PROFESSIONAL MEDICAL 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 receive an individual provider number even if they are members of a group or clinic or are 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 on the service date with ND Medicaid. Servicing providers acting as locum tenens must also enroll in 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 Automated Voice Response System by dialing 1.877.328.7098.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies detail 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.

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, an inpatient hospital, etc. 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 practitioner when the member's condition requires the service of another. If a consulting practitioner subsequently assumes responsibility for a portion of patient management, they provide concurrent care.

ND Medicaid reimburses 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 in more than one specialty area establishes a 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 of concurrent care.

ENCOUNTERS FOR ROUTINE AND ADMINISTRATIVE SERVICES

Encounters/Services for the following ICD-10 codes are allowed under the following 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 if further specifics are required.

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 E/M services are used to assess a patient's health or condition and provide direction for the patient's healthcare. Some E/M services must include the following three components, and some require only two out of the three:

- History;
- Exam;
- 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 when determining the risk will depend on the patient's condition(s), age, co-morbidities, lifestyle, and other medications. 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 as part of an E/M visit. There is a mindset that because it says prescription (RX) management, if a provider prescribes, the risk level qualifies as moderate. A prescription being written or discontinued, or a decision to maintain a current medication or dosage would need to be supported in documentation that the provider evaluated the medications.

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

Documentation for prescription drug management would need to show the work and/or risk involved by the billing provider when managing a prescription.

- Is the prescription something that could be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?
- Is the prescription 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 they may sustain a subsequent hemorrhage?

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

- Ability of a patient to self-administer the medication. Education to the patient on performing injectables or ability to open a pill bottle and take a pill out.
- Caregiver or family member at home to monitor the effects of the drug.
- Any concern about the patient's understanding with taking their medication.

Adding new or deleting drug(s) should include narrative in the medical note to explain why the change was made.

If determining the level of E/M code 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 for reporting prolonged E&M care in the outpatient setting and CPT© 99418 for 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.

CLINICAL TRIALS – ROUTINE PATIENT COST

Routine patient costs are covered for recipients participating in a qualifying clinical trial. "Routine patient costs" include:

- provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial that would otherwise be covered outside the course of participation in the qualifying clinical trial.
- required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

Some examples of routine costs in a clinical trial could include otherwise covered physician services, laboratory or medical imaging services that assist with prevention,

diagnosis, monitoring, or treatment of complications arising from clinical trial participation.

Routine patient cost does not include any item or service:

- provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the beneficiary, and
- not otherwise covered under North Dakota Medicaid through the state plan or waiver.

(1) In general

As noted in 42.U.S.C.§300gg-8, a qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition, and is described in any of the following clauses:

(A) The study or investigation is approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:

(I) The National Institutes of Health.

(II) The Centers for Disease Control and Prevention.

(III) The Agency for Healthcare Research and Quality.

(IV) The Centers for Medicare & Medicaid Services.

(V) A cooperative group or center of any of the entities described in subclauses (I) through (IV) or the Department of Defense or the Department of Veterans Affairs.

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(VII) Any of the following if the conditions described in subparagraph (B) are met:

(aa) The Department of Veterans Affairs.

(bb) The Department of Defense.

(cc) The Department of Energy.

(ii) The clinical trial is conducted pursuant to an investigational new drug exemption under section 355(i) of title 21 or an exemption for a biological product undergoing investigation under section 262(a)(3) of this title.

(iii) The clinical trial is a drug trial that is exempt from being required to have an exemption described in clause (ii).

(2) Conditions

For purposes of subparagraph (1)(I)(VII), the conditions described in this subparagraph, with respect to a clinical trial approved or funded by an entity described in such subparagraph (A)(I)(VII), are that the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines—

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(ii) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

Coverage Determinations
The health care provider and principal investigator must fill out the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial regarding the appropriateness of the qualifying clinical trial. Health care providers must retain this attestation as part of the patient's medical record.

SERVICE AUTHORIZATION REQUIREMENTS

If routine patient costs for a clinical trial are incurred out-of-state and require a service authorization, please adhere to the following steps:

- **Follow Service Authorization Requirements**: Refer to the service authorization guidelines outlined in this manual for general procedures.
- **Coverage Determinations**: Coverage determinations for routine patient costs related to an out-of-state clinical trial must be completed within **72 hours** of request.
- **Required Documentation**: Attach the completed **Medicaid Attestation Form** regarding the Appropriateness of the Qualifying Clinical Trial to the Service Authorization documentation.

By following these steps, we can ensure timely processing and adherence to Medicaid guidelines for out-of-state clinical trial costs.

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
- Medical Clearance for incarceration without an acute injury/illness/symptom

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 with an indicator of '1', '2', or '3' in the Multiple Procedure field on the CMS PFS RVU File. Multiple procedures performed during the same operative session by the same physician or associate are reimbursed:

- 100% allowable for 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 appended with modifier 50
- Enter 1 unit on a line reported with modifier 50
- Do not use modifier 50 with procedure codes that are identified as bilateral or for codes that use the words **one** or **both** within 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 consists of the surgery and the time following surgery, during which routine care by the physician 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 the care occurs during the global period. ND

Medicaid covers medically necessary surgical services. Reimbursement for all surgeries is based on a global surgery package, which 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 of 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 on 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)
- Miscellaneous service: dressing changes and local incisional care; removal of operative pack, 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

CLAIM FORM

Physician services must be billed using the CMS 1500 claim form or 837P. 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, nurse midwife, or a physician assistant must contain their NPI and may not be submitted under the supervising physician's NPI number.

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

Aprill 2025

Section	Summary
	Format changes and clarifications made on existing coverage added throughout policy.