

Provider Bulletin

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**NORTH DAKOTA
DEPARTMENT OF
HUMAN SERVICES**

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Reminder: Place of Service (POS) Reporting on Professional Claims

ND Medicaid requires that an accurate POS code is included on all professional claims (item 24B on the CMS 1500 form). POS codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The most current listing of the POS code set can be found at: <https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html>.

Complete and Immediate Dentures

ND Medicaid allows complete (D5110 and D5120) and immediate (D5130 and D5140) dentures for ND Medicaid-eligible members once every five years. Immediate dentures may only be reimbursed once per patient lifetime and cannot be billed for replacement dentures. Service authorization is required for immediate and complete dentures.

Updated/New Forms

ND Medicaid has updated the Medical Procedure/Device Service Authorization Request Form (SFN 511—<https://www.nd.gov/eforms/Doc/sfn00511.pdf>).

ND Medicaid has added a new form specific to Genetic Testing Service Authorization Request (SFN 527—<https://www.nd.gov/eforms/Doc/sfn00527.pdf>).

Psychological Testing

ND Medicaid has increased the psychological testing limits to 10 hours per calendar year effective April 1, 2018. Service authorization is required after the 10 hours per year limit has been met or exceeded. This applies to CPT codes 96101-96125.

Out-of-State Medical Care

When referring a ND Medicaid member for out-of-state care, the service must be prior authorized if it is at a site that is more than 50 miles from North Dakota's border. Out-of-country services are not covered and will not be paid.

The member's primary care provider or in-state physician specialist is required to submit a **Request for Service Authorization for Out-of-State Services** (SFN 769—<http://www.nd.gov/eforms/Doc/sfn00769.pdf>) to ND Medicaid at least two weeks before scheduling an out-of-state appointment. A prior authorization request is needed each time the member is to be seen out-of-state. The request form must include:

- Member's name, Medicaid ID number and date of birth.
- Diagnosis.
- Purpose of the visit (e.g., consult, follow-up, surgery, etc.).
- Medical information substantiating the need for out-of-state services.
- A written second opinion from an appropriate in-state specialist, following a current (within three months) examination, which supports the medical need for out-of-state care.
- The physician and facility being referred to.
- Assurance that the service is not available in ND.

Medical necessity for out-of-state care must be substantiated. A referral should not solely be made based on a member's request or because a service is not available in the referring provider's network. The member must be referred to an in-state provider when available. All referral attempts must be documented.

ND Medicaid staff determines if the referral meets state requirements for out-of-state care and approves or denies the request in writing. A copy of the determination is sent to the in-state referring provider(s), out-of-state provider(s), member and the member's county social service office.

Transfers for emergency out-of-state services may be done at the discretion of the in-state provider but are subject to a review by ND Medicaid staff. The transferring facility **must notify ND Medicaid within 48 hours of the transfer and submit a Request for Service Authorization for Out-of-State Services (SFN 769)**. Documentation must include: destination, date of transfer, mode of transportation, and discharge summary. In the event that air ambulance is used for transportation, documentation of the medical necessity to use air ambulance rather than ground ambulance is to be included. Air ambulance should only be used in situations that are emergent.

If the out-of-state services are approved, the member's county social service office is responsible for assisting the member with the arrangements for travel, lodging and meals.

Claims received from out-of-state providers will not be paid if the services do not have an approved authorization. Service Authorization approval does not guarantee payment. Reimbursement for any service is contingent upon the eligibility of the member at the time services are provided; the provider must be enrolled with ND Medicaid; any applicable third parties must be billed prior to billing ND Medicaid and the member may be responsible for any recipient liability before payment is made.

If you have questions, please call ND Medicaid at (800) 755-2604 and ask to speak to a program administrator regarding out-of-state services.

Updated Medicaid Policies

ND Medicaid has updated the following policies:

- Individualized Education Program Medicaid Services Billed by Schools: <http://www.nd.gov/dhs/info/mmis/docs/school-based.pdf>
- Local Public Health Unit: <http://www.nd.gov/dhs/info/mmis/docs/public-health-clinics.pdf>
- Telemedicine: <http://www.nd.gov/dhs/info/mmis/docs/telemedicine.pdf>

Primary Care Case Management (PCCM) Program Update

Approximately 60 percent of all Medicaid members are enrolled in Primary Care Case Management (PCCM). PCCM enrollees are required to choose a primary care provider (PCP) to manage their medical care and any authorizations needed for specialists.

Upon enrollment, letters are sent to notify members that they have 14 days to choose a PCP or one will be automatically assigned. After 14 days, members receive a letter telling them who their PCP is and that they must receive health care services from the PCP or get authorization from the PCP to see a different provider. This letter also explains that they have 90 days after assignment of a new PCP, to change their PCP without “good cause”.

If a member wants to change their PCP after the 90 days, there must be a good cause reason. Examples of cause reasons: moving out of the PCP’s area or the PCP moves out of the member’s area, a significant change in member’s health that requires coordination by a different provider, being unable to see the PCP when needed or receiving poor care from the PCP.

The last 60 days of the 12 month PCP span is the annual open enrollment period. The member receives a letter prior to the open enrollment period to notify them that it is coming up. If no change is made during the annual open enrollment period, the system automatically updates the current PCP for another 12 month PCP span for the member. The member would not have another 90 day period to change their PCP without good cause. PCP changes made during this annual 60-day open enrollment period start the day after the open enrollment period.

Validating the need for a PCP referral: Validate the need for a PCP referral **prior to** providing services. Requesting county workers to change PCP dates to cover past claims is not allowed.

The need for a PCP referral can be validated by:

- **Calling the Automated Voice Response System (AVRS):** Validating the need for a PCP referral is as quick as a phone call to the Automated Voice Response System (AVRS) directions are clearly outlined on the AVRS fact sheet at: <http://www.nd.gov/dhs/info/mmis/docs/mmis-avrs-fact-sheet.pdf>
- **Through MMIS web portal:** If a member has both PCCM enrollment and an active PCP on the date of service (DOS) in the claim, is a referral needed for services that require a PCP referral.

To save time and frustration, look first for PCCM enrollment for the DOS in question. When there is no PCCM enrollment, there is no need to look further as no PCP referral will be required for any service when a member is not enrolled in PCCM. **This is regardless of if there is an active PCP span or not.** (It is important to note that there is a CMS requirement that forces the PCP spans to be left open following the end dating of PCCM enrollment.)

PCCM Referral Guide: The PCCM Referral Guide is a valuable tool with guidelines and answers the most frequently asked questions: <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/pccm-referral-guide.pdf>

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Primary Care Case Management (PCCM) Program Update - CONTINUED FROM PAGE 3

PCP reminder: It is the responsibility of each PCP to notify the Medicaid Managed Care staff via email at dhsmci@nd.gov of the following changes that affect their PCP status:

- Changes in provider type or provider specialty (e.g. a family practice provider who starts working in cardiology only).
- PCP accepting patient status change requests:
 - ◊ Open PCP (accepting new patients).
 - ◊ Full provider (a full provider has requested to not take more than their current number of members without their prior approval).
 - ◊ Opted out (provider no longer wants to be a PCP for any members).

Group Provider reminder: It is the responsibility of each Group Provider to notify the Medicaid Provider Enrollment staff via email at dhsenrollment@nd.gov of the following changes:

- Adding a new provider affiliation—complete SFN 1330 (<https://www.nd.gov/eforms/Doc/sfn01330.pdf>).
- Terminating a provider affiliation—complete SFN 1331 (<https://www.nd.gov/eforms/Doc/sfn01331.pdf>).
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Provider Revalidation

ND Medicaid provider enrollment staff have started revalidating enrolled providers. Provider enrollments are required to be revalidated no less frequently than every five (5) years, per 42 Code of Federal Regulation, 455.414 (https://www.ecfr.gov/cgi-bin/text-idx?SID=b15813050a8e33e6926bdd1342189dc6&mc=true&node=se42.4.455_1414&rqn=div8).

Providers will be contacted prior to the revalidation date that appears in Health Enterprise Medicaid Management Information System (MMIS). Provider enrollment staff will reach out to providers via email and in the future, notices will be sent to providers via the web portal in MMIS. Providers should ensure that they have access to their webmail that is associated with their MMIS enrollment. Providers will not be notified by mail. It is the provider's responsibility to ensure that correct contact information is in MMIS, including a valid email address.

The revalidation process will include reviewing information currently associated with the provider's enrollment, requesting updated licensure or certification information, providing an updated Drug Enforcement Agency number (if applicable), providing a signed SFN 615 (Medicaid Program Provider Agreement) and an updated SFN 1168 (Ownership Controlling Interest and Conviction Information form—group and sole proprietor enrollments only). Providers subject to application fees will also be required to submit an application fee in order to revalidate their enrollment. **Providers that do not revalidate their enrollment within the timeframe included in the notice will have their Medicaid provider enrollment terminated.**

Provider Maintenance Updates

Providers are responsible for ensuring that the ND Medicaid provider enrollment unit has current provider information on file. This includes alerting enrollment staff when a provider has an updated license, the provider is leaving the facility, adding a new affiliation, retirements, etc. Termination notices should be provided on the SFN 1331 Provider Termination form (<https://www.nd.gov/eforms/Doc/sfn01331.pdf>) and a request to add an affiliation on the SFN 1330 Request to Add an Affiliation form (<https://www.nd.gov/eforms/Doc/sfn01330.pdf>). Updates may be faxed to 701-328-1544 Attn: Provider Enrollment or sent via email to dhsenrollment@nd.gov.

Durable Medical Equipment (DME) Hearing Aid Providers

Attention all **Durable Medical Equipment (DME) Hearing Aid Providers**: please review the following guidance on the Service Authorization (SA) submittal process and the ND Medicaid Hearing Aid Policy.

Service Authorization (SA) Submittal Process

Review SA before submitting to ensure all required information is present:

- Billing Provider Name and NPI—this is the name of the clinic, group or sole proprietor and associated NPI that will be listed in Box 33 (a) and (b) of the CMS 1500 or electronic equivalent (not the individual rendering provider).
- Be sure the modifier NU and the appropriate designating modifier is submitted—LT (left) and RT (right). The LT/RT is not to be used when requesting the dispensing fee HCPC codes V5160, V5241, V5090 and V5110.
- A provider has 90 days to submit a SA request. For example: member is seen by the physician/practitioner on 3/1/18. The provider has until 5/30/18 to submit the SA request with all required supporting documents for review. If the SA is submitted on or after 5/31/18, the SA will deny as provider-liable and may not be resubmitted.
- Insurance information is entered in notes section.
- Diagnosis code(s) are entered.
- Attach all required supporting documents as listed in the ND Medicaid Hearing Aid Policy (<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/policy-hearing-aids.pdf>) and clarified below.

Instructions on how to submit DME SAs can be found at: <http://www.nd.gov/dhs/info/mmis/docs/mmis-dme-service-authorization-entry-qrg.pdf>.

Hearing Aid Policy Required Supporting Documents:

- Notes from the prescribing physician/practitioner are required within 60 days of the date the SA is submitted. The notes must provide sufficient clinical rationale to substantiate the medical need for evaluation for a hearing device.
 - The physician/practitioner is to address hearing issues the member is having in their exam documentation. The documentation is to support the need to order/refer the member to audiology for evaluation. Without this required visit it is assumed the member is self-referred. Self-referrals are a non-covered service.
 - This physician/practitioner visit is required to rule out other medical reasons that may be causing issues that can decrease hearing. If the physician/practitioner determines the member needs a hearing evaluation, they are to issue a prescription for it.
- Prescription from the physician/practitioner who referred the member to audiology is required. A valid prescription/order/referral requires the following elements:
 - Member's name,
 - Member's date of birth or Medicaid number,
 - Diagnosis code,
 - Length of need,
 - Item being requested (hearing aid left or right, etc.),
 - Legible physician/practitioner signature and date when signed.
- A completed Certificate of Medical Necessity (CMN) SFN 581 (<https://www.nd.gov/eforms/Doc/sfn00581.pdf>) is required.
 - Sections A, B, and C are completed by the audiologist.
 - Section D is completed by the prescribing provider.
- Audiologist's office notes and the related audiogram.

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Frequent SA issues causing denied claims:

- Member is not seen by a physician/practitioner prior to being evaluated by audiology and having audiogram done.
- Missing required physician/practitioner notes and instead sending ENT notes. Since an ENT is a specialist and requires a referral from a physician/practitioner, the ENT notes can be sent as supportive but are not considered a substitute for the member's physician/practitioner notes and the corresponding prescription for a hearing evaluation by audiology. ENTs should not be signing the CMN or ordering hearing aids as this is done by the member's physician/practitioner.
- A member can be seen and evaluated by their physician/practitioner on the same day as seen by audiology, but the member needs to see their physician/practitioner first.
- If a provider is re-submitting SA with corrections and/or missing documents—be sure to use the original SA's start date. For example: W000000001 denied for missing audiogram on 3/1/18 with a start date of 3/6/18. Provider re-submits new SA W000000090 including the audiogram and all other required supporting documents on 4/3/18. The resubmitted SA's start date is 3/6/18, **not** 4/3/18.
- Missing purchase modifier for all HCPC codes including dispensing.
- Missing attached required supporting documents which prevents review.
- Missing the member's insurers in the notes section of the SA.
- Using the incorrect modifier for binaural usage.
 - To request binaural hearing aids, units requested is 1 unit with the NU and LT/RT modifiers.
 - To request a monaural hearing aid, units requested is 1 unit with the NU and LT or RT modifier.

Other DME-related information can be found at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html>.

Proof of Liability Insurance

Providers are no longer required to submit proof of business liability insurance to ND Medicaid as part of the enrollment and revalidation processes. It is the providers' responsibility to ensure that they have the necessary insurance in place for their practice.



Preventive Health Services for Medicaid Members Age 21 and Over

ND Medicaid provides coverage for Preventive Health Services for both male and female members age 21 and over. This includes the age-specific Evaluation and Management Preventive Medicine Service CPT Codes (99385-99386 and 99395-99396) as well as associated screening labs and x-rays specified as A or B Recommendations by the U.S. Preventive Services Task Force (USPSTF) with the exception of BRCA testing which will continue to require Service Authorization and is limited to members with a personal history of malignancy.

Preventive Health Services are services provided to a member to avoid or minimize the occurrence of illness, infection, disability, or other health conditions. Preventive health services are covered when the following conditions are met:

- The service is provided to the member in person;
- The service affects the member's health condition rather than the member's physical environment;
- The service is not otherwise available to the member without cost as part of another preventative health program funded by a government or private agency;
- The service is not part of another covered service;
- The service minimized an illness, infection, or disability that will respond to treatment;
- The service is generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize an illness;
- The service is ordered in writing by a physician or other qualified healthcare professional and included in the plan of care.

The following services are not covered as a preventive service:

- Services that are for vocational purposes (pre-employment or Department of Transportation exams);
- Services that deal with external, social, or environmental factors that do not directly address the recipient's physical or mental health.