Program Integrity Updates
September 28, 2017

ND Department of Human Services
Medical Services Division
CMS granted ND a 2 year RAC Waiver.
Perm updates

- It is once again time for us to prepare for the Review Year (RY) 2019 Payment Error Rate Measurement (PERM) audit.
  - No longer a Federal Fiscal Year (FFY) Review
  - Claim sample 7-1-2017 to 6-30-2018

- PERM is a Federally mandated audit that happens every 3 years.
The Lewin Group (Lewin) will serve as the Statistical Contractor (SC),

Chickasaw Nation Industries (CNI) will serve as the Review Contractor (RC),

Booz Allen Hamilton (BAH) will serve as the Eligibility Review Contractor (ERC)
FRAUD, WASTE & ABUSE (FWA)

- How do I report Medicaid fraud or abuse?

- Contact - Shanna Mills
  - Fraud & Abuse Administrator
  - c/o Medical Services Division
  - 600 E Boulevard Ave Dept. 325
  - Bismarck ND 58505-0250
FRAUD, WASTE & ABUSE (FWA)

- By completing the Surveillance and Utilization Review Section (SURS) Referral Form (SFN 20) at http://www.nd.gov/eforms/Doc/sfn00020.pdf
- By calling 1-800-755-2604 or 701-328-4024
- By email at medicaidfraud@nd.gov
- By fax at 701-328-1544
Since Medicaid is the payor of last resort in almost all situations, providers must bill the primary insurance carrier first. Providers should not be submitting claims to both the primary insurer and Medicaid at the same time.

Providers can call 701-328-2347 with questions or can submit questions to tplmedicaid@nd.gov.
MODIFIER 50

- ND Medicaid continues to see a high volume of claims reporting bilateral procedures on two lines.

- Effective October 5\textsuperscript{th}, 2015 bilateral procedures should be reported on a single line utilizing modifier 50.
MODIFIER 50

- This was communicated to providers in the September 2015 MMIS Bulletin, http://www.nd.gov/dhs/info/mmis/docs/mmis-bulletin-sept2015.pdf,
- as well as the North Dakota MMIS System Changes document posted in March of 2014 https://www.nd.gov/dhs/info/pubs/docs/medicaid/mmis-system-changes.pdf
MODIFIER 50

- Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50.
- Modifier -50 applies to any bilateral procedure performed on both sides at the same operative session.
MODIFIER 50

- The bilateral modifier -50 is restricted to operative sessions only.

- Modifier -50 may not be used to:
  - report surgical procedures identified by their terminology as “bilateral,” or
  - report surgical procedures identified by their terminology as “unilateral or bilateral”.
MODIFIER 50

- The unit entry to use when modifier -50 is reported is one.
- Any questions regarding the use of the -50 modifier can be directed to:

  Jennifer Sanders, CPC
  Utilization Review, ND Medicaid
  jasanders@nd.gov
When submitting claims with unlisted procedures documentation is always needed.

It needs to be indicated within the submitted documentation the portion that corresponds to the unlisted code being billed.

Failure to indicate this will result in the unlisted code being denied.
When requesting additional visits for PT/OT/ST a signed physician plan of care or recertification of the plan of care is required every 60 days.

Requests for addition evaluations requires a physician order.

A physician order is also required if the patient is discharged from care and treatment is to start again.

A physician order is valid once, it cannot be used multiple times and is valid for 30 days.
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Below is the link to our claims submission guidelines. You are able to find the links to the Physical Therapy, Occupational Therapy and Speech-Language Pathology guidelines there.

http://www.nd.gov/dhs/info/mmis/guidelines.html
Federal regulations require all ordering, prescribing, or referring providers for Medicaid recipients (both Medicaid Managed Care and traditional Medicaid recipients) to be enrolled with ND Medicaid.

Providers can enroll as a provider for all Medicaid recipients, or they can choose to only enroll for traditional Medicaid, or only managed care (e.g. Sanford Health Plan, PACE, SCHIP).
**PROVIDER ENROLLMENT**

- Given this federal requirement, providers that are contracted with a Managed Care Organization (MCO), but NOT currently enrolled with traditional Medicaid, will be receiving directions from the MCO instructing them on the process to meet the federal requirements and enroll with ND Medicaid.

- Also, any new provider that contracts with a Medicaid or CHIP MCO will receive directions at that time to enroll with ND Medicaid (and their MCO claims will not pay until they complete that enrollment).
Traditional Medicaid will also be making the necessary changes to begin denying all claims when the ordering, prescribing, or referring provider is not enrolled with ND Medicaid.

For example, if a locum tenens or medical resident is not currently enrolled, claims with them listed as the prescriber will be denied.
PROVIDER ENROLLMENT

- For questions regarding the enrollment process, visit the Department’s website at
  - www.nd.gov/dhs/info/mmis.html and scroll down to the enrollment section (which will take you here:
    http://www.nd.gov/dhs/info/mmis/materials.html)
QUESTIONS
CONTACT INFORMATION

- Dawn Mock, dmock@nd.gov or (701) 328-1895
  (Program Integrity Administrator)

- Jeanne Folmer, jfolmer@nd.gov or (701) 328-4831
  (SURS Administrator)

- Shanna Mills, smills@nd.gov or (701) 328-4024
  (Fraud & Abuse/TPL Administrator)