PROVIDER INFORMATION

COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND POLICIES

Providers enrolled with ND Medicaid must follow all applicable rules of ND Medicaid and all applicable state and federal laws, regulations, and policies including:

- United States Code (U.S.C.) governing the Medicaid program;
- Code of Federal Regulations (CFR);
- North Dakota Century Code;
- North Dakota Administrative Code;
- Federal Department of Health and Human Services policies governing the Medicaid program;
- Written policies of the North Dakota Department of Health and Human Services; and
- All state laws and rules governing provider licensure and certification, as well as the standards and ethics of their business or profession.

Providers must be familiar with all current rules and regulations governing the ND Medicaid program. Provider manuals are to help providers in billing ND Medicaid; they do not have all ND Medicaid programs rules and regulations. Any rule citations in the manual are for reference and are not a summary of the entire rule.

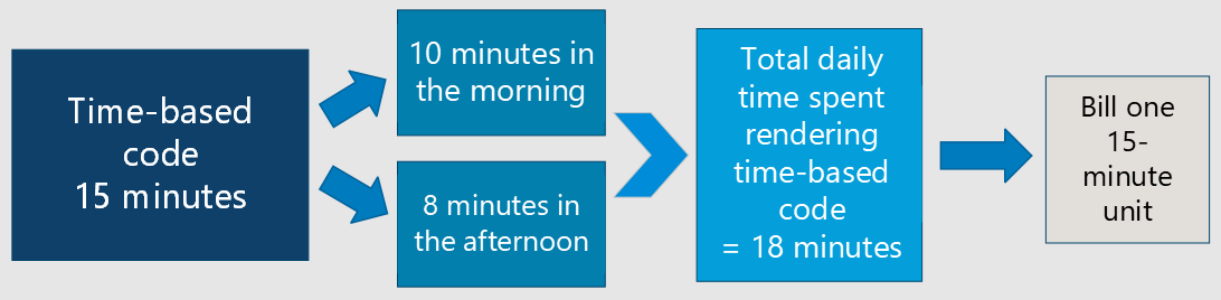
TIME BASED UNITS

Time is the face-to-face time spent with a member.

When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.

A unit of time is attained when the mid-point is passed. For example, a 15-minute unit is attained when 8 minutes have elapsed. A second 15-minute unit is attained when a total of 23 minutes have elapsed.

When billing for one code that is billed in units throughout a day, report the total amount of units on one claim line.



MEMBER PARITY

Providers must treat members and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by applicable regulations).

DOCUMENTATION GUIDELINES FOR MEDICAID SERVICES

Documentation records must:

- Thoroughly document the extent of services rendered and billed. These records are used to decide medical necessity and correct billing.
- Be in their original or legally reproduced form. This may be electronic.
- Support the time spent rendering a service for all time-based codes. «i.e. Start and stop time or total time spent with the member providing a service. »
- Be kept for a minimum of seven (7) years from the date of their creation or the date when they were last in effect, whichever is later. Note: state law may require a longer retention period for some provider types.
- Be signed by the ND Medicaid-enrolled provider rendering the service. Claims selected for an audit that don't have signed records shall be denied.
- Be legible, promptly completed, dated, and authenticated «(signed)» in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy. Signatures must follow Medicare requirements.
- Be kept confidential.

WHAT DOES DOCUMENTATION INCLUDE?

Documentation includes:

1. Medical records including:
    - Patient's name and date of birth;
    - Date of service;
    - The length of time spent with the member, as necessary to support payment for billed services;
    - Name and title of provider rendering the service, if other than the billing practitioner;
    - Chief complaint or reason for each visit;
    - Pertinent medical history;
    - Pertinent findings on examination;
    - Medication, equipment and/or supplies prescribed or provided;
    - Description of treatment or service provided;
    - Recommendations for additional treatments, procedures, or consultations;
    - Diagnostic tests and results;
    - Dental photographs/teeth models;
    - Certification of medical necessity (if applicable)
    - Plan of treatment and/or care and outcome; and
    - Signature and date by the person ordering or rendering the service.

- Service authorization information;
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to members;
- Records and original invoices for items that are prescribed, ordered, or furnished; and
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers, and other financial information.

AMENDING MEDICAL DOCUMENTATION

Any change or addition to a medical record needs to have the current date of that entry and be signed by the person making the change or addition.

Late entries supply additional information that was not included in the original record.

- The person documenting must have total recall of the omitted information.

Additions provide information that was not available at the time the original record was made.

- The reason for adding or clarifying information must be added to the medical record.

Corrections are necessary when there is an error in the documentation.

- Do not omit or write over any errors in the medical record. Draw a single line through the erroneous information, ensuring the original entry is legible.
- Sign or initial and date the deletion and state the reason for the correction.
- Document the correct information on the next line or space and refer back to the original entry.

These requirements apply to electronic health records. When a hard copy is generated from an electronic record both records must show the correction. A corrected record must clearly reflect the specific change made, the date of the change, and the identity of the person making the entry.

FALSIFIED INFORMATION

Deliberate falsification of medical records may be cause for termination from the Medicaid program. Examples of falsifying medical records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over or adding to existing documentation (except as described in the AMENDING MEDICAL DOCUMENTATION section above).

WHAT IS MEDICAL NECESSITY?
Medically necessary/medical necessity means

- Medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment;
- Consistent with the recipient's diagnosis or symptoms;
- Appropriate according to generally accepted standards of medical practice;
- Not provided only as a convenience to the recipient or provider;
- Not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and
- Provided at the most appropriate level of service that is safe and effective.

See N.D. Admin. Code § 75-02-02-03.2(10).

HOW DO I HANDLE CONFIDENTIALITY AND RECORDS ACCESS?
All member and applicant information and related medical records are confidential and must be protected subject to applicable laws. ND Medicaid personnel and authorized agents are permitted access to information concerning any services that may be covered by Medicaid. This access does not require authorization by the member because disclosure to carry out treatment, payment, or healthcare operations are allowed under HIPAA. See C.F.R. § 164.506. This includes health plans contracting with ND Medicaid for information relating to Medicaid services reimbursed by the health plan.

Providers must make available for examination and photocopying, upon request from authorized agents of the state or federal government, all:

- Medical records,
- Quality assurance documents,
- Financial records,
- Administrative records, and
- Other documents and records that must be maintained.

If providers are using electronic medical records, they must have a medical record system that ensures the record may be accessed and retrieved promptly. Failure to make records available may result in the provider’s suspension and/or termination from Medicaid.

Release of records to other individuals may only happen if there is a signed release from the member authorizing access to the records or if the disclosure is for a permitted purpose under applicable confidentiality laws.

REQUIREMENTS FOR ORDERING, REFERRING AND PRESCRIBING PROVIDERS
ND Medicaid requires ordering, referring, or prescribing providers to enroll as a participating provider. ND Medicaid cannot pay for ND Medicaid-covered services requiring a referral, order, or prescription unless the referring, ordering, or prescribing provider is enrolled. «Services requiring an order or referral are listed on the Medicaid Covered Services policy. «See Ordering/Referring/Prescribing Providers policy and list of codes requiring ORP Provider NPI for more info.»

AM I ELIGIBLE TO BILL THROUGH A SUPERVISING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI)?

Providers eligible to enroll with ND Medicaid may not bill through a supervising provider's NPI (See Section "Am I Able to Enroll as a Provider?" for more information.)

Services rendered by trainees and health care providers with limited licenses, meaning providers licensed as assistants and those who must practice under supervision[1] pursuant to North Dakota laws and regulations applicable to their profession, may be billed through the supervising provider's NPI number so long as the supervisee is not required to enroll and bill under their own NPI (Behavioral health care providers[2] eligible to render behavioral health rehabilitative services may not bill for services under a supervising practitioner's NPI). Please see the Behavioral Health Rehabilitative Services policy for more information).

Services provided by a health care provider with a limited license or a trainee practicing under supervision must:

- be documented in medical records.

Supervising health care providers must be responsible for:

- satisfying all applicable state law and regulatory supervision requirements; and
- patient care provided by a supervisee.

VERIFICATION OF MEMBER ELIGIBILITY

Providers must verify a member's Medicaid eligibility status before supplying services to the member. This can be done in one of three ways:

1) Log into ND Health Enterprise MMIS https://mmis.nd.gov/portals/wps/portal/EnterpriseHome. Click on the Member tab then select Check Eligibility.
2) Call the Provider Relations Call Center at (701) 328-7098 or (877) 328-7098.
3) Use the Automated Voice Response System (AVRS). Directions for using AVRS are below.

The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- Member Inquiry
- Payment Inquiry

[1] Supervision means the physician or other supervising provider must direct and oversee the service according to professional requirements in state law, rules, or guidelines of a regulating/licensing board or organization. It does not mean that the physician or other supervising provider must be present in the room when the service is rendered unless applicable laws or regulations for the profession require in-room presence.

[2] Behavior Modification Specialists, Licensed Associate Professional Counselors, Licensed Master and Baccalaureate Social Workers, Mental Health Technicians, Registered Nurses.

- Claims Status
- Service Authorization Inquiry

AVRS Access Telephone Numbers (available 24/7)
Toll Free: 877-328-7098
Local: 701-328-7098

Providers are granted access to the Automated Voice Response System (AVRS) by entering their ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One provider PIN number is assigned to each Medicaid ID number. Providers who have a NPI that is associated with more than one Medicaid ID number must use the PIN number assigned to the Medicaid ID number used to access AVRS.

Touch Tone Phone Entry	Function
*****	Repeat the options
9 (nine)	Return to main menu
0 (zero)	Transfer to Provider Call Center (M-F 8am – 5pm CT) -or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVRS at any point to speak with a provider call center customer service representative. The call center is available during regular business hours from 8am to 5pm central time, Monday through Friday, and observes the same holidays as the state of North Dakota. Providers may leave a voicemail message when the call center is not available. Provider voicemail messages will be responded to in the order received; and except during heavy call times, response will be the following business day during regular business hours.

AVRS Options	Secondary Selections
Option 1: **Member Inquiry**	Callers may select any of the following options: • Eligibility/Recipient Liability • Primary Care Provider (PCP) • Coordinated Services Program (CSP) enrollment • Third Party Liability (TPL) • Vision • Dental • Service Authorizations • 1915(i) Eligibility
Option 2: **Payment Inquiry**	Remittance Advice payment information is available for the specific time frame entered.
Option 3: **Claims Status**	Claim information is available based upon the Member ID number entered, including: • TCN (Transaction Control Number) • Billed Amount

	• Claim Submit Date • Date(s) of Service • Claim Status (paid, denied, suspended) • Paid Amount (if applicable)
Option 4: **Service Authorization Inquiry**	Service Authorization information is available based upon the Member ID number entered, including: • Service Authorization (SA) Number • Date(s) of Service • Authorization Status

PAYMENT FOR SERVICES

Medicaid payment for covered services will be made to providers when the following conditions are met:

- Provider is enrolled with ND Medicaid.
- Services are rendered by practitioners licensed and operating within the scope of their practice as defined by law.
- Member is eligible for Medicaid on the date of service.
    - Verify a member's eligibility status and PCCM[3] enrollment prior to supplying services to the member. If the member is enrolled in PCCM, you must assure referrals from the member's designated PCP are in place for any services received by the member to receive consideration of payment by ND.
    - NOTE: The date of service cannot be after a member's date of death[4].
- Service is medically necessary.
    - ND Medicaid may review medical necessity at any time before or after payment.
- Service is covered by ND Medicaid and is not considered experimental or investigational.
- Service authorization requirements are met where applicable.
- Medicaid are billed according to rules and instructions as described in this manual, the most current Provider Bulletin, and the ND Medicaid website.
- Billed charges are usual and customary.
    - Usual and customary charge" refers to the amount the provider charges the public, in most cases, for a specific item or service. Providers may not charge ND Medicaid a higher fee than that charged to non-Medicaid covered individuals, even if the ND Medicaid fee schedule amount is greater than the provider's usual and customary charge. If special discounts are available to non-Medicaid covered individuals, claims submitted to ND Medicaid must represent the same discounted charges as those available to the general public.

[3] The Primary Care Case Management (PCCM)program ended 12/31/2023. Information contained in this policy applies to dates of service prior to 01/01/2024.

[4] A claim may process and pay if the member's date of death is not yet updated in the state eligibility system. Paid claims with a date of service after the date of death will be recouped on audit.

- Payment to providers from Medicaid and all other payers do not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at $0.
- Claims meet timely filing requirements.
- If the member has TPL, services were billed in accordance with the TPL requirements.

SERVICE AUTHORIZATIONS

Service authorizations (SA) are required for certain procedures, services, and items before being initiated, supplied, or performed. Please refer to specific service chapters or manuals as appropriate for more SA-related guidance. A list of services requiring service authorizations can be found here. Failure to obtain an SA will result in the denial of the service or supply.

All claims are subject to post-payment review or audit. Any service or supply paid without an approved SA is subject to recoupment. Approved service authorizations are service, supply, and provider-specific and are non-transferrable. An approved SA can only be modified by a written request from a provider at the department's discretion. Web-based authorizations cannot be altered by the department and require resubmission.

Before submitting SA documentation, please:

- Ensure forms are complete and accurate.
- Include pertinent SA documentation. You may expedite the review process by highlighting documentation that specifically supports the SA's medical necessity.
    - Documents must include:
        - Matching requested date spans on all forms and documents.
        - Order/referral dates that are related to the SA requested dates.

Requests not meeting these criteria could be returned, denied, or rejected as incomplete.

RETROACTIVE SERVICE AUTHORIZATIONS

Retroactive service authorizations may be submitted for consideration up to 90 days from the date of service with good cause i.e., urgent/emergent medical conditions, retrospective eligibility. They should not be used on a routine basis.

Retroactive authorization requests are reviewed and decided internally on a case-by-case basis.

The Department will only consider timely, retroactive, or extension SA requests if all required forms and supporting information are submitted. Submissions that are incomplete or missing information will be returned or denied. Any re-submissions will need to be updated for dates, documentation, and orders so that they are current and complete based on the type of SA being submitted. The Department will not keep documentation from earlier submissions. Decisions will be based on the newest date of submission, not an earlier submission date.

WHAT IF THE MEMBER HAS OTHER INSURANCE?
Do not send claims to Medicaid until the charges are processed by the primary payer for members also covered by Medicare, other insurance, or when another third-party is responsible for the cost of the member's health care.

NATIONAL CORRECT CODING INITIATIVE (NCCI)
ND Medicaid follows the National Correct Coding Initiative (NCCI) Edits. The Centers for Medicare and Medicaid Services (CMS) developed these edits based on coding conventions defined in the American Medical Association's Correct Procedure Terminology Manual, national and local polices and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS annually updates the National Correct Coding Initiative Coding Policy Manual. For additional information reference www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html.

MEDICAID PAYMENT IS PAYMENT IN FULL
Providers must accept Medicaid payment as payment in full for any covered service, except recipient liability that should be collected from the member.

WHEN CAN A MEDICAID MEMBER BE BILLED?
In most circumstances, providers may not bill members for services covered by Medicaid. Providers may bill members directly under the following circumstances:

- For recipient liability (RL) amount documented on the remittance advice. Providers (except for Point-of-Sale Pharmacy) may not collect RL at the time of service.
- For services not covered by ND Medicaid, if the member was given advance notice prior to rendering services.
- If a provider chooses not to enroll as a Medicaid provider, the member is responsible for all charges if the member was given advance notice prior to rendering services.

Providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid; Medicaid payment is payment in full.
- When the provider bills Medicaid for a covered service and Medicaid denies the claim because of billing errors; or
- When the provider fails to secure the necessary service authorization.