Claims Guidance

PURPOSE

The Claims Guidance policy is an overview of ND Medicaid claim requirements. Providers should refer to the applicable policy for service specific guidance.

TIMELY FILING

ND Medicaid requires providers to submit claims in accordance with the timely filing requirements of North Dakota Administrative Code 75-02-05-04.6.

ND Medicaid tracks timely filing based on the date ND Medicaid receives the claim. When the claim is received a receipt is captured as a Julian date. ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service unless there is an exception.

The Timely Filing policy contains additional information regarding timely filing.

MEDICARE CROSSOVER CLAIMS

A crossover claim is a claim for a member who is eligible for ND Medicaid and Medicare, including Medicare Advantage and Extended Plans. A claim for a member with Medicare coverage must be submitted to Medicare prior to being submitted to ND Medicaid. ND Medicaid must receive an original Medicare crossover claim submission within one hundred eighty (180) days from the date on the Medicare Explanation of Benefits (EOB). Claims must be submitted with Medicare payment information on the claim. This time limit may be extended only if there are situations involving member or provider retroactive eligibility.

The Timely Filing policy contains additional information regarding Medicare crossover claims.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional sources of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. 42 Code of Federal Regulation (CFR) § 433 requires state Medicaid programs to cost avoid for services that have third-party coverage. Providers must identify any liable third-party payers prior to billing Medicaid in

most instances. Providers may not refuse services to a member because the member has third-party coverage.

The Third-Party Liability policy contains additional information regarding third-party liability.

PROCEDURE CODES

Providers must use the applicable edition based on the date of service of the Current Procedural Terminology (CPT©) and Healthcare Common Procedure Coding System (HCPCS) manuals when submitting a claim form to ND Medicaid that requires a procedure code. A procedure code is the numerical identifier (generally CPT© or HCPCS) for medical services or supplies.

Unless ND Medicaid has provided specific guidance to the contrary, providers must follow the guidelines in the CPT© or HCPCS manual. Providers must select the name of the procedure or service that accurately identifies the service performed. Do not select a procedure code that merely approximates the service provided. If no specific code exists, the provider should use the appropriate unlisted procedure code. Any service or procedure must be adequately documented in the medical record. All claims submitted with an unlisted procedure code require documentation be attached to the claim. Billing with an unlisted procedure code when a more specific procedure code exists is considered abuse of the program and may be investigated by the Medicaid Program Integrity Unit (PIU) or Medicaid Fraud Control Unit (MFCU).

National Correct Coding Initiative (NCCI)

The National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding leading to inappropriate payments in Medicare and Medicaid. The Affordable Care Act of 2010 required state Medicaid agencies to incorporate "NCCI methodologies" in their claims processing systems. The National Correct Coding Initiative (NCCI) consists of two types of edits that ND Medicaid claims are subject to:

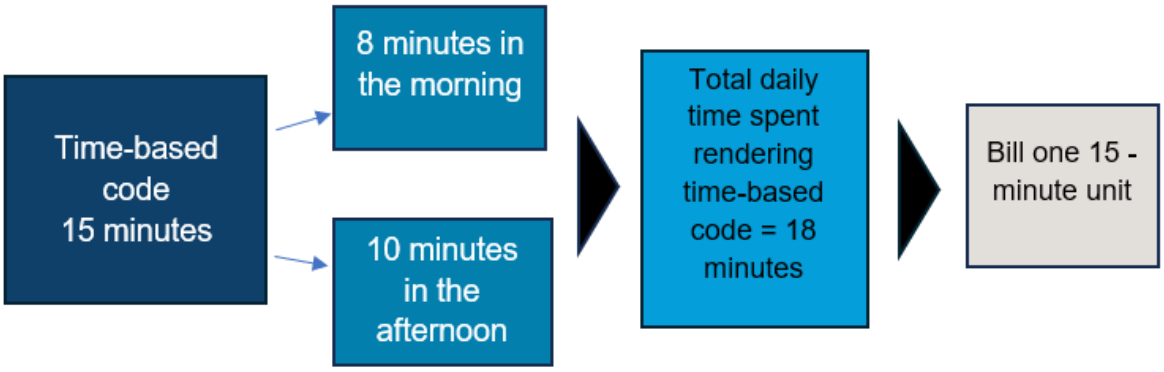
- Procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT©) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are used.

- Medically Unlikely Edits (MUEs) define for each HCPCS/CPT© code the maximum units of service (UOS) that a provider would report under most circumstances for a single recipient on a single date of service.

TIME BASED UNITS

Many procedure codes contain a time basis for code selection. Unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, code descriptors to the contrary, or ND Medicaid guidance to the contrary, providers must abide by the following guidelines:

- Phrases such as “interpretation and report” in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time;
- Time is the face-to-face time with a member;
- When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time must be used; and
- When another service is performed concurrently with a time-based service, the time associated with the concurrent service may not be included in the time used for reporting the time-based service.



HCPCS/CPT© UPDATES

ND Medicaid implements HCPCS/CPT© releases on a quarterly basis based on the file sent to ND Medicaid by the Center for Medicare and Medicaid Services (CMS). New HCPCS/CPT© codes will be dated to the appropriate effective date as sent to ND by CMS. New HCPCS/CPT© codes released each quarter will be available to bill on their effective date.

DIAGNOSIS CODES

ICD-10-CM REQUIREMENTS

Claims must include valid ICD-10-CM diagnosis codes assigned according to the ICD-10-CM Official Guidelines for Coding and Reporting. ICD-10-CM must reflect the patient's diagnosis or condition, as documented in the medical record. The codes must be as specific as possible, including laterality and any applicable extensions, and must align with services rendered. Additionally, the date of service, provider information, and supporting clinical documentation are essential to justify the medical necessity of the diagnosis. Failure to meet these requirements can result in denied or delayed claims.

PROFESSIONAL CLAIMS

The following provider types must submit claims to ND Medicaid using a CMS 1500 claim form or 837P:

- 1915i
- Ambulance Services
- Ambulatory Surgical Centers
- Applied Behavioral Analyst
- Private Duty Nursing
- Chiropractors
- Clinical Nurse Specialists
- Community Mental Health Centers
- CRNAs
- Diabetes Education Programs
- Dieticians and Nutritionists
- Durable Medical Equipment and Supplies
- Home and Community based Services
- Independent Laboratories
- Licensed Marriage and Family Therapist
- Local Public Health Units (LPHU)
- Non-Emergency Medical Transportation
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapist (Clinic-based)
- Optical Supply Companies
- Optometrists
- Physical Therapist (Clinic-based)
- Physician Assistants

- Physicians
- Podiatrists
- Psychiatrists
- Psychologists
- Radiology Units and Independent Diagnostic Testing Facilities
- School Districts
- Speech Language Pathologists (Clinic-based)
- SUD Providers
- Transportation Providers

Professional claims are required to be submitted electronically using the 837P, HIPAA-compliant X12 format. Paper claim submissions are only allowed when there has been an approved exemption by the Department. See the Paper Claims section below for more information on paper claim submission.

INSTITUTIONAL CLAIMS

The following providers must submit claims to ND Medicaid using a UB-04 claim form or 837i transaction:

- Adult Residential Facilities
- Basic Care Facilities
- Dialysis Facilities
- Federally Qualified Health Centers (FQHCs)
- Home Health
- Hospice
- Hospitals, including Hospital Units
- Indian Health Service/Tribal Health Programs
- Intermediate Care Facilities (ICF/IID)
- Nursing Facilities
- Residential Habitation
- Rural Health Clinics (RHCs)
- Substance Use Disorder Facilities
- Swing Bed

Institutional claims are required to be submitted electronically using the 837I, HIPAA-compliant X12 format. Paper claim submissions are only allowed when there has been an approved exemption provided by the Department. See the Paper Claims section below for more information on paper claim submission.

Inpatient and outpatient services are required to be billed on separate claims unless the billing provider is a prospective payment system (PPS) provider.

DENTAL CLAIMS

Dental claims are required to be submitted electronically using the 837D, HIPAA-compliant X12 format. Paper claim submissions are only allowed when there has been an approved exemption provided by the Department. Paper claims must be typewritten and all information on the claim form must be in the exact field and cannot cross over into incorrect fields. Please refer to the applicable paper claim instructions for assistance in completing the claim form and for exemption guidelines. Dental claims submitted on paper must be submitted using the original ADA Dental Claim form printed in red OCR ink.

ELECTRONIC CLAIMS

Companion Guides for North Dakota trading partners are to be used in conjunction with the Accredited Standards Committee (ASC) X12 Technical Report Type 3 (TR3) Guides, including all related errata documents.

The Companion Guides define state-specific requirements in electronic transactions, remaining within the framework and code sets as defined in the TR3s, which support rules as defined by the Health Insurance Portability and Accountability Act (HIPAA).

The Companion Guides can be found on the Electronic Data Interchange (EDI)/Electronic Claim Billing webpage.

PAPER CLAIMS

Any paper claims will be returned to the provider unless an exemption has been automatically granted or approved by ND Medicaid.

If a provider meets one of the following criteria, they are eligible for an automatic exemption. The provider does not need to take any action to submit paper claims.

- Providers submitting 25 claims or less in a calendar year (adjusted claims do not count toward the 25 claims limit); or
- Providers who do not submit claims with ICD-10 diagnosis codes; or
- Individual QSP providers; or
- Long Term Care Facilities such as nursing homes, swing bed and basic care facilities where Medicaid is not the primary payer; or

- Psychiatric Residential Treatment Facilities (PRTFs).

Providers who are not included on the automatic exemption list above and wish to receive an exemption will need to submit an Exemption for Submitting Electronic Claims form. (SFN 447).

Exemption requests must include:

- Provider name, NPI, contact name and phone number
- The calendar year for which the exemption is requested
- The approximate date you will be ready to submit claims electronically
- Detailed explanation of the reason for exemption

DEFINITIONS

Claim – A bill for one or more services for one beneficiary Original Claim – First claim submission

Mass Adjustment – Adjustment generated by ND Medicaid.

Replacement Claim – Replacement (Adjustment) of a previously processed claim.

Resubmission Claim – Resubmission of a previously processed denied claim.

Timely Filing Override Request Form – Form that may be submitted to request a timely filing override for exceptions that fall outside of what has been outlined in the policy. This form is only to be used for limited reasons (see form for further details).

Transaction Control Number (TCN) – 17-digit claim number.

Void Claim – Reversal of a previously processed claim.

RESOURCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations
- The Medicaid National Correct Coding Initiative

CONTACT

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POLICY UPDATES

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Section	Summary
	Policy created