" (Sign language or oral interpretive services, per 15 minutes). Code "T1013" must be billed with the appropriate number of units provided (one (1) unit = 15 minutes of service). At least 8 minutes must be spent to report one unit. Providers can submit claims for a maximum of 8 units (2 hours) per office visit. The time billed for interpretation services cannot exceed the length of time of the office visit.

Dental providers must bill for the interpretive services using Current Dental Terminology (CDT) code "D9990" (certified translation or sign-language services, per visit).

If the interpreter is not providing services in-person, providers should follow the current North Dakota Medicaid guidelines for billing telehealth/teledentistry visits (appropriate modifiers/codes).

SPEECH-LANGUAGE SERVICES

ND Medicaid covers speech-language services provided to a member by a speech-language pathologist enrolled with ND Medicaid and licensed to practice in the state in which the services are provided.

COVERED SERVICES

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

Speech-language services require an order (prescription) from a physician or practitioner of the healing arts allowed to prescribe under their scope of practice according to state law. Speech-language services must also have a referral from the member's primary care provider, which includes a referral for "evaluation and treatment".

Speech-language 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 speech-language pathologist.

Speech-language services provided on an ongoing basis for members who have experienced trauma, have a chronic condition, or have a condition due to congenital abnormality, deprivation, or disease that interrupts or delays the sequence and rate of normal growth, development, and maturation are covered if provided to maximize the member's functional level.

Speech-language services provided to a resident in a nursing facility or ICF/IID are not separately billable. ND Medicaid pays for speech-language services through the rate established for these facilities.

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

92507	Treatment of speech, language, voice, communication, and/or hearing processing disorder
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production

92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing and/or oral feeding function
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92606	Therapeutic services for use of non-speech-generating device with programming
92607	Evaluation of patient with prescription of speech-generating and alternative communication device
92609	Therapeutic services for use of speech-generating device with programming
92610	Evaluation of swallowing function
92611	Fluoroscopic and video recorded motion evaluation of swallowing function
96105	Assessment of expressive and receptive speech with interpretation and report per hour
96110	Developmental screening (eg, developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 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

PLAN OF CARE

Speech-language services must be provided in accordance with a documented plan of care that is dated and signed by the speech-language therapist responsible for oversight of the plan. The therapy must be ordered by a physician or other licensed practitioner of the healing arts.

The initial plan of care shall contain, at minimum:

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

The plan of care shall be consistent with the related evaluation which is considered part of the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a relatively short amount of time, generally not to exceed 90 days. 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.

The speech-language therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the physician or other licensed practitioner of the healing arts who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment, since initial or previous plan of care update;
- New, modified, or carried-over short-term goals; and
- New, modified, or carried-over long-term goals.

REQUIREMENTS OF GROUP THERAPY

Group therapy may not represent the entire plan of treatment for any individual. Group sessions must be documented within the treatment plan. Medical documentation must include the following;

- Percentage of treatment that group therapy represents;

- Identification of goals being met by group therapy sessions; and
- Identification of the need for group therapy.

LIMITATIONS

Speech therapy evaluations are limited to one per calendar year. Speech-language services are limited to 30 visits per calendar year for members age 21 and over.

SERVICE AUTHORIZATIONS

A service authorization is required for additional evaluations and re-evaluations for members of any age and for visits that exceed 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 speech-language pathologist 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 current plan of care and relevant progress notes must be submitted with the service authorization. The form is available at www.nd.gov/eforms.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress toward goal attainment;
- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified, or carried-over goals.

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The speech-language pathologist must demonstrate good cause for the failure to secure the required prior service authorization request.

NONCOVERED SERVICES

- Speech-language services provided without an order from a physician or licensed practitioner of the healing arts;
- Services that are not part of the member's plan of care, or are specified in a plan of care 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 speech-language disorder;

- 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; and
- Maintenance therapy.

STERILIZATION AND HYSTERECTOMY

This chapter covers elective and non-elective Sterilizations.

ELECTIVE STERILIZATIONS

Elective sterilization means any medical procedure, treatment, or operation for the purpose of making 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; and
- 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:

www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated_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 who needs 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

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 is followed.

BILLING GUIDELINES

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 must be entered in the Notes/Remarks section on the Web Portal or billing notes section for EDI transactions.

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/eforms .

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

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.

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 C.F.R. § 456.3](#) says 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 [North Dakota Administrative Code § 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 which 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 billed units 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 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 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.

TELEHEALTH

Telehealth is the use of telecommunications and information technology to provide access to physical, mental, and behavioral health care across distance.

POLICY DEFINITIONS

Digital Health consists of online digital evaluation and management (E/M) services¹ which are patient-initiated services with health care professionals. These are not real-time services. Patients initiate services through HIPAA-compliant secure platforms which allow digital communication with the health care professional. Online digital evaluation and management services are for established patients only. These services do not include nonevaluative electronic communications of test results, scheduling of appointments, or other communication that does not include evaluation and management.

Distant Site is the location of the health care professional.

Originating Site is the location of the patient.

Synchronous Telehealth is two-way, real-time interactive communication between a patient and their health care provider using technology such as interactive video/television, audio/visual secure online digital portals, and videoconferencing. Synchronous telehealth involves two collaborating sites: an “originating site” and a “distant site.” The patient is located at the originating site and the health care professional is located at the distant site.

Audio-Only Telephone Services can be delivered by using older-style “flip” phones or a traditional “land-line” phones that only support audio-based communication. Only certain services are covered using audio-only telephone services (see linked list of covered services below).

Telehealth is an umbrella term which includes digital health and synchronous two-way real-time interactive audio/visual services. It does not include store and forward services.

COVERED SERVICES

ND Medicaid covered codes are published here: [Telehealth Covered Services](#)

REQUIREMENTS

All qualified telehealth services must:

- Meet the same standard of care as in-person care.

¹ Physicians and other qualified professionals whose scope of practice include E/M services may bill for E/M digital health visits. These professionals include physicians, nurse practitioners, and physician assistants.

- 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 delivery of the service. The service must be provided using a HIPAA-compliant platform.
- Use appropriate coding as noted in the following tables. Health care professionals must follow CPT®/HCPCS coding guidelines.

DIGITAL HEALTH EVALUATION AND MANAGEMENT SERVICES

Cumulative online digital evaluation and management (E/M) services occurring within a seven-day period beginning with the health care professional's review of the patient-generated inquiry. Included services not separately billable:

- For the same or a related problem within seven days of a previous E/M service,
- Related to a surgical procedure occurring within the postoperative period of a previously completed procedure,
- Any subsequent online communication that does not include a separately reported E/M service.
- E/M services related to the patient's inquiry provided by qualified health care professionals in the same group practice.

Separate reimbursement may be allowed for:

- Online digital inquiries initiated for a new problem within seven days of a previous online digital E/M service.

Permanent documentation storage (electronic or hard copy) of the encounter is required.

AUDIO ONLY TELEPHONE E/M SERVICES

Services must be initiated by an established patient or guardian of the established patient.

Do not report this service if:

- It is decided that the patient will be seen within 24 hours or at the next available urgent visit appointment,
- There is an E/M service for the same or a similar problem within the previous seven days
- The patient is within a postoperative period and related to the surgical procedure.

PROFESSIONAL CLAIMS

Modifier	93	Synchronous telehealth service rendered via telephone or other real-time interactive audio-only telecommunication system.
HCPCS Code(s)	Q3014	Telehealth originating site facility fee (If applicable. Cannot be billed if patient is outside of the healthcare facility, or for digital health services).
Place of Service	02	Telehealth provided in a location other than the patient’s home.
	10	Telehealth provided in patient’s home.

INSTITUTIONAL CLAIMS

Applicable Revenue Codes(s)	780	Telehealth – facility charges related to the use of telehealth.
HCPCS Code(s)	Q3014*	Telehealth originating site facility fee (If applicable. Cannot be billed if patient is outside of the healthcare facility, or for digital health services).
Applicable Modifier(s)	GT or 95	Via interactive audio and video telecommunication systems. Billed by performing health care professional for real-time interaction between the professional and the patient who is located at a distant site from the reporting professional. Modifiers are not required for Medicare primary claims.
	93	Synchronous telehealth service rendered via telephone or other real-time interactive audio-only telecommunications system.

** HCPCS Code Q3014 must be billed in conjunction with Revenue Code 780 to indicate the originating site facility fee.*

PAYMENT LIMITATIONS

Audio-only telephone services (CPT™ 99441-99443) are only available through December 31, 2024.

Payment will be made only to the distant health care professional during the telehealth session. No payment is allowed to a professional at the originating site if their sole purpose is the presentation of the patient to the professional at the distant site.

Payment will be made to the originating site as a facility fee only in the following

places 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 telehealth service.

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

INDIAN HEALTH SERVICES AND TRIBAL 638 FACILITIES

Telehealth 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 of whether the originating site is outside the “four walls” of the facility or clinic.

FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Revenue code 0780 should only be reported along with Q3014 when the FQHC is the originating site. When providing telehealth services to patients located in their homes or another facility, FQHCs and RHCs should continue to bill the revenue codes listed in the FQHC and RHC portions of this manual along with the CPT® or HCPCS code for the service rendered appended with modifier GT or 95.

Refer to the FQHC and RHC portions of this manual for the revenue codes to bill for the various services.

NONCOVERED SERVICES

Services that are not covered include:

Type of Noncovered Service	CPT®/HCPCS Code
Store and forward	G2010
Virtual check-in	G2012
Interprofessional services	99446-99449, 99451
Digital Assessment and Management Services	98970-98972

REFERENCE CITATIONS

42 CFR 410.78 - Telehealth services

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.78>

Telehealth coverage from Medicaid.gov

<https://www.medicare.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 members for health care and related services.

PRIVATE HEALTH CARE PLANS AND THIRD-PARTY PAYERS

Providers and 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 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 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 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.

TIMELY FILING OF CLAIMS

ND Medicaid must receive a provider's original Medicaid primary claim submission within one hundred eighty (180) days from the date of service.

ND Medicaid must receive a provider's original secondary/tertiary claim submission within three hundred sixty-five (365) days from the date of service.

The Timely Filing Policy is located at www.hhs.nd.gov/human-services/medicaid/provider

TRANSPLANT SERVICES

ND Medicaid covers transplants for members who have been evaluated by a transplant program and determined to be qualified for the transplant.

DEFINITIONS

“Organs” include heart, lungs, liver, pancreas, kidneys, multi-visceral and intestines.

“Tissues” include corneas, skin, veins, heart valves, tendons, ligaments, and bones.

“Stem Cell/Bone Marrow” includes autologous bone marrow, allogeneic bone marrow, and umbilical cord blood transplants.

PROVIDERS

Organ and bone marrow transplants must occur in a hospital that has a Medicare provider agreement and comply with all Medicare requirements for organ transplants.

The Medicare requirements do not apply to transplants only tissue or stem cell. The provider/facility performing the transplant must be enrolled in ND Medicaid.

COVERED SERVICES

Medicaid coverage is limited to approved services rendered during periods when the member is eligible for ND Medicaid.

Coverage requirements apply to solid organ, tissue, and bone marrow/stem cell transplants. Coverage includes medically necessary transplants and related services which includes preoperative evaluation, member and donor surgery, cadaveric expenses, tissue typing, and searches and matches. Expenses related to the donor are to be billed under the member’s ID number.

ND Medicaid does not cover costs associated with organ removal from a Medicaid-eligible member living donor and provided to another individual. Costs in these situations are the responsibility of the entity covering the organ transplant surgery.

Procedure must be performed in order to prolong life, maintain, or improve quality of life, and must be ethically acceptable.

All transplant services must be medically necessary, not experimental, and must ensure similarly situated individuals are treated alike.

REFERRALS AND SERVICE AUTHORIZATIONS

Transplants that occur within North Dakota must follow Primary Care Case Management program referral requirements.

Prior authorization is required for transplants that occur outside of North Dakota.

A referral from an enrolled in-state Medicaid practitioner must be made for the member to be evaluated at an out of state transplant facility. After the out of state transplant facility completes its evaluation of the member and determines the member is a qualified candidate for the transplant, an enrolled Medicaid practitioner must make a referral for the transplant procedure and request authorization from ND Medicaid.

AFTERCARE

Each out of state after care appointment requires authorization.