

Professional and Surgical Services

Purpose

ND Medicaid covers services provided by physicians and [other licensed practitioners](#) (OLPs) licensed to practice in the state where the services are provided and enrolled with ND Medicaid. Physicians and OLPs must obtain an individual provider number, even if they are members of a group or clinic or employed by an outpatient hospital or other organized healthcare delivery system that employs physicians.

Applicability

Eligible Providers

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid and be listed on the claim form. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

Physician services can be provided by the following enrolled providers as allowed by the scope of their licensure:

- Physicians
- Physician Assistants
- Advanced Practice Registered Nurses
 - Nurse Practitioner
 - Clinical Nurse Specialist
 - Certified Nurse Midwife
 - Certified Registered Nurse Anesthetist

Eligible Members

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the [Member Eligibility Manual](#) for additional information regarding eligibility including information regarding limited coverage categories.

Covered Services and Limits

General Provider Policies

The [General Provider Policies](#) details basic coverage requirements for all services.

Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The [Procedure Code Look-up Tool](#) can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates.

Services provided by a physician and OLPs are not restricted to a specific place of service unless specified by a CPT® code description. Physicians and OLPs may provide services in the clinic, a member's home, a nursing home, an outpatient hospital, or an inpatient hospital. Refer to the ND Medicaid Professional Fee Schedule to determine if specific services are covered.

Concurrent Care

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

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

ND Medicaid will not pay for concurrent care in the following circumstances:

- 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 of concurrent care.

Encounters for Routine and Administrative Services

Evaluation and Management services billed with the following diagnosis codes are covered under certain circumstances.

- Z02.2 Encounter for examination for admission to a residential institution
 - Nursing Home Admission Physical Examinations
 - Annual physicals are required for members living in an [Intermediate Care Facility for Individuals with Intellectual Disabilities](#) (ICF/IID)
- Z02.89 Encounter for other administrative examinations
 - Refugee/New American / Immigration Physicals
- Z04.8 Encounter for examination and observation for other specified reason
 - Documentation supporting medical necessity must be submitted for all claims containing this diagnosis

Complications

Complications requiring additional services from the surgeon that do not require a return trip to the operating room are included in the global payment. Surgical complications requiring a return to the operating room are not included in the global fee. Report complications requiring a return trip to the operating room with modifier 78 appended to the original procedure code.

Refer to the [Medicare global surgery guidelines](#) for further details.

Evaluation and Management (E/M) Codes

In the absence of specific guidance or for additional detail, providers should refer to the most current version of the CPT® manual. Components of E/M services are used to assess a patient's health or condition and to guide the patient's care. Some E/M services must include the following three components, and some require only two of the three:

- History;
- Exam; and/or
- Medical Decision Making (MDM).

MDM is assessed based on three key elements:

- **Number and Complexity of Problems:** The number and complexity of the patient's problems addressed during the encounter.
- **Amount and Complexity of Data:** The amount and complexity of medical records, diagnostic tests, and other data reviewed and analyzed.
- **Risk of Complications:** The risk of complications, morbidity, and/or mortality associated with the patient's presenting problem(s), diagnostic procedure(s), and/or management options (see paragraph below specific to prescription drug management)

Level of E/M Service Performed

E/M codes are organized into various levels and categories. Generally, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. Providers must ensure that the codes selected reflect the services furnished. Providers should use the most current version of the CPT® manual for guidance.

Prescription Drug Management Requirements for E/M Coding

Prescription drug management may be part of the MDM element when choosing the level of E/M code supported by documentation. The variables involved in determining risk will depend on the patient's condition(s), age, comorbidities, lifestyle, and other medications. For example, one patient with Coronary Obstructive Pulmonary Disease (COPD) will have different risks when compared to other patients with COPD. One may be older, one may have diminished health, or one may have cancer with COPD.

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications during an E/M visit. There is a misconception that, because it says "prescription (RX) management," if a provider prescribes, the risk level is considered moderate. Writing, discontinuing, or maintaining a current medication or dosage must be supported by documentation that the provider evaluated the medications.

Note: Simply listing current medications is not considered "prescription drug management."

Documentation for prescription drug management must show the work and/or risk involved on the part of the billing provider when managing a prescription.

- Could the prescription be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?
- Is the prescription for a non-complex drug for a patient with no allergies or complications? Example – a patient taking anticoagulants.
- Did the patient have a stroke, and is there a risk of a subsequent hemorrhage?

Additional considerations for prescription drugs that may support risk management when included in the documentation:

- A patient's ability to self-administer medication. Educating the patient on performing injections or on opening a pill bottle and removing a pill.
- A caregiver or family member at home to monitor the effects of the drug.
- Any concerns about the patient's understanding of taking their medication?

Adding or deleting a drug should include a narrative in the medical note explaining why the change was made. If the level of an E/M code is determined based on total time, the MDM elements would not apply.

Prolonged E/M Services

Effective for dates of service on or after July 1, 2023, CPT® 99417 should be used to report prolonged E&M care in the outpatient setting, and CPT® 99418 should be used in the observation and inpatient settings. G2212 will be accepted on claims for dual-eligible members.

Visit Complexity

HCPCS Code G2211 – visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or complex condition, is not paid separately from the Evaluation and Management furnished on that day.

Allergy Immunotherapy – Allergy Testing

Covered services for allergy immunotherapy and testing include:

- 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).

Limitations

Allergenic extracts may be administered by either a single injection or multiple injections.

Documentation in the member's health record must substantiate the number of injections administered.

Only licensed practitioners operating within their scope of practice who refine raw antigens into allergenic extract may bill for the service. This service includes the sterile preparation of an allergenic extract by titration, filtration, and related procedures, and the verification of its integrity using culture or other qualitative methods. Purchasing refined antigens, measuring dosages, and adding diluents are not refining raw antigens.

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

The payment for the injection administration will include monitoring of the injection site and observation of the member for an 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.

Service Authorization Requirements

Please utilize the [ND Medicaid Procedure Code Look-up Tool](#) to view service authorization requirements.

Non-Covered Services

General Non-Covered Services

The [Noncovered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid.

Non-Covered General and Administrative Services

- Occupational Health Screenings;
- Pre-Employment Screenings;
- DOT Physicals;
- Volunteer Activity Screenings; and
- Medical Clearance for incarceration without an acute injury/illness/symptom.

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 meeting the medical standard for the provision of allergy immunotherapy.

Documentation Requirements

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the [Provider Requirements Policy](#).

Reimbursement Methodology and Claim Instructions

Timely Filing

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

Third-Party Liability

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

Client Share (Recipient Liability)

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. The [Client Share Policy](#) contains additional information.

Reimbursement

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Multiple Procedure Payment Reduction

Procedures subject to the multiple procedure reduction can be identified by an indicator of '1', '2', or '3' in the Multiple Procedure field of the CMS PFS RVU File. Multiple procedures performed during the same operative session by the same physician or associate are reimbursed:

- 100% allowable for the highest paying surgical procedure
- 50% allowable for all additional surgical procedures

Bilateral Procedures

Use modifier 50 only when the exact same service or code is reported for each bilateral anatomical site, as follows:

- Report bilateral surgical procedure codes on one line, with modifier 50
- Enter 1 unit on a line reported with modifier 50
- Do not use modifier 50 with procedure codes identified as bilateral or with codes that use the words one or both in the code description

Bilateral procedures (reported with modifier 50) are paid at 150% of the fee schedule amount.

Global Surgical Package

The global surgical package period includes the surgical procedure and the postoperative period, during which routine physician care is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if they occur during the global period. ND Medicaid covers medically necessary surgical services. Reimbursement for all surgeries is based on a global surgery package that follows Medicare global surgery guidelines and includes pre-, post-, and intraoperative work related to the surgical procedure. ND Medicaid follows Medicare guidelines for the number of days in the global package. Preoperative physicals by a primary physician are not included in the global package. The evaluation of the surgeon's need for surgery is also covered outside the global surgical package. The visit identifying the need for surgery is not included in the global fee, even if it occurs on the preoperative day or the day of surgery. Use CPT modifier -57 to bill the E/M service for established members' visits or consultations the day before or the day of major surgery when the decision for surgery is made during the visit.

E/M services provided on the same day as the procedure are generally not payable unless they are significant, separately identifiable, and billed with modifier -25.

Postoperative care includes the following:

- Evaluation and management services;
- Pain management;
- Treatment of complications (for example, treatment of infection related to the surgery); and
- Miscellaneous service: dressing changes and local incisional care; removal of operative packs, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes or removal of tracheostomy tubes.

Obstetric Care Billing Requirements

For members with Medicaid primary, antepartum, delivery, and postpartum care must be billed separately.

Global obstetric CPT® codes 59400, 59510, 59610, and 59618 are not covered for members with Medicaid primary coverage. They will be allowed if the member's primary insurance has paid and any coinsurance or deductible amounts remain on the claim.

Antepartum Care

Antepartum care includes the initial prenatal history and physical examination; subsequent prenatal history and physical examinations; documentation of weight, blood pressure, fetal heart tones, routine urinalysis; monthly visits through 28 weeks of gestation; biweekly visits through 36 weeks of gestation; and weekly visits through delivery. All antepartum care should be billed as individual evaluation and management services. CPT® 59425 and 59426 should be billed to ND Medicaid only when the member's primary insurance covers these codes.

Delivery Services With or Without Postpartum Care

Delivery services include hospital admission, admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery-only

services (59409, 59514, 59612, 59620), report inpatient postdelivery management and discharge services using E/M service codes (99238, 99239). Delivery and postpartum

services (59410, 59515, 59614, 59622) include delivery services and all inpatient and outpatient postpartum services.

Medical complications of pregnancy (e.g., cardiac and neurological conditions, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management may require additional resources and may be reported separately.

Postpartum Care Only

Postpartum care-only services (59430) include synchronous audio-video visits, synchronous audio-only visits, brief communication technology-based services, or office or other outpatient visits following vaginal or cesarean section delivery.

Multiple Deliveries

Providers should use the following codes when billing for multiple deliveries:

Vaginal Delivery

Birth Order	CPT® and Description	Instructions and Notes
First Newborn	59409 vaginal delivery only 59410 vaginal delivery only, including postpartum care 59612 VBAC delivery only 59614 VBAC; including postpartum care	<ul style="list-style-type: none"> • Use the appropriate vaginal delivery code for the first newborn • Reimbursed at 100% of the fee schedule amount
Subsequent Newborn(s)	59409 vaginal delivery only 59612 VBAC delivery only	<ul style="list-style-type: none"> • Use the appropriate vaginal delivery-only code with modifier -59 appended • Reimbursed at 50% of the fee schedule for each newborn. <p>Note: Report the number of subsequent newborns in the units field and bill them on a single claim line.</p>

Cesarean Section (C-section)

Birth Order	CPT® and Description	Instructions and Notes
First Newborn	59514 C-section delivery only 59515 C-section delivery only, including postpartum care 59620 C-section delivery only after VBAC 59622 C-section only after VBAC, including postpartum care	<ul style="list-style-type: none"> • Use the appropriate Cesarean delivery code for the first newborn • Reimbursed at 100% of the allowable charge regardless of the subsequent newborns
Subsequent Newborn(s)	59514 C-section delivery only 59620 C-section delivery only after VBAC	<ul style="list-style-type: none"> • Use the appropriate Cesarean delivery-only code with modifier 59 appended <p>Note: Report only once regardless of the number of babies delivered.</p>

Vaginal Delivery followed by Cesarean Delivery

Birth Order	CPT® and Description	Instructions and Notes
First Newborn	59409 vaginal delivery only 59612 VBAC delivery only	<ul style="list-style-type: none"> Use the appropriate vaginal delivery-only code with modifier 59 appended Reimbursed at 50% of the fee schedule amount
Subsequent Newborn(s) (C-section)	59514 C-section delivery only 59515 C-section delivery only, including postpartum care 59620 C-section delivery only after VBAC 59622 C-section delivery only after VBAC; including postpartum care	<ul style="list-style-type: none"> For the subsequent newborn(s) delivered by Cesarean, use the appropriate C-section delivery code The primary procedure will be reimbursed at 100% of the allowable charge, and the secondary procedure will be reimbursed at 50% of the allowable charge <p>Note: If more than one subsequent baby is delivered via C-section, report only once, regardless of the number of babies delivered.</p>

Claim Form

Physician services must be billed using the CMS-1500 claim form or the 837P HIPAA-compliant form. Detailed claim instructions are available on the [ND Medicaid Provider Guidelines, Policies & Manual webpage](#).

Claim Requirements

A claim submitted by a clinical nurse specialist, a nurse practitioner, a nurse midwife, or a physician assistant must include their NPI and may not be submitted under the supervising physician's NPI.

Modifiers

Claims must include any relevant modifying circumstance of the services or procedure by adding the applicable modifier to the procedure code.

References

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

Related Policies

- [Immunizations](#)
- [Physician Administered Drugs](#)
- [Preventive Services and Chronic Disease Management and Health Tracks](#)
- [Telehealth](#)

Contact

Provider Call Center

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

Policy Updates

April 2025

- Format changes and clarifications were made to existing coverage and added throughout the document

July 2025

- Removed the Clinical Trials section and created a separate Clinical Trials policy

January 2026

- Allergy-Immunotherapy/Allergy Testing
 - Section added

April 2026

- Obstetric Care Billing Requirements
 - Section added
- ADA-compliant updates made throughout the document