

# ***Provider Bulletin***

**In this Issue**

New Provider Enrollment	1
Provider Enrollment	
Revalidations	2
Provider Application Status	2
Provider Enrollment Effective	
Date	3
Payment Error Rate	
Measurement Audit Update	3
Genetic Testing Update	3
Updated Service Authorization	
Form for Vision Services	3
Hospital Presumptive Eligibility	4
Fluoride Varnish	4
Coordinated Services Program	5
Claims—Adjust or Appeal?	6
Medicaid Members with Primary	
Insurance	6
Claims Submission Reminders	6
2019 Access to Healthcare	
Survey	7
Unified Program Integrity	
Contractor	7
Identifying 340B-Acquired Drugs	7

**New Provider Enrollment**

New Application — How to apply to be a ND Medicaid provider:

1. Submit an online application: <https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>.
2. Review required documents checklist. Checklists are located at: <https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html>.
3. Submit required documents along with the checklist.
  - Regular email (no SSNs or bank information): [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov).
  - Upload by secure link. For an invitation to upload by secure link, email [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov). An email invitation will be sent back to you.
  - Fax to 701-328-1544, Attention: Provider Enrollment.

If you do not submit or correctly complete all of the required documents, this will cause a delay in processing your application and may impact your enrollment effective date. All providers go through the screening process required by the Centers for Medicare and Medicaid Services (CMS). Enrollment is dependent upon successful completion of the required screening. The time needed to process an application includes the screening process.

After the application is approved, you will receive a letter with your new Medicaid ID (also called Health Enterprise ID number). In order to keep the enrollment active, renewed license and Drug Enforcement Agency numbers must be provided to the department.

If you have any questions, email [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov)



**NORTH DAKOTA  
DEPARTMENT OF  
HUMAN SERVICES**

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

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## Provider Enrollment Revalidations

Revalidations are required to be performed for all providers at least once every five years (this includes ordering or referring physicians or other professionals) per 42 CFR 455.414. The department may, at its discretion, require revalidation on a more frequent basis.

Providers must ensure they have a correct email address associated with their approved application to receive their revalidation notification. Once you receive your revalidation notification, read it carefully and follow the instructions.

Revalidation documentation will only be accepted if submitted within three months of the revalidation due date, unless the revalidation was initiated by the department. Any documents submitted outside of that timeframe will be deleted without any additional notification. The Department will post a roster at <http://www.nd.gov/dhs/info/mmis/revalidation.html> with revalidations that are due within three months of the date the roster is posted. The roster will be updated at the beginning of each month.

### General instructions – Individual Records:

1. Determine if the individual is still providing services for the billing group indicated in the email.
  - If yes, move to step 2.
  - If no, complete the termination form attached to the email and submit by one of the options below under step 4.
2. Use the checklist attached to the notification and obtain the required documents.
3. Complete the checklist and submit it as a coversheet with your documents.
4. Submit all completed documentation within 30 days.
  - Regular email (no SSNs or bank information): [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov)
  - Upload by secure link. For an invitation to upload by secure link, email [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov). An email invitation will be sent back to you.
  - Fax: 701-328-1544, Attention: Provider Enrollment.

### General instructions – Group Records:

1. If you are also enrolled with Medicare — ensure there are no discrepancies between the agency ownership reported to Medicare and the agency ownership reported to ND Medicaid. ND Medicaid is unable to move forward with the revalidation process until any ownership discrepancies are corrected and the ownership information for both programs match.
2. Use the checklist attached to the notification and obtain the required documents.
3. Complete the checklist and submit it as a coversheet with your documents.
4. Submit all completed documentation within 30 days.
  - Upload by secure link. For an invitation to upload by secure link, email [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov). An email invitation will be sent back to you.
  - Fax: 701-328-1544, Attention: Provider Enrollment.

## Provider Application Status

Once an online application is submitted, it will be in 'pending' application status until supporting documentation is submitted. Once supporting documentation is received, the application status changes to 'in process'. Canceled applications are due to a provider not providing requested documentation in the allotted timeframe. That application will remain in 'cancelled' status until a provider submits the missing documentation. **Enrollment staff do not reach out to providers after the application is cancelled, so it is the provider's responsibility to ensure they are providing timely follow up.**

If you have any questions, email [dhsenrollment@nd.gov](mailto:dhsenrollment@nd.gov) or call 701-328-4033.

## Provider Enrollment Effective Date

Effective December 1, 2018, ND Medicaid will not process a request for provider enrollment until the provider enrollment staff receives all required enrollment documents, in addition to submitting the online application. Unless a retroactive enrollment effective date is requested, the application effective date will be the date that staff approve the application.

This policy also applies to adding affiliations and adding/changing taxonomies.

Provider specialty coversheets are online at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html> and list the documentation required for enrollment. It is the provider's responsibility to submit complete and accurate documents that are required for enrollment purposes.

### Consideration for a retroactive enrollment effective date

A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a complete application packet is received. Providers must request a retroactive enrollment effective date when submitting the complete enrollment packet.

Providers who have requested a retroactive effective enrollment date may submit claims for covered services provided prior to receipt of all required enrollment documents if the provider met all eligibility requirements at the time the service was provided and if appropriate documentation of the services provided is maintained.

\*ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety days for situations involving emergent care provided to a ND Medicaid member.

## Payment Error Rate Measurement (PERM) Audit Update

The federal Payment Error Rate Measurement (PERM) audit is well underway. The PERM audit measures improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP) where each state is audited on a rolling three year basis and annually produces national and state-specific improper payment rates for each state Medicaid program. The improper payment rates are based on federal reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.

Providers started receiving medical records requests from the review contractor, Chickasaw Nation Industries, in July 2018. Please ensure that your release of information departments are responding to the records requests in a timely manner.

A sample copy of the envelope, initial request for records letter and the claim category letter packet can be found at <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-perm.html>.

If you have questions about the PERM audit, call 701-328-4831 or email [jfolmer@nd.gov](mailto:jfolmer@nd.gov).

## Genetic Testing Update

Genetic testing procedures for Materni T21 (CPT code 81420) and Cologuard (CPT code 81528) no longer require service authorization. Any requests that are received will be returned.

## Updated Service Authorization Form for Vision Services

State Form Number (SFN) 292 — Request for Service Authorization for Vision Services — has been updated at <https://www.nd.gov/eforms/Doc/sfn00292.pdf>. Effective immediately, all requests for vision services are required to be sent on the updated service authorization form. Any requests received on outdated forms will be returned.

## Hospital Presumptive Eligibility Best Practice Recommendations

The Affordable Care Act required state Medicaid agencies to implement Hospital Presumptive Eligibility (HPE). HPE allows a hospital, once approved by the state to be a qualified entity, to make certain Medicaid eligibility determinations for individuals on a temporary basis. The HPE eligibility period begins on the date which a qualified entity makes an HPE determination for an individual and ends the earlier of one of the following:

- Date in which a decision is made on a full Medicaid application which was submitted; or
- Last day of the month following the month in which the HPE determination was made.

If a full Medicaid application is submitted and the individual qualifies for Medicaid, Medicaid Expansion, or Healthy Steps, part or all of the HPE eligibility period will be changed to the Medicaid category of eligibility determined.

### Best Practice Recommendations for HPE

Before HPE application submission – determine whether individual(s) are already eligible by checking with ND Health Enterprise MMIS for ND traditional Medicaid or with the managed care organization (Sanford Health Plan) for ND Medicaid Expansion.

- If individual(s) qualify for ND traditional (fee for service) Medicaid – submit the claim(s) to ND Medicaid utilizing the ND Medicaid member ID number.
- If individual(s) qualify for ND Medicaid Expansion – submit the claims(s) to Sanford Health Plan utilizing the assigned member ID number.
- If no current eligibility is found for the individual(s) – submit the HPE application for a determination.

After the HPE application determination:

- If individual(s) do not qualify for HPE – encourage individual to submit a full Medicaid application.
- If individual(s) qualify for HPE – hold all claims for services at least 60 days. This allows individual(s) to submit a full Medicaid application and for eligibility to be determined under the correct category (traditional Medicaid, Medicaid Expansion, or Healthy Steps).
  - At the end of the 60 days, re-check eligibility by checking with ND Health Enterprise MMIS or with the managed care organization (Sanford Health Plan).
  - If individual(s) qualify for ND traditional Medicaid – submit the claim(s) to ND Medicaid utilizing the ND Medicaid member ID number.
  - If individual(s) qualify for ND Medicaid Expansion – submit the claims(s) to Sanford Health Plan utilizing the assigned member ID number.
  - If no current eligibility is found – contact the local county social service office where the individual lives to determine what may have occurred with the original HPE determination.

## Fluoride Varnish

When fluoride varnish is applied in a clinic or facility setting, CPT 99188 must be billed by a physician or other qualified health care practitioners. In addition to applying fluoride varnish during dental visits, it can be applied at the time of a well child visit/Health Tracks screening. Fluoride varnish can be billed to ND Medicaid a maximum of two times per year, per patient. For more information, refer to the Medicaid coding guideline at <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/cpt/fluoride-varnish.pdf>.



Bookmark the ND Medicaid providers page: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html>.

Check back for periodic updates!

## Coordinated Services Program

The Coordinated Services Program (CSP) is utilized by ND Medicaid to improve the continuity and quality of medical care for members, improve utilization patterns to control Medicaid expenditures and provide education on the proper access of services at the appropriate level of care. Members may be referred to the CSP for multiple reasons which may include

- Over utilization of multiple providers and clinics;
- Early prescription refills and usage of multiple pharmacy providers;
- Excessive use of emergency room services for non-emergent care; and/or
- Prescription use that is excessive or potentially life-threatening to the health of the member indicated by multiple prescribing providers, multiple controlled drugs or overlapping prescriptions with counterproductive therapeutic value.

### Program Requirements

- Members referred to the CSP must choose a primary care provider by selecting a family practice, general practice, nurse practitioner, physicians assistant or internal medicine provider.
- CSP members are restricted to one pharmacy of their choice to manage their prescriptions.
- Based on dental services utilization, a member may also be restricted to one dentist of their choice.
- The members' selection of service providers is subject to approval by ND Medicaid.

### CSP Provider Absences

If a CSP provider is busy or out for the day, they can refer for a one-day visit to a covering provider. The clinic can decide if the member needs to be seen or can wait for their CSP provider. If a CSP provider is going to be absent from practice for an extended period of time, the CSP provider should refer the member to another provider to serve as the CSP provider so the member can access necessary urgent/emergent care. The member should wait for the return of their CSP provider for services that are considered routine care.

### Referrals

- Only the CSP provider can refer, except in the case of absences as stated above.
- The CSP referral form must be mailed or faxed to ND Medicaid. The CSP provider may also notify ND Medicaid by telephone at 701-328-4033, if the referral is urgent.
  - \* Mailing address: ND Department of Human Services, Medical Services Division, Attention: CSP Referrals, 600 E Blvd Ave, Dept 325, Bismarck, ND 58505.
  - \* Fax to 701-328-1544, Attention: CSP Referrals.
- CSP referrals must have a member's first and last name, date of birth, member's ND Medicaid ID number, the CSP provider's first and last name, the referred to provider's first and last name, referred to provider's national provider identification (NPI) number and the begin and end date on the referral form.
- No retrospective CSP referrals will be accepted.
- If there is no CSP referral on file, the claims will be denied and the member will be responsible for the bill.
- All services that are provided in the emergency room are reviewed for medical necessity. An example of noncovered services in the emergency would be prescription refills. All routine services should be addressed with the CSP provider. All emergency room, walk-in, and urgent clinic claims must have notes attached for review.
- Only the member's CSP provider can authorize a referral to a specialist.
- Referrals must be for medically necessary services.
- If possible, submit referrals to the ND Medicaid office prior to the date of service.

For questions about the CSP, call 701-328-2347 or email [medicaidtpl@nd.gov](mailto:medicaidtpl@nd.gov).

## Claims — Adjust or Appeal?

Providers have the right to appeal the denial or reduction in the level of service payment per NDCC 50-24.1-24 (1). As a reminder, there are many situations in which a denied claim can be adjusted rather than undergoing the formal appeals process. Adjusting a denied claim will decrease the turn-around time for claims payment. The following are examples of items that can be resolved through the adjustment process.

- Additions/deletions/changes to modifiers, diagnosis or procedure codes
- Change to units
- Changes to billed amount
- Change in date of service
- Primary care provider referrals (attach copy of referral)
- Timely filing
  - Transaction Control Number (TCN) and remittance advice date of the previously processed claim are required in box 22 of the CMS 1500 claim form and box 80 of the UB claim form or the equivalent loop and segment of the 837.

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/timely-filing-policy.pdf>

Claims must be adjusted within one year of the date of denial. The following links provide instruction on the adjustment/claims replacement process: <https://www.nd.gov/dhs/info/mmis/docs/mmis-replacement-claims-fact-sheet.pdf>; <https://www.nd.gov/dhs/info/mmis/docs/mmis-hcbs-web-portal-claims-void-replacement-procedures.pdf>.

## Medicaid Members with Primary Insurance

If a member has a primary insurance, this is known as third-party liability (TPL). The primary insurance name has to be listed in box 9D of a CMS 1500 claim form or box 50 of a UB-04 claim form.

The explanation of benefits (EOB) must be attached to the claim showing what was paid from the primary insurance(s) when listed in box 9D or 50. If you list a payer in 9D of box 50, you must attach an EOB. The ND Medicaid TPL policy is at: <http://www.nd.gov/dhs/info/mmis/docs/third-party-liability.pdf>.

The primary insurance EOB must match what is billed to ND Medicaid for procedure codes, amounts, units, etc.

Exception: If a member has a Medicare or Medicare replacement plan and the ONLY procedure(s) being billed is something that the Medicare/Medicare replacement plan never covers, for example: hearing aids, eye refraction code, eye glass fitting codes, eye glass frame codes or incontinence garment code. In this case, no EOB is required and there should be nothing listed in box 9d or box 50.

## Claims Submission Reminders

**Web portal when Medicare is the primary health insurance** — Medicare A or B primary claims cannot be billed through the web portal. They can be billed electronically through the provider clearing house.

**J Codes** — No paper claims with J codes are accepted. Claims must be billed electronically or through the web portal if Medicare is not primary. If Medicare is primary, claims must be billed through the provider clearinghouse.

**Handwritten information in paper claims** — ND Medicaid will not accept a paper claim that is not legible. The claim will be sent back without being loaded into the system.

**Timely filing** — review the ND Medicaid timely filing policy: <https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/timely-filing-policy.pdf>.

## 2019 Access to Health Care Survey of Medicaid Households

In response to a 2016 rule from the Centers for Medicare and Medicaid Services (CMS), ND Medicaid initiated the first Medicaid household survey in the fall of 2016, in conjunction with North Dakota's first Access Monitoring Review Plan (AMRP). A follow-up AMRP is required of all states in October 2019. A second household survey will be sent to traditional Medicaid households in early 2019 and covers primary care, specialty care, behavioral health care, obstetrics, and home health care subsequent to a hospital stay.

The survey asks: When you or your family member covered by Medicaid needed care from (the identified provider group), how often did your household get care as soon as you needed it? Response options are: Never – Sometimes – Usually – Always.

Results from the 2016 survey can be viewed at: <http://arcg.is/2kKJOUN>. The results of the 2019 survey will be available by mid-2019.

## Unified Program Integrity Contractor

To better coordinate audits, investigations, and data analyses, and to lower the burden on providers, the Unified Program Integrity Contractor (UPIC) awarded by the Centers for Medicare and Medicaid Services (CMS), will combine and integrate the existing Zone Program Integrity Contractors, Program Safeguard Contractors, Medicare-Medicaid Data Match programs, and Medicaid Integrity Contractors into a single contractor to perform Medicare and Medicaid program integrity work on behalf of CMS.

CMS has selected Qlarant as a UPIC to detect, prevent, and proactively deter fraud, waste, and abuse in Medicare and Medicaid programs in the western jurisdiction, which includes North Dakota.

Qlarant will use a combination of advanced technology, data analytics, and expert evaluation to provide a powerful process consistent with CMS's goals and expectations, which will ultimately benefit Medicare beneficiaries and Medicaid members.

More information on UPIC audits will be provided in future provider bulletins. Any questions related to the UPIC may be directed to Jeanne Folmer, Program Integrity Audit Coordinator at [auditre-sponse@nd.gov](mailto:auditre-sponse@nd.gov).

## Identifying 340B-Acquired Drugs

Medical providers participating in the 340B Drug Program are required to identify all outpatient drugs acquired under the 340B program. Providers have asked if ND Medicaid will accept the newly established JG and TB modifiers.

Effective January 1, 2018, ND Medicaid began accepting the JG and TB modifiers for identifying 340B Drug Program claims. These modifiers are accepted on both the 837I and 837P transactions. ND Medicaid also still accepts the UD modifier for this same purpose for all claim types. As all family planning clinic medications are known to be 340B acquired, family planning clinics will continue to bill without any JG, TB or UD modifiers.

As a reminder, providers (except family planning clinics) may not use 340B Drug Program acquired drugs for the Medicaid Expansion population.