NORTH DAKOTA MEDICAID

Provider Bulletin

THE REIMBURSEMENT NEWS SOURCE

In this Issue

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

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Out-of-State Referrals

- Out-of-state services at sites more than 50 statute miles from North Dakota's borders **must be prior authorized**. Out-of-country services are not a covered service under North Dakota (ND) Medicaid and will not be paid.

- A minimum of two weeks before scheduling an appointment, ND Medicaid must receive the ***Request for Service Authorization for Out-of-State Services (SFN 769)*** from the recipient's primary care provider or in-state specialist physician.

- **The request must include:**

  1. Recipient's name, Medicaid ID number, and date of birth.
  2. Diagnosis.
  3. Medical information supporting the need for out-of-state services.
  4. A written second opinion from an appropriate in-state board certified specialist, following a current (within three months) examination, which substantiates the medical need for out-of-state care.
  5. The physician and facility being referred to.
  6. Assurance that the service is not available in ND.

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

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

Out-of-State Referrals Continued

- 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 Medicaid staff. The transferring facility must notify ND Medicaid within 48 hours of the transfer. 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 must be included. It is expected that air ambulance will only be used in situations that are emergent.
- Claims received from out-of-state providers will not be paid without written prior authorization.
- If the out-of-state services are approved, the recipient's county social service office is responsible for assisting the recipient with the arrangements for travel, lodging, and meals.

DMEOPS Providers

Cochlear Implant and Bone Anchored Hearing Aid

Effective October 1, 2014, please utilize the new Cochlear Implant and Bone Anchored Hearing Aid (BAHA) policy as these items will no longer be reviewed as Durable Medical Equipment (DME): www.nd.gov/dhs/services/medicalserv/medicaid/docs/cochlear-implant-baha.pdf.

Only replacement parts, batteries, etc., will continue to be reviewed as DME using the SFN 1115 form. Please reference the above policy and the 2014 DME fee schedules for replacement items that are covered.

Breast Pumps – AC/DC personal

Effective July 1, 2014 the (HCPC) E0603s reimbursement has been increased to $120.

Genetic Testing

ND Medicaid follows the Local Coverage Determination (LCD) L24308 published by Noridian Healthcare Solution, for genetic testing. Prior authorization must be obtained for any genetic testing (Tier 1 or Tier 2 molecular pathology) that falls outside the scope of this LCD. Please submit a completed SFN 511 along with supporting documentation, which includes the following:

- Patient diagnosis or clinical indication (ICD-9 code) or (ICD-10 code) after October 1, 2015;
- Test ordered (CPT code or test name);
- Indication/reason for test;
- Signs, symptoms, and duration;
- Prior related diagnostic and/or genetic tests and their results;
- Laboratory studies and results;
- Family medical/genetic history;
- Medications and duration (if related);
- Prior treatments or other clinical findings (when relevant);
- How the test results will be utilized in the member's care.

Claim Filing Deadlines

New claims: Providers have one year from the date of service to submit new claims.

Processed claims: Providers have one year from the last Remittance Advice date to resubmit or adjust claims.

Medicare crossover claim: Providers have six months from the Medicare Explanation of Benefits (EOB) date to submit the claims.

The Department's Timely Filing Policy is available on our website at:

www.nd.gov/dhs/services/medicalserv/medicaid/provider-policies.html

Service Authorization Forms

As ND Medicaid moves forward to a new claims processing and payment system, service authorization forms have been revised to reflect the changes required for the new ND Health Enterprise MMIS. ND Medicaid will now require the ND Medicaid recipient number, billing NPI and/or servicing NPI provider number (if applicable), and service code. The service code can be the CPT, HCPCS, revenue code, or ICD code that is applicable to the service being requested. These requirements are applicable to the following forms:

Home Health Request for Prior Authorization SFN 15 (Fillable)

Service Limits Prior Authorization Request SFN 481 (Fillable)

Medical Procedure/Device Prior Authorization Request - SFN511 (Fillable)

Vision Prior Authorization Form (Fillable)

Partial Hospitalization Prior (PHP) Service Authorization/Continued Stay – SFN 73 www.nd.gov/eforms/Doc/sfn00073.pdf (Fillable)

Medicare Advantage

When a nursing facility resident has a Medicare Advantage/Medicare Part C plan, the facility needs to bill as if the individual has long-term care insurance. Medicare Advantage Plans are private insurance and claims are not adjudicated the same as a claim with Medicare Part A. The nursing facility should bill the appropriate revenue code and identify the amount paid by the plan. ND Medicaid will pay the difference between the established rate and the amount paid by the plan.

ICD-10 Claims Submission

ICD-9 codes will no longer be accepted on any claims with dates of service on or after October 1, 2015. Claims containing ICD-9 codes for services on or after October 1, 2015, will be denied. For dates of service before October 1, 2015, submit claims with appropriate ICD-9 code(s). For dates of service on or after October 1, 2015, submit claims with appropriate ICD-10 code(s). Claims that are billed with both ICD-9 and ICD-10 codes will be denied.

Inpatient hospital claims that are reimbursed based on DRG should be submitted based on the discharge date. If the discharge date is before October 1, 2015, the claim should be submitted with the appropriate ICD-9 diagnosis and procedure codes. If the discharge date is on or after October 1, 2015, the claim should be submitted with the appropriate ICD-10 diagnosis and procedure codes.

Outpatient hospital claims and inpatient claims for services not reimbursed based on DRG must be billed separately for each calendar month of service. If the dates of service are before October 1, 2015, the claim should be submitted with the appropriate ICD-9 diagnosis and procedure codes. If the dates of service are on or after October 1, 2015, the claim should be submitted with the appropriate ICD-10 diagnosis and procedure codes.

Provider Audits

The Surveillance Utilization Review Section (SURS) conducts audits in order to determine areas where potential overpayments may exist. These audits have resulted in recoveries, policy creation and policy clarification. SURS is in the process of completing the following audits: CPT code 99233 billed the day before discharge, Revenue code 278, High level ultrasound 76811, and the Epidural Anesthesia audit.

Future audit topics include: Diabetic supply usage, Low level ED E/M codes billed with a laceration repair, and Public Health Nursing visits. SURS also conducts compliance audits in order to determine if providers that were cited in a previous audit have taken the necessary steps in order to avoid additional errors specific to that particular audit topic.

RAC Audits

The Medicaid Recovery Audit Contractor (RAC), Cognosante, is currently completing Pharmacy and DME audits. Cognosante has started additional audits on J-codes and PA/CNS modifiers. They will be adding the following audits in the coming months: Level 4 & 5 ED professional E/Ms, Critical Care newborn to adult, Duplicate billing, Ambulance mileage, Modifier 59 in radiology, Modifier 62, and Global billing in radiology.

The Department asks that all providers send updated contact information for the RAC liaison within your organization to auditresponse@nd.gov; please include name, address, phone, and e-mail address. The RAC audit letters are time sensitive and with updated contact information we can make sure the letters get to the appropriate person in a timely manner.

Medicaid RAC Toll-free # - (855) 637-2212 or (855) NDRAC12

ND RAC Fax # - (701) 281-4300

Email Address - northdakotarac@cognosante.com

Website - www.ndrac.com

PERM Audits

The Payment Error Rate Measurement (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, managed care, and eligibility components of Medicaid and CHIP in the fiscal year 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.

If no documentation or sufficient documentation is not submitted, the claim(s) will be considered an error and subject to recoupment. All states are required to participate in PERM audits. The PERM audit cycle is every three years. The current state PERM cycle is Federal fiscal year 2015 which started October 1, 2014, and goes through September 30, 2015. The PERM audits include eligibility determination, medical records, and claims processing.

The review contractor for PERM is A+ Government Solutions and they will start sending records request letters in August 2015.

www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html

- Please note that all records requests are time sensitive.
- Provider contacts - please send two contacts for the PERM Audits within your organization to auditresponse@nd.gov: please include name, address, phone and e-mail.

Third Party Liability (TPL)

In 1986, federal law required state Medicaid programs to avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid. With few exceptions, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as "third party liability" or TPL. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by federal statute).

Providers must obtain information about a recipient's health care coverage from the recipient, the recipient's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits. Providers should obtain an assignment of benefits from the recipient to ensure direct payment from the third party payer. For Medicaid purposes, health insurance is defined as any third party benefit that is available to the eligible Medicaid recipients for medical treatment and related services.

Any questions regarding TPL can be directed to: MedicaidTPL@nd.gov.

Fraud and Abuse

In order to meet federal requirements set in 42 Code Federal Regulations, Chapter IV, Part 455, the Department has a dedicated Program Integrity Unit. Within this unit, staff are assigned to investigate possible cases of fraud, waste, and abuse.

- **What is fraud?** Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person.
- **What is abuse?** Abuse is when provider practices are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or services that fail to meet professional recognized standards for healthcare. Abuse may also include recipient practices that result in unnecessary costs to the Medicaid and CHIP programs.

Types of fraud or abuse:

Provider: committed by practitioner, health facility, or other entity that provides services to Medicaid recipients.

Examples:

- Billing for a more expensive service than was actually rendered.
- Billing twice for the same service(s).
- Billing separately for services that should be combined into one billing (unbundling).

Recipient: committed by a Medicaid or CHIP recipient.

Examples:

- Providing false information to obtain Medicaid or CHIP eligibility.
- Paying cash for some services (prescriptions) to bypass refill edits.
- A recipient may lend someone their Medicaid card so the individual can obtain unauthorized medical services.

Since January 1, 2015, there have been 42 fraud referrals to the Medicaid Program Integrity Unit. These were received via the fraud email address, phone calls, mailed letters, or claims findings.

If you suspect fraud, waste, or abuse please report to the Program Integrity Unit the following ways:

By: 1-800-755-2604 or 1-701-328-4024

By email: medicaidfraud@nd.gov

By letter: Fraud and Abuse Administrator
c/o Medical Services Division
600 E. Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250

Primary Care Case Management (PCCM) Program Update

The Primary Care Case Management (PCCM) program functions statewide as a Medicaid Managed Care Program. Certain Medicaid populations are required to enroll in the PCCM program. Recipients can either choose, or be assigned to a Primary Care Provider (PCP). The PCCM program provides adequate access to primary care: to provide coordination and continuity of health care services, to avoid duplication of services, to focus on delivering high quality, and to ensure efficient and effective health care services.

For any provider to be selectable as a PCP they need to be of the following provider types **and** working in one of the following provider specialty areas:

> **Provider Types:** 020-Physicians, 036-Advanced Registered Nurse Practitioners, 036-Physician Assistants (will be selectable as a PCP after implementation of ND Health Enterprise MMIS). These provider types must be working in the **Provider Specialty** areas: 001-General Practice, 011-Internal Medicine, 016-Obstetrics/Gynecology, 049-Pediatrics, 173-Family Practice.
>
> **Provider Type:** 047-Indian Health Services working in the **Provider Specialty** areas of 091-General Acute Care Hospital, 132-Ambulance, 300-End Stage Renal Dialysis Treatment, and 359-Clinic/ center.
>
> **Provider Type:** 026-Ambulatory Health Care Facilities working in the **Provider Specialty** areas of 268-Rural Health Clinics (RHC), or 361-Federally Qualified Health Center (FQHC).

If a Medicaid provider application specifies that the provider is one of the above types and is working in one of the specialty areas listed above, the state manually opens a PCCM participation span for that provider upon enrollment and this places them on the available PCP list. If the provider's application does not specify that they are of one of these types and they work in one of these specialty areas, that provider will not be placed on the available PCP list.

Changes in affiliations/service locations. Physician assistants (PA) will be recognized as one of the selectable PCP types following the October 5 implementation of ND Health Enterprise Medicaid Management Information System (MMIS).

PAs that choose to be a PCP for recipients in the PCCM program will have the same rights and responsibilities as the advance practice nurse practitioners and primary care physicians that choose to be a PCP.

Because a Physician Assistant license does not reflect a specialty area, they will not be placed on the available PCP list upon enrollment. They will need to follow the steps below for providers not on the available PCP list.

Any provider who is not on the available PCP list and would like to be, will need to contact the Managed Care staff with the following information:

1. Verification of their name and Medicaid provider number.
2. Verification that they are practicing in one of the provider specialties required, as noted above.
3. Completed Contract to Provide Primary Care Case Management Services (SFN 1296) located at www.nd.gov/eforms/Doc/sfn01296.pdf.

This information can be sent through the Managed Care inquiry inbox at dhsmci@nd.gov, or by mailing a hard copy of this information in the business reply envelope provided. Physician Assistants can start now to provide the above information so the PCCM participation span can be opened as soon as possible after the October 5 ND Health Enterprise MMIS implementation.

(PCCM) Program Update Continued

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

1. Changes in provider type or provider specialty (i.e. a family practice provider who starts working in cardiology only).

2. PCP accepting patient status change requests:

    a. Open PCP (accepting new patients).
    b. Full provider (keeping current patients but not accepting new patients without providers prior approval).
    c. Opted out (provider no longer wants to be a PCP for any recipients).

More information about the PCCM program is available starting on page 83 of the General Information for Providers Manual at www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf

Watch for updates on new ways to communicate changes through ND Health Enterprise MMIS after October 5 go-live.

Top Billing Errors

A "clean claim" is a claim that is submitted without errors and will auto adjudicate. Error codes prevent a claim from auto adjudicating though the MMIS claim processing system and can cause delays in processing of claims. Some of the top billing errors that will prevent a claim from adjudicating include the following:

Error 060 Submitted Charges Is Missing or Invalid. This error code can be avoided by ensuring that a valid billed amount is listed for each line item billed.

Error 014 Net Charge Out Of Balance. This error code can be avoided by ensuring that the totals between the primary insured and the net total on the claim balance and field 28 on the CMS 1500 claim form is not left blank.

Error 008 Recipient Number Is Not On File. This error can be avoided by ensuring that the correct ND Medicaid recipient identification number is valid and listed correctly on the claim form.

Error 005 Provider Name And Number Disagree. This error can be avoided by ensuring that the provider information on the claim matches what is in our system from when the provider enrolled. The system will try to match the provider number with the first two characters of the provider's name that is in our system.

Error 464 Hospital Bill On Professional Claim Form. This error can be avoided by ensuring that the correct claim form is being used for the services that are being billed.

Error 113 Performing Physician Not On Provider File. This error can be avoided by ensuring that not only is the provider NPI listed on the claim, but also the provider's ND Medicaid provider number.

NEW FACES IN MEDICAID

Alexi Murphy: Pharmacist II, pharmacy support.

Deb Vesey: HCBS Program Administrator

Jeanne Folmer: Program Integrity Audit Coordinator in the Program Integrity unit.

Julie Jochim: UR Clinical Administrator

Korbin Pehl: UR Clinical Administrator

Martina Many Guns: Provider Enrollment Specialist

Paula Hinton: Autism Program Assistant

Peggy Geloff: Administrative Receptionist and Administrative Assistant for the Support Staff Unit.

Shanna Mills: Administrator for TPL and Fraud and Abuse in the Program Integrity Unit.

Stacey Koehly: Administrative Assistant for the Support Staff Unit.

Trisha Page: Autism Coordinator

Valerie Thomsen: SURS Analyst with the Program Integrity Unit.

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