NORTH Dakota | Human Services
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North Dakota Medicaid Provider Newsletter
March 2022

Welcome to the North Dakota Medicaid Provider newsletter. We hope this newsletter provides you with important and beneficial information about the North Dakota Medicaid Program. If you have any suggestions for future articles, please send your ideas to dhsmed@nd.gov.

In this edition, you can learn about:

- Member eligibility renewals,
- New timely filing policy for Medicaid claims,
- Common reasons why claims are denied or suspended,
- Primary care provider referrals, and more!

Thank you for being a North Dakota Medicaid provider and serving our Medicaid members.

Member eligibility renewals

Medicaid coverage eligibility renewals were put on hold during the public health emergency to support the health and well-being of North Dakotans.

When the COVID-19 public health emergency ends, which is a federal decision, state Medicaid programs will need to determine whether Medicaid participants still qualify for Medicaid coverage. All state Medicaid agencies are required to complete this task.

Medicaid programs will also need to modify policies and procedures implemented temporarily during the public health emergency.

The North Dakota Department of Human Services is putting plans in place to address Medicaid coverage changes and help connect any impacted North Dakotans to other coverage resources, including the federal health care marketplace (HealthCare.gov) because many individuals may qualify for affordable health care coverage due to subsidies.

The department also intends to launch a comprehensive communications campaign to ensure impacted individuals are aware of pending changes and receive information about coverage options.

Does a Medicaid member need a primary care provider (PCP) referral?

When providers are checking to see if a Medicaid member needs a referral from a primary care provider (PCP), they **FIRST** need to check if the member is still enrolled in the Primary Care Case Management (PCCM) benefit plan.

If the member is enrolled on the date of service and is seeing a provider other than the PCP or a substitute PCP (a PCP type provider that works in the same facility), then a referral is required from the PCP or a substitute PCP **prior to** the service being provided.

If the member is not enrolled in the PCCM benefit plan on the day of service, there is no requirement for a PCP referral regardless of if there is a PCP listed.

**Please note that all PCP participation spans stay open for 60 days after the PCCM enrollment is ended. This is a federal requirement to keep an opening with that PCP in the event that the member is re-enrolled in the PCCM benefit plan within 60 days.

It is important to remember:

- **ND Medicaid does not accept retrospective PCP referrals** except for the 15-day grace period allowed for walk-in clinics to get the PCP referral after seeing a member.

- **Hospital and Emergency Room (ER) providers cannot make referrals**. Follow-up care after hospitalization and ER visits requires a referral from the PCP or a substitute PCP (a PCP type provider that works in the same facility).

The following status options are available to every PCP by requesting changes in their PCP status through dhsmci@nd.gov.

1. **Open**: The provider is open to acting as a PCP for more members.

2. **Full at a Designated Number**: The provider wants to be a PCP, but only for the current number of members who are assigned to them. This designated number given by the provider, is entered in the PCCM participation span as the max number of members. The provider understands that if some members leave, others may be added to keep the provider at the designated number of members. Once the provider's actual number of members has reached the designated number of members, no new members will be added without the PCP's written permission being submitted to dhsmci@nd.gov.

3. **Full until Closed**: The provider would like to be a PCP only to the current members. Zero is entered in the PCCM participation span as the max number of members. As members leave the provider, no other members should be added. Eventually, the provider will have no members. At that time, the PCCM participation span will be closed, and the provider will no longer be listed as an

available PCP. No new members would be added without the provider's written permission being submitted to dhsmci@nd.gov.

4. **Closed**: The provider would like to have their PCCM participation span closed. If this happens, all members who currently have the provider designated as their PCP will receive a letter telling them that they will need to choose a different PCP. The provider will no longer be listed as an available PCP for members to choose.

New Changes
Eligibility workers have been instructed to make PCP changes at any time regardless of open enrollment periods or good cause reasons that were required in the past. Efforts are being made to simplify the PCP change process possibly by the end of 2022. One option is to have a small group of individuals who are available by phone, so members can call one number (the Human Service Zone Call Center, not yet established) to have their PCP changed over the phone. PCP begin dates will **still NOT** be allowed to be added retrospectively.

Policy and system changes have been completed, so that if a member requests to have a certified nurse midwife as their PCP, the eligibility worker can now assign that certified nurse midwife as a PCP. As ND Medicaid does with other OB/GYN providers, none of these will be auto assigned, but can be entered by the eligibility worker upon the request of the member.

Claims Corner: Timely filing Information

The North Dakota Department of Human Services has a new timely filing policy that went into effect with claim dates of service on or after Jan. 1, 2022.

The **MOST significant change** is that original claims without Medicare or third party liability must be submitted within 180 days from the day of service.

Timely filing policy: https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/timely-filing-policy.pdf

Claims Corner: Why am I not getting paid?

Our claims experts share eight most common reasons why claims are denied or suspended in the ND Health Enterprise Medicaid Management Information System (MMIS).

1) 18 – Exact duplicate
Claim denied due to a previously paid claim with the same:
- Billing and rendering provider
- Date of service
- Procedure code/revenue code
- Billed amount

2) 204/27/26 – Member not eligible
Verify that the date of service was submitted correctly and is within the member's eligibility span. If this information is incorrect, correct and resubmit a 837 electronic or web portal electronic claim.

Verify that the member's identification number, last name, first name and date of birth were submitted correctly. If this information is incorrect, correct the claim and resubmit a 837 electronic or web portal electronic claim.

Verify that the date of service and the revenue or CPT procedure code(s) were submitted correctly. If this information is incorrect, correct the claim and resubmit a 837 electronic or web portal electronic claim.

If the above information has been verified to be accurate on the submitted claim, the member is not eligible for services and will be responsible for the charges.

3) 22 – Member has other insurance
Verify that the other insurance information/payment is on the claim showing the amount paid, deductible/coinsurance, contractual obligation, patient responsibility, etc.

If this information is not on the claim, correct the claim and resubmit a 837 electronic or web portal electronic claim with the other insurance on the detail line(s).

If approved to bill a paper claim form, an insurance explanation of benefits (EOB) is required to be attached to the claim form.

If faxing the insurance EOB, SFN 177 MMIS Claims Attachment form is required. It must have the Provider NPI or Medicaid ID Number, Member ID number and TCN number.

4) N255/16 – Billing provider taxonomy mismatch/invalid
Verify that the billing provider taxonomy code was submitted correctly.

If this information is incorrect, correct the billing provider taxonomy code and resubmit a 837 electronic or web portal electronic claim.

5) N288/16 – Missing/Invalid Rendering/Attending Taxonomy code
Verify that the rendering/attending provider taxonomy code was submitted correctly.

If this information is incorrect, correct the rendering/attending provider taxonomy code and resubmit a 837 P or 837 I electronic or web portal electronic claim.

6) B7 – Rendering/Attending Provider ID submitted on the claim is not on file
Verify that the rendering/attending provider on the 837 P or 837 I electronic claim form is correct and is an active provider with ND Medicaid.

If correct, resubmit a 837 P or 837 I or web portal electronic claim.

If correct and not an active rendering/attending provider, complete a provider enrollment application located online at https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment.

Need help? Email NDMedicaidEnrollment@noridian.com

7) M51/16 – Procedure code required to be submitted with revenue code
Verify that the procedure code was submitted on the claim.

If this information is missing, correct and resubmit the 837 I electronic or web portal electronic claim.

Verify that the procedure code was submitted on the claim.

If the procedure code was submitted, verify if the procedure code is correct. If not, correct and resubmit the 837 I electronic or web portal electronic claim. If the procedure code is correct, the procedure code is invalid.

8) MA30/MA43/16 – The patient status is invalid with the type of bill frequency code
Verify that the type of bill is correct according to the statement covered period (FL4) and patient discharge status code (FL17).

If this information is incorrect, resubmit the 837 I electronic or web portal electronic claim with the correct type of bill. If the type of bill is correct, the type of bill is invalid for the services billed.

Providers need to be careful when submitting their claims to select the correct bill type frequency to ensure proper payment.

Bill Types frequency (last digit of the bill type)
1 Admit through Discharge Claim
This code is to be used when a member is admitted and discharged in the same month. The member CANNOT be in the “still a patient” status.

2 Interim – First Claim
This code is used for the first claim and the discharge status (FL17) as “still a patient.”

3 Interim – Continue Claim
This code is used for the second and any ongoing months that have a discharge status (FL17) as “still a patient.”

4 Interim – Last Claim
This code is used for the final claim billed for the member.

REMINDERS:

Submit billing/claim note on adjusted claims
Providers who are adjusting claims need to be providing a claim note indicating the reason why the claim is being adjusted.

HCFA 1500 Paper Claim
Field Locator (FL) – 19 additional claim information

Web Portal Professional Claim
Claim Note
Type Code – Select additional information
Type Note – add any pertinent information to why the claim is being adjusted.
Examples: Rate change, corrected units, corrected procedure code, etc.
Electronic 837 P
Loop and segment – 2300 NTE

Professional

2300	NTE	Claim Note
2300	NTE01	Note Reference Code
2300	NTE02	Description

Type Note – add any pertinent information to why the claim is being adjusted.
Examples: Rate change, corrected units, corrected procedure code, etc.

UB04 Institutional Paper Claim
Field Locator (FL) – 80 remarks
Type Note – add any pertinent information to why the claim is being adjusted.
Examples: Rate change, corrected units, corrected procedure code/revenue code, etc.

Web Portal Institutional Claim
Billing Note
Type Note – add any pertinent information to why the claim is being adjusted.
Examples: Rate change, corrected units, corrected procedure code/revenue code, etc.

Electronic 837 I
Loop and segment – 2300 NTE

Institutional

2300	NTE	Claim Note
2300	NTE01	Note Reference Code
2300	NTE02	Description

Type Note - add any pertinent information to why the claim is being adjusted
Examples: Rate change, corrected units, corrected procedure code/revenue code, etc.

Web Portal Dental Claim
Claim Note
Type Note - add any pertinent information to why the claim is being adjusted
Examples: Rate change, corrected units, corrected ADA code, corrected tooth number/surface/oral cavity etc.

Electronic 837 D
Loop and segment – NTE

Dental

2300	NTE	Claim Note
2300	NTE01	Note Reference Code
2300	NTE02	Description

Type Note – add any pertinent information to why the claim is being adjusted.
Examples: Rate change, corrected units, corrected ADA code, corrected tooth number/surface/oral cavity, etc.

Third Party Bill Policy
ND Medicaid defines a third-party biller as an organization that acts on behalf of another party performing various insurance duties. A third-party biller may assist in the process of insurance coverage or claims submission or perform various other tasks.

Third Party Bill Policy link:
https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/third-party-bill.pdf

Announcing a change with paper dental claims

As of May 1, 2022, ND Medicaid will no longer accept any paper dental claims. Paper dental claims received on or after May 1, 2022, will be returned to the provider unless an exemption has been approved by ND Medicaid.

Requesting an Exemption
Providers who are not included on the automatic exemption list above and wish to receive an exemption, will need to submit an exemption request in writing or via email using the department's approved form online at https://www.nd.gov/eforms/Doc/sfn00447.pdf.

Submit by fax, email, or mail to:
Fax: Providers can fax this form to 701-328-1544 - ATTN: Michelle Adams
Email: mladams@nd.gov
Mailing address:
Medical Services - ATTN: Michelle Adams
North Dakota Department of Human Services
600 E. Boulevard Ave., Dept. 325
Bismarck, ND 58505-0250

All dental claims must be submitted as a 837 D electronic transaction or through the ND Provider Web Portal at https://mmis.nd.gov/portals/wps/portal/.

Electronic claims submission instructions are online at http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html.

NOTE: FAXED claims are not accepted for submitting for payment.

Questions: Contact the ND Medicaid Call Center at 877-328-7098 / 701-328-7098 or email mmisinfo@nd.gov.

Reminder about recipient liability

Recipient liability (RL) is a monthly amount some members pay toward the cost of their medical services, before Medicaid pays for services received, similar to a monthly deductible.

As claims are applied to a member's ID, ND Medicaid applies RL to the claim amounts based on the order in which the claims are submitted and processed. The RL may be applied to one or more claims. Once the entire monthly RL amount is applied, ND Medicaid pays for other covered services received during the month.

When RL is applied to a claim, ND Medicaid sends a notice to the member showing the provider's name, date of service, and the amount of RL owed to the provider. The member is responsible for paying the RL to the provider(s) listed on the notice.

Providers are notified via the remittance advice (RA) of the amount of RL owed from a member. Providers (except for Point of Sale Pharmacy) may not collect RL at the time of service.

When filing claims with the ND Medicaid program, the provider agrees to accept ND Medicaid payment as payment in full. The provider CANNOT BILL the recipient for any part of the bill unless the RA indicates an RL applies to the services, or it is a noncovered service.

ND Medicaid has created a fact sheet for Medicaid members that explains RL in more detail - https://www.nd.gov/dhs/info/pubs/docs/medicaid/fact-sheet-medicaid-recipient-liability.pdf.

Provider Contact Information

The North Dakota Health Enterprise Medicaid Management Information System (MMIS) has the availability to add contact information specific to different responsibilities within an organization.

The Medical Services Division's Program Integrity Unit requests a contact person for audits, medical records and recovery letters, if different from the audit contact person.

The information request includes a person's name, title (optional), email and phone number. This contact information helps the Program Integrity Unit in ensuring we are reaching out to the appropriate staff.

Please send your contact information to NDMedicaidEnrollment@noridian.com.

Upcoming Meetings

Medicaid Medical Advisory Committee
May 17 – 4 to 6 p.m. CT
Aug. 16 – 4 to 6 p.m. CT
Nov. 15 – 4 to 6 p.m. CT

Autism Spectrum Disorder Task Force
May 23 – 1 to 4:30 p.m. CT
Aug. 29 – 1 to 4:30 p.m. CT
Nov. 28 – 1 o 4:30 p.m. CT

Money Follows the Person Program
May 17 – 1 to 4 p.m. CT
Aug. 9 – 1 to 4 p.m. CT
Nov. 8 – 1 to 4 p.m. CT

U.S. Department of Justice N.D. Settlement Agreement Stakeholders
June 9 – 1 to 3 p.m. CT
Sept. 15 – 1 to 3 p.m. CT
Dec. 8 – 1 to 3 p.m. CT

REMINDER:
ND Medicaid Provider newsletters are published four times a year. If you missed an edition, you missed a lot. See past newsletters at https://www.nd.gov/dhs/info/pubs/medical.html under Provider Newsletter heading.