

Provider Bulletin

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**NORTH DAKOTA
DEPARTMENT OF
HUMAN SERVICES**

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**MAGGIE D. ANDERSON,
MEDICAID DIRECTOR**

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Provider Enrollment Revalidations

Enrollment revalidations are required for all provider records, regardless of provider type, at least every five years (this includes ordering or referring practitioners). This applies to both group and individual records. ND Medicaid may, at its discretion, require revalidation on a more frequent basis.

Here is what to expect:

- Providers that have upcoming revalidations will be contacted via the email address associated with their enrollment. **Please make sure the contact information in your record is up to date to avoid missing this notification.** It is the provider's responsibility to ensure that ND Medicaid has accurate contact information on file.
- In the email, you will receive a checklist of what is needed. Please complete the checklist and submit it as a coversheet for the documentation listed.
- Fax all documentation requested for revalidations to 701-328-1544, Attn: Provider Enrollment. You may also request a secure site to upload documentation to by emailing dhserollment@nd.gov. Do not send revalidation documents to dhserollment@nd.gov.
- If you receive a revalidation notice for a provider who is no longer affiliated with any of your facilities, please respond that the provider has terminated employment and include his or her termination date for each location (you may also submit a termination form (<https://www.nd.gov/eforms/Doc/sfn01331.pdf>)).

If you have any questions, email dhserollment@nd.gov or call 701-328-4033.



Provider Site Visits

Site visits are required upon enrollment and revalidation of a provider type that is designated as moderate or high risk, per 42 CFR §424.518, §455.450 and §455.432. The site visit is to ensure that the information submitted to ND Medicaid is accurate and the provider meets enrollment requirements for the type of service or supplies they are providing.

All service locations associated with a group application must be disclosed at the time of enrollment or when the additional service locations are added to an existing enrollment.

Physical therapists have been designated as moderate risk providers per the regulation cited above and all new enrollments require state staff to conduct site visits at the facilities they are affiliating with. The group that is enrolling or affiliating with a physical therapist must disclose all service locations where the physical therapist is providing services.

If additional service locations need to be added after enrollment, please submit a request by following the instructions on page 19 of the provider enrollment FAQ (<https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/provider-enrollment-faq.pdf>).

If you have any questions, please email dhsenrollment@nd.gov or call 701-328-4033.

Third Party Liability for Prenatal Services

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amends section 1902(a)(25)(E) of the Social Security Act to require a state to cost avoid for prenatal services and require the state to collect information on third party liability (TPL) before making payments. Effective February 9, 2018, state Medicaid agencies must use standard coordination of benefits cost avoidance when processing prenatal services claims. For further information, refer to the Center for Medicaid & CHIP Services information bulletin dated June 1, 2018 (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf>).

ND Medicaid has multiple ways to identify TPL. Once ND Medicaid is notified that another payer may be obligated as the primary payer, the member's information must be updated with the other payer information to avoid claims from paying in error. In some instances, ND Medicaid is not given the correct information or all of the information needed to accurately update TPL information for a member. In these situations, generic carrier information is used until the system can be accurately updated. When reviewing a member's TPL information, if you see 1111111257, 1111111154 or 1111111157, the member should be instructed to contact their county social services eligibility worker to properly update the TPL information. ND Medicaid is not be able to update a member's policy information over the phone. If the member states that the policy is no longer active, there must be a certificate of coverage on file in order to end-date a policy.

If you have questions, contact the ND Medicaid TPL Unit at medicaidtpl@nd.gov or 701-328-2347.

Fingerprint-Based Criminal Background Checks

Effective July 1, 2018, high-risk providers and any person with a five percent or more direct or indirect ownership interest in the provider are subject to a fingerprint-based criminal background check (FCBC) upon ND Medicaid enrollment or revalidation (42 CFR §455.434, NDCC 50-24.1-03.3, NDAC 75-02-05-11).

High-risk providers include:

- Prospective (newly enrolling) home health agencies.
 - Prospective (newly enrolling) suppliers of durable medical equipment, prosthetics and orthotics supplies (DMEPOS).
 - Providers that have been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous ten years.
 - A provider with a payment suspension imposed by a state Medicaid agency (SMA) based on a credible allegation of fraud, waste or abuse. The provider remains "high risk" for ten years beyond the date of the suspension.
 - Any provider that is excluded by a SMA or OIG, but has a waiver to enroll with a SMA.
 - Any provider that upon enrollment or revalidation, is found to have an existing Medicaid overpayment that meets all of the following criteria:
 - Is *\$1,500 or greater,
 - Is more than 30 days old,
 - Has not been repaid at the time the application was filed,
 - Is not currently being appealed, and
 - Is not part SMA-approved repayment plan for the entire outstanding overpayment.
- *Note: the \$1,500 threshold is aggregate of all outstanding debts and interest, to include the principal overpayment balance amount and the accrued interest amount for a given provider.
- Any provider that would have been subject to a temporary moratorium that was issued by the SMA or the Centers for Medicare and Medicaid Services (CMS) that was lifted in the previous six months.
 - Any provider/provider type/provider specialty the SMA determines as high risk. That determination may include, but is not limited to: chronic billing errors, complaints, national fraud trends, etc.

Providers identified as high risk will be subject to FCBC, including both newly enrolling providers and providers who are already enrolled. Newly enrolling providers must submit FCBC upon enrollment. ND Medicaid will reach out to providers identified as high risk who are already enrolled in the near future to request FCBC. Individual owners with five percent or more interest in the entity are also subject to FCBC. Providers and owners are required to submit fingerprints within 30 days of the date of their notification letter from ND Medicaid. If the fingerprints are not received within that timeframe, the application will be denied and providers would not be eligible for reimbursement for services or supplies provided to ND Medicaid members. Providers may reapply with ND Medicaid by submitting a new application and FCBC.

ND Medicaid may rely on screening provided by Medicare or another SMA, as long as the risk levels are the same and conducted within five years of the enrollment or revalidation date. However, this is contingent upon the owners being the same as those that were fingerprinted by Medicare or another SMA. Owners who were not fingerprinted by Medicare or another SMA will be subject to FCBC. Additionally, if the provider has revalidated with Medicare and is now moderate risk for Medicare but that same entity is new to ND Medicaid, they are considered high risk to ND Medicaid and subject to FCBC.

If there are background information findings, the provider or owner will be notified in writing by ND Medicaid. If you have any questions, email dhsenrollment@nd.gov or call 701-328-4033.

Dental Documentation Requirements

All Medicaid services must be properly documented by the practitioner rendering the service. The general principles of dental record documentation are outlined below. For any questions on electronic signatures, reference the electronic signature requirements section below.

General Principles of Dental Record Documentation*

1. The dental record must complete and legible.
2. The dental record must 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; and patient complaints and resolutions.
3. The information in the dental record must be dated, signed and handwritten in ink by the person rendering the service. It can also be computer printed.
4. Appropriate health risk factors must be identified.
5. The patient's progress, response to and changes in treatment and revision of diagnosis must be documented.
6. The information contained in the dental record must not contain abbreviations.
7. The identifying practitioner must 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 rendered in the outpatient hospital or ambulatory surgical center must be supported by an operative report showing medical necessity of the services performed.

*Source: https://www.ada.org/~media/ADA/Public%20Programs/Files/MPRG_Dental_Records.pdf?la=en.

Electronic Signatures

Documentation submitted to ND Medicaid must be signed by the practitioner performing the service. All medical/dental/vision record entries must be legible and complete, dated and time stamped, and authenticated in written or electronic form by the person responsible for rendering or evaluating the service provided consistent with organization policy.

Electronic signatures in medical records will be accepted in the following format:

- Chart 'Accepted By' with practitioner's name
- 'Electronically signed by' with practitioner's name
- 'Verified by' with practitioner's name
- 'Reviewed by' with practitioner's name
- 'Released by' with practitioner's name
- 'Signed by' with practitioner's name
- 'Signed before import by' with practitioner's name
- 'Signed: Dr. _____' with practitioner's name
- Digitized signature that is handwritten and scanned into the computer
- 'This is an electronically verified report by Dr. _____'
- 'Authenticated by Dr. _____'
- 'Authorized by: Dr. _____'
- 'Digital Signature: Dr. _____'
- 'Confirmed by' with practitioner's name
- 'Closed by' with practitioner's name
- 'Finalized by' with practitioner's name
- 'Electronically approved by' with practitioner's name
- 'Signature Derived from Controlled Access Password'

Continued on page 5...

Electronic Signatures (continued from page 4)

Unacceptable signatures are:

- Dictated, but not read
- Signed, but not read
- Auto-authenticated
- Rubber Stamp Signatures (Source: 7/29/08: MLN Matters SE0829 CMS States: “Stamped signatures are NOT acceptable on any medical record.”)

If there is no signature appended to medical record documentation, claims will be denied for no signature.

Retired Coding Guideline

Effective October 1, 2018, the coding guideline for intramuscular or subcutaneous injections will be retired. Effective for dates of service on and after October 1, 2018, ND Medicaid will apply National Correct Coding Initiative Procedure to Procedure editing to CPT 96372 when billed in conjunction with an evaluation and management service.

Service Management Providers Needed

ND Medicaid needs more service management providers for the Medicaid Autism Spectrum Disorder Waiver. The role of the service manager (SM) is to assist participants in gaining access to waiver and other services. The SM will also develop the overall participant service plan with the family.

SMs must complete North Dakota’s mandated reporter training and have one of the following degrees:

- Bachelor’s degree in any of the following: social work, psychology, occupational therapy, physical therapy, child development and family science, communication disorders (includes audiology or speech pathology), special education, sociology or elementary education, and two years work experience with children with autism or related conditions.
- Master’s degree in counseling or psychology or a doctorate in medicine.
- Five years experience working with children with autism or related conditions and/or their families.

All providers must have a certification or other national or state designation of expertise in autism within the first two years of enrollment with ND Medicaid.

If you have any questions, contact Katherine Barchenger at 701-328-4630 or kbarchenger@nd.gov.



Bookmark the ND Medicaid providers page: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html>. Check back for periodic updates!