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.

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.

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 (taken from 42 U.S. Code § 1396d):

(i) 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).

(B) Conditions

For purposes of subparagraph (A)(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 an attestation regarding the appropriateness of the qualifying clinical trial. Health care providers must retain this attestation as part of the patient's medical record. The attestation is found here.

If routine patient costs for a clinical trial occur out-of-state and require a service authorization, please follow the service authorization requirements in this manual and the following requirements. Additional requirements: Coverage determinations for routine patient costs for an out-of-state clinical trial must be completed within 72 hours. Attach the completed Medicaid Attestation Form regarding the Appropriateness of the Qualifying Clinical Trial to the Service Authorization documentation.

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 ICF/IID

Z02.89 Encounter for other administrative examinations

- Refugee/New American / Immigration Physicals
  - A description of the service i.e. “refugee” or “New American” must be noted in Box 19 of the CMS 1500 or 837-P equivalent field or Box 80 of the CMS UB-04 or 837-I equivalent field

Z04.8 Encounter for examination and observation for other specified reason

- Documentation supporting medical necessity must be submitted for all claims containing this diagnosis

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
- Camp Physicals

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

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.

SPORTS PHYSICALS

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.

TELEHEALTH

See Telehealth policy for additional information.