

NORTH DAKOTA MEDICAID

Provider Bulletin

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Sharing PHI Through Email

ND Medicaid staff receive emails containing protected health information (PHI) that are not sent using secure and encrypted methods. **Standard email is not considered a secure and encrypted method for sharing PHI.** Although a patient's medical record number or an unique patient identifier that excludes the person's name is being shared/ emailed, a signature line or email address may contain a second identifier such as the health care organization, which would provide enough information to potentially identify a patient.

To safeguard PHI, we strongly encourage the utilization of secure, encrypted email out of an electronic health record if one exists or to utilize the North Dakota Health Information Network's (NDHIN's) **Communicate** (direct secure messaging) email to send and receive this information. **Communicate** allows users to send structured and unstructured information and files such as consults, lab reports, transcribed documents, PDF files, excel spreadsheets and much more. ND Medicaid utilizes secure email to correspond with third party billers regarding patient claim status.

Get more information about **Communicate** at <https://www.nd.gov/itd/statewide-alliances/ndhin/services/communicate> or by contacting Tina Gagner at tgagner@nd.gov or 701.328.1126.



**NORTH DAKOTA
DEPARTMENT OF
HUMAN SERVICES**

~
**MAGGIE D. ANDERSON,
MEDICAID DIRECTOR**

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ND Medicaid Identification Numbers and Cards

North Dakota Medicaid-eligible individuals may have a card or Medicaid ID with a 9-digit number that starts with ND (NDXXXXXXX), or a 9-digit number that starts with three zeroes (000XXXXXX). **Both formats are valid and clients should not be turned away based on which format of Medicaid ID they provide.**

Payment Error Rate Measure (PERM) Audit

The PERM program measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note the error rate is not a "fraud rate", but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

- The Centers for Medicare and Medicaid Services (CMS) is required to annually estimate the amount of improper payments in Medicaid and CHIP.
- The goal of PERM is to measure and report an unbiased estimate of the true improper payment rate for Medicaid and CHIP.
- On July 5, 2017, a new PERM Final Rule became effective, making significant changes to both the claims and eligibility measurement.
- The PERM review period has been adjusted from a federal fiscal year (FFY) to review payments made from July through June to align with state fiscal years and to provide additional time to complete the cycle before reporting improper payment rates. This cycle will review Medicaid and CHIP payments made in Reporting Year (RY) 2019 (July 1, 2017 through June 30, 2018).
- The state-specific sample size calculation establishes a national annual sample size, which will be distributed across states.
- The PERM claims sample will be used for the eligibility measurement with eligibility reviews being conducted on the recipient associated with the sampled claim.
- A federal eligibility review contractor (ERC) will conduct PERM eligibility reviews with support from each state.

The PERM audit is important to all Medicaid providers. CMS and the review contractor, **Chickasaw Nation Industries (CNI)**, will be sending letters to various Medicaid providers requesting medical records to validate that the service was ordered, provided, documented and billed appropriately. Please make sure that your release of information departments are aware and responding to the records requests in a timely manner. **Providers should start receiving the letters in late March or April 2018.**

- CNI makes initial calls to providers to verify provider contact information.
- CNI establishes a point-of-contact with providers and sends record requests.
 - ◊ Providers have 75 calendar days to submit documentation.
- CNI makes reminder calls and sends reminder letters on days 30, 45, and 60 until the medical records are received.
 - ◊ If the provider does not respond, CNI sends a non response letter on day 75 to the state PERM representative.
 - ◊ If submitted documentation is incomplete, CNI requests additional documentation.
 - ◊ The provider has 14 days to submit additional documentation.
 - ◊ A reminder call is made and a letter is sent on day seven.
 - ◊ If the provider does not respond, CNI sends a non response letter after 14 days to the state PERM representative.

Failure to submit documentation, or if the submitted documentation is incomplete, the claim is considered an error and subject to recoupment.

Questions may be directed to:
Jeanne Folmer, CFE, CPC, CHA
Program Integrity Audit Coordinator
Medical Services Division
ND Department of Human Services
(701) 328-4831
auditresponse@nd.gov

2018 North Dakota Medicaid Expansion Program Network Changes

Several changes occurred as of January 1, 2018, for ND Medicaid Expansion.

Service Area: The service area includes the state of North Dakota and the adjoining counties that border North Dakota in Minnesota, Montana and South Dakota. The pharmacy service area includes the states of North Dakota, Minnesota, South Dakota and Montana.

Network: To be a payable network provider for ND Medicaid Expansion, the provider must:

- Reside within the newly defined ND Medicaid Expansion service area.
- Be contracted with Sanford Health Plan or Express Scripts (pharmacies).
- Be enrolled with ND Medicaid.

ND Medicaid Program Enrollment Requirement: Federal law [42 CFR §438.602(b)], requires managed care organizations to confirm that network providers are enrolled with the state's Medicaid program prior to payment for dates of service on or after January 1, 2018. *Enrollment with ND Medicaid does **not** require a provider to render services to ND fee-for-service (traditional) Medicaid recipients.*

Impact on providers, pharmacies, suppliers and transportation providers

The impact on providers depends on whether you are within or outside of the service area, contracted or not contracted with Sanford Health Plan or enrolled or not enrolled with ND Medicaid.

If you are a Sanford Health Plan contracted provider located inside the service area and enrolled with the ND Medicaid program, you will be considered payable by Sanford Health Plan for services provided to a ND Medicaid Expansion recipient per the benefit plan as applicable.

If you are a Sanford Health Plan contracted provider located inside the service area and not enrolled with ND Medicaid, you will be considered non payable by Sanford Health Plan for any services provided to a recipient. **You have 120 days from the date of service to enroll with ND Medicaid.** Once enrolled, ND Medicaid communicates to Sanford Health Plan via a monthly roster, which is used to update the claims payment system and provider directory. Sanford Health Plan will automatically reprocess any received claims denied as "provider not enrolled in ND Medicaid program." Providers will not have to resubmit these specific claims.

If you are a provider within the service area but not contracted with Sanford Health Plan or a provider outside of the service area with or without a Sanford Health Plan contract, you will be considered an out-of-network provider and do not have to be enrolled with ND Medicaid. However, the ND Medicaid Expansion plan does not have out-of-network benefits unless one of the following conditions applies:

- Emergent or urgent medically necessary services (if emergency care is needed, members are always directed to go to the closest hospital or call 911).
- Family planning services.
- Medically necessary services that cannot be provided within the network and prior authorization has been obtained from Sanford Health Plan.

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2018 North Dakota Medicaid Expansion Program Network Changes—CONTINUED from page 4

Out-of-network providers will be reimbursed the maximum allowed amount or contracted amount (if contracted with Sanford Health Plan) if one of the above conditions applies to the services provided. The reimbursement of these services is considered payment in full and the ND Medicaid Expansion recipient cannot be balance billed.

To determine your enrollment status or to become an enrolled provider with ND Medicaid, refer to the Sanford Health Plan site at www.sanfordhealthplan.com/providers/2018-NDME-Network-Changes. This step-by-step guide can be used to determine your ND Medicaid provider enrollment status and enrollment needs. If you are a network provider and are already enrolled as a traditional Medicaid provider, there is no requirement for a new application. ND Medicaid will add the Sanford Health Plan network to your enrollment via a roster provided by Sanford Health Plan. If you are not already enrolled as a ND traditional Medicaid provider, an application is required.

Who do I contact if I have questions regarding enrollment? Contact ND Medicaid Provider Enrollment at dhsenrollment@nd.gov for questions with enrollment.

Important Reminder—Network providers and out-of-network providers may seek reimbursement from a ND Medicaid Expansion recipient if one of the following is applicable: item or service which are not a covered ND Medicaid Expansion benefit or recipient was informed and agreed (in writing) to be responsible for payment prior to receiving the item or service and at least one of the following:

- Item or service prior authorization request not approved by Sanford Health Plan; or
- Item or service not considered reasonable or necessary under established criteria for the benefit.

For items or services requiring a prior authorization, screening, or an assessment before the item or service is provided, the provider may not bill the recipient when any of the before mentioned items were not submitted in a timely manner to Sanford Health Plan.

Standardized patient/financial responsibility forms, which providers or facilities have all individuals receiving services sign are not to be considered as the recipient agreeing to be responsible for payment prior to receiving the item or service. This agreement must be individualized with regard to both the recipient and item or services being provided.

Non-Covered Evaluation and Management Services

Reminder—the following evaluation and management (E/M) services are considered non covered when provided to ND Medicaid members: 99288; 99358-99359; 99367-99368; 99401-99404; 99411-99412; 99441-99444; 99446-99449; 99450-99456; and 99497-99498.

Local Coverage Determinations/National Coverage Determinations Medical Necessity Editing

ND Medicaid utilizes the following Local Coverage Determinations (LCDs) published by Noridian Healthcare Solutions, LLC, and National Coverage Determinations (NCDs) published by CMS for determining medical necessity. ND Medicaid does not recognize the use of Advance Beneficiary Notices (ABNs). Any services covered by LCD/NCD on this list that does not follow the LCD / NCD requirements, will be denied as a contractual obligation (CO) for not meeting medical necessity.

LCD ID	Description
A54655	Parenteral Iron Administration in Beneficiaries with Chronic Kidney Disease (CKD) with Iron Deficiency Anemia (IDA) or Reduced Iron Stores
L33979	Skin Lesion Removal (Excludes Actinic Keratosis and MOHS)
L34040	Polysomnography and Other Sleep Studies
L34051	Vitamin D assay Testing
L34052	Chest X-ray Policy
L34072	Sensory Evoked Potential and Intraoperative Neurophysiology Monitoring
L34076	Injections – Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma
L34199	Treatment of Ulcers and Symptomatic Hyperkeratoses
L34980	Lumbar Epidural Injections
L34995	Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy
L35172	Botulinum Toxin Types A and B
L35175	MRI and CT Scans of the Head, Brain, and Neck
L36312	MoIDX: CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing

NCD ID	Description
190.12	Urine Culture, Bacterial
190.13	Human Immunodeficiency Virus Testing (Prognosis and monitoring)
190.14	Human Immunodeficiency Virus Testing (Diagnosis)
190.15	Blood Counts
190.16	Partial Thromboplastin Time (PTT)
190.17	Prothrombin Time (PT)
190.18	Serum Iron Studies
190.19	Collagen Crosslinks, any method
190.20	Blood Glucose Testing
190.21	Glycated Hemoglobin/Glycated Protein
190.22	Thyroid Testing
190.23	Lipids Testing
190.25	Alpha-fetoprotein
190.26	Carcinoembryonic Antigen
190.27	Human Chorionic Gonadotropin
190.28	Tumor Antigen by Immunoassay CA 125
190.29	Tumor Antigen by Immunoassay CA15-3/CA 27.29
190.30	Tumor Antigen by Immunoassay CA 19-9
190.31	Prostate Specific Antigen
190.32	Gamma Glutamyl Transferase
190.33	Hepatitis Panel/Acute Hepatitis Panel
190.34	Fecal Occult Blood Test

Full version of the LCDs can be found at: <https://med.noridianmedicare.com/web/jfb/policies/lcd/active>

Full version of the NCDs can be found at: <https://www.cms.gov/medicare-coverage-database/indexes/lab-ncd-index.aspx>

American Dental Association (ADA) Claim Form

As of January 1, 2018, ND Medicaid will require all dental offices that bill on paper to use the 2012 version of the ADA claim form.

MMIS is now able to accept a zero in front of the tooth number, so it is **no longer necessary to white out the zero prior to submitting a claim.**

Services to Individuals with a Developmental Disability

ND Medicaid will provide additional compensation to dentists who treat individuals who need extra care. Providers will receive the standard fee for the dental services provided plus a special payment of \$100 for the extra time needed. Please refer to the *Services to an Individual with a Developmental Disability* section in the dental manual online at www.nd.gov/dhs/services/medicalserv/medicaid/docs/dental-manual.pdf.

Service Authorization

Electronic attachments are now being accepted for service authorizations submitted through the web portal. This includes radiographs, periodontal charting, orthodontic screenings and dental records/medical documentation.

ND Medicaid has phased out paper service authorizations and is now entirely web-based, making authorizations more efficient and approvals completed more quickly.

Retrospective authorizations will not be considered if older than 90 days from the date of service. Please contact ND Medicaid with any authorizations that need immediate consideration.

Web-based submissions that require documentation will require the documentation to be submitted electronically.

For assistance in attaching records or in submitting a web-based service authorization, contact Sara at 701-328-4825 or sregner@nd.gov.

General Principles of Dental Record Documentation

1. The dental record should be complete and legible.
2. The dental record should include:
 - Patient name and demographic information (patient name must be identified on each page)
 - Medical and dental history, including medication prescription history
 - Progress and treatment notes
 - Diagnostic records and radiographs
 - Treatment plan
 - Patient complaints and resolutions
3. The information in the dental record should be dated, signed and handwritten in ink by the person providing the service. It can also be computer printed.
4. Appropriate health risk factors should be identified.
5. The patient's progress, response to and changes in treatment and revision of diagnosis should be documented.
6. The information contained in the dental record should not contain many abbreviations.
7. The identifying practitioner should be clearly noted in the dental record.
8. The CPT, CDT and ICD-10 codes reported on the CMS-1500 claim form, ADA dental claim form or UB-04 claim form must be supported by the documentation in the dental record.
9. Any services provided in the outpatient hospital or ambulatory surgical center must be supported by an operative report showing medical necessity of the services performed.

Source: www.ada.org

Medicaid Management Information System (MMIS) Updates/Reminders

CMS 1500 Form—Taxonomy codes on a CMS 1500 form go in field 24J. The top box is for the rendering provider taxonomy code and the bottom box is for the rendering provider's NPI number. Fields 33A (Billing/Group NPI number and 33B (taxonomy code for the Billing/Group) are required. Paper CMS 1500 claims only: if Medicare or Medicare supplement are the primary insurance, the word Medicare must be in field 9d.

UB04 Form—the Billing/Group NPI number goes in field 56 and the taxonomy code for the Billing/Group belongs in field 81a. Attending/rendering NPI number and taxonomy code goes in field 76. Field 77 is for the operating provider only.

It is important that all providers verify and confirm that their billing office or billing vendor have the correct taxonomy and NPI information for all individual and group providers in your practice. Billing/group NPI number and taxonomy code are required for all claims to process correctly.

Supporting documentation may be required for claims, referrals, service authorizations, etc. To expedite the adjudication process, please mail or fax supporting documents after the claim has been submitted.

All claim adjustments must be submitted using the appropriate billing form for that specific claim type and following the proper billing instructions online at www.nd.gov/dhs/info/mmis/claims-instructions.html.

There are two forms that can be used for submission of attachments:

- State Form Number (SFN) 177 (MMIS Attachments Cover Sheet): Attachments need to be accompanied by SFN 177, which is online at: www.nd.gov/eforms/Doc/sfn00177.pdf.
- Confirmation page for ND Health Enterprise MMIS web-entered claims—print the confirmation page and use as a cover sheet for attachments that you mail or fax to the ND Medicaid. If this confirmation page is not available, please use SFN 177.

All correspondence sent to ND Medicaid needs to have the following identifiers, if applicable: provider NPI or Medicaid number, member Medicaid number, transaction control number (TCN), service authorization (SA) number and referral number. Correspondence that does not contain one or more of the above identifiers may cause delays and/or the inability to process your submission. Each submission category has a dedicated fax number, each of which is noted on the SFN177. Reminder—there is no need to submit attachments for denied claims.

Non compliant claims will be returned to the provider with a cover sheet to identify the missing data.

Providers and authorized staff can view a remittance advice (RA) via the Enterprise Provider Web Portal at any time, even if a paper RA was previously provided. Review at www.nd.gov/dhs/info/mmis/docs/mmis-accessing-remittance-advice-grg.pdf. Since all of the RAs are available on the Web Portal, customer service representatives will no longer print and fax/mail RAs.

Have questions? Contact the ND MMIS customer service department at 877-328-7098.

Results from Medicaid Access to Care Survey

In November 2016, ND Medicaid asked for feedback on recipient experiences in finding health care providers and services in the state. The survey focused on timely access to these five services:

- **Primary care services** (provided by a physician, nurse practitioner, physician assistant, federally-qualified health center or dental provider)
- **Physician specialty services** (cardiology, urology and radiology care)
- **Behavioral health services** (mental health and substance use disorder services)
- **Pre and post-natal childbirth services** (pregnancy, child birth and post-delivery care)
- **Home health services** (health care in the home)

A total of 6,679 households (including responses from each North Dakota county) told Medicaid about their health care experiences. The survey's top highlight was 90 percent of Medicaid households reported usually or always having timely access to health care providers and services. Medicaid beneficiaries from North Dakota's most rural counties noted good access as well.

The survey also showed some access challenges. Some families, regardless of whether their health care coverage is Medicaid or other insurances, have to travel some distance to access health care. The two top challenges noted were lack of transportation and some providers were not accepting Medicaid patients.

An interactive story map shows the survey results county-by-county. The map is available online at <http://arcg.is/2kKJOUN>. Medicaid will distribute another Medicaid household survey in 2018.