Medicaid Expansion
Provider Manual

Blue Cross Blue Shield of North Dakota

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INTRODUCTION

Blue Cross Blue Shield of North Dakota (BCBSND) recognizes that, at times, the administrative requirements of managing a patient's health care can be complex. This Provider Manual answers the common questions about health plan coverage, claims filing procedures, policies and other facts related to administering care to BCBSND members.

This Provider Manual is not a complete statement of all provider-related policies, procedures or standards of BCBSND. It outlines certain, but not all, policies and procedures adopted by BCBSND with respect to provider participation, claims filing and related subjects. Other policies and procedures are published regularly in HealthCare News, on the BCBSND website, in our member benefit certificates or health plans, or in other special publications, letters or notices, including credentialing standards, appeals policies and procedures, network terms and conditions, and provider contracts.

Unless otherwise indicated, all references in this manual to "company" refer to Blue Cross Blue Shield of North Dakota.

Disclaimer: Participation Agreements and Benefit Plans Supersede This Manual

If information within this manual conflicts with your contractual Participation Agreement or a member's benefit plan, the Participation Agreement or benefit plan information should be used. This manual is provided for the convenience of BCBSND Medicaid Expansion participating providers. The manual is not a legally binding document, and its content does not guarantee coverage of any service, treatment, drug or supply. Coverage is governed exclusively by the terms of the member's benefit plan.

BCBSND makes no representations or warranties with the content of this manual. Neither this manual nor any statement in it constitutes a contract, policy, promise or obligation on the part of BCBSND.

BCBSND may revise this manual without notification. BCBSND may also change any contract, policy, benefit plan or process referenced in this manual without updating this publication. Changes to this manual, or to policies or procedures referenced in this manual, may be made by BCBSND at any time. BCBSND may give notice of such updates in a variety of ways, including a letter to providers, publication in HealthCare News newsletter or other publications of BCBSND, or posting to the BCBSND website at www.BCBSND.com. If you have questions about coverage, contact Provider and Member Service at 1-833-777-5779.

BCBSND Accreditation

BCBSND holds full Utilization Review Accreditation Commission (URAC) accreditation for Health Plan and Health Plan with Health Insurance Marketplace. URAC is an independent, nonprofit health care accrediting organization promoting health care quality through accreditation, education and measurement. URAC reviews a company's operations to ensure that the company is conducting business in a manner consistent with national standards. URAC accredits many types of health care organizations for different programs, such as Health Plan Accreditation, which reviews the entire organization's health plan standards. The standards guide policy development in areas important to provider networks, including:

- Network management
- Credentialing
- Quality management, including quality measures reporting requirements
- Health utilization management

For more information about URAC, visit www.urac.org.

ELIGIBILITY COVERAGE AND BENEFITS

The North Dakota Department of Health and Human Services (DHHS) determines eligibility for the North Dakota Medicaid Expansion Program and provides the required information to BCBSND. A member will lose eligibility and coverage for Medicaid Expansion when any of the following occurs:

- The member ceases to be a resident of North Dakota or moves outside of the state of North Dakota.
- The member ceases to satisfy any eligibility requirement for the North Dakota Medicaid Expansion Program.
- The member is enrolled in or covered by Medicare, North Dakota's traditional Medicaid Program or any other state's Medicaid Program.
- The member dies.

This benefit plan does not cover newborns or dependents. Members who become pregnant may change to the North Dakota Medicaid Program.

ND DHHS will notify members of the effective date of coverage. BCBSND will mail members an identification card and enrollment packet with plan materials.

ND DHHS may notify BCBSND that a member has lost eligibility retroactively. When this happens, federal regulations require BCBSND to recoup payments.

Below is a list of Covered Services. Note, this is not a guarantee of payment. If you have questions regarding eligibility and/or benefits, call Provider Services at 1-833-777-5779.

Covered Services

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Inpatient Hospital and Medical Services		
▪ Inpatient Hospital Services	100% of Allowed Charge	No Coverage
▪ Inpatient Medical Care Visits	100% of Allowed Charge	No Coverage
▪ Transitional Care Unit Services	100% of Allowed Charge	No Coverage
▪ Ancillary Services	100% of Allowed Charge	No Coverage
▪ Inpatient Consultations	100% of Allowed Charge	No Coverage
▪ Concurrent Services	100% of Allowed Charge	No Coverage
Inpatient and Outpatient Surgical Services		
▪ Professional Health Care Provider Services	100% of Allowed Charge	No Coverage
▪ Assistant Surgeon Services	100% of Allowed Charge	No Coverage
▪ Ambulatory Surgical Facility Services	100% of Allowed Charge	No Coverage
▪ Hospital Ancillary Services	100% of Allowed Charge	No Coverage
▪ Anesthesia Services	100% of Allowed Charge	No Coverage
▪ Bariatric Surgery	100% of Allowed Charge Benefits are subject to a lifetime maximum of one operative procedure per member when precertification is received from BCBSND. Covered services must be received from a surgical facility approved by BCBSND.	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Transplant Services		
▪ Inpatient and Outpatient Hospital and Medical Services	100% of Allowed Charge when precertification is received from BCBSND. Covered services must be received from a transplant facility approved by BCBSND.	No Coverage
Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment	100% of Allowed Charge Benefits are subject to a lifetime maximum of two surgical procedures per member and a maximum benefit allowance of one splint per member per benefit period.	No Coverage
Outpatient Hospital and Medical Services		
▪ Home and Office Visits	100% of Allowed Charge	No Coverage
▪ Diagnostic Services	100% of Allowed Charge	No Coverage
▪ Emergency Services	100% of Allowed Charge for emergency room facility fee billed by a hospital.	100% of Allowed Charge for emergency room facility fee billed by a hospital.
	100% of Allowed Charge for office or emergency room visit billed by a professional health care provider.	100% of Allowed Charge for office or emergency room visit billed by a professional health care provider.
	100% of Allowed Charge for all ancillary services received in an emergency room or professional health care provider's office.	100% of Allowed Charge for all ancillary services received in an emergency room or professional health care provider's office.

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
▪ Urgent Care Services at Urgent Care Center or Facility	100% of Allowed Charge	No Coverage
▪ Dental Services		
• Accidental Injury	100% of Allowed Charge	No Coverage
• Dental Anesthesia and Hospitalization	100% of Allowed Charge Precertification is required.	No Coverage
▪ Second Opinions		
• Diagnostic Services	100% of Allowed Charge	No Coverage
• Related Office Visit	100% of Allowed Charge	No Coverage
▪ Radiation Therapy and Chemotherapy	100% of Allowed Charge	No Coverage
▪ Dialysis Treatment	100% of Allowed Charge	No Coverage
▪ Home Infusion Therapy Services	100% of Allowed Charge	No Coverage
▪ Allergy Services	100% of Allowed Charge	No Coverage
▪ Phenylketonuria (PKU) – Foods and food products for the dietary treatment of members born after 12/31/62 with phenylketonuria	100% of Allowed Charge	No Coverage
▪ Amino Acid-Based Elemental Oral Formulas	100% of Allowed Charge	No Coverage

Wellness Services

A health care provider will counsel members as to how often preventive services are needed based on the age, gender and medical status of the member.

▪ Preventive Screening Services		
• Routine Physical Examination (Office Visit)	100% of Allowed Charge	No Coverage
▪ Immunizations	100% of Allowed Charge	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
	Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus, Tetanus, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.	
▪ Routine Diagnostic Screenings:	100% of Allowed Charge	No Coverage
• Lipid disorders screening once every five years		
• Osteoporosis screening for female members once every two years		
• Sexually Transmitted Disease (STD) screening		
• Diabetes screening		
• Hepatitis C Virus (HCV) screening		
• Lung cancer screening for members age 50 and older with a smoking history of 20 packs per year		
• Hepatitis B Virus (HBV) screening for members at high risk		
• Tuberculosis screening	100% of Allowed Charge	No Coverage
▪ Breast Cancer Screening		

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
• Mammography with or without Digital Breast Tomosynthesis Screening (3D Mammography)	100% of Allowed Charge. One service for members between the ages of 35 and 40. One service per year for members age 40 and older.	No Coverage
▪ Cervical Cancer Screening	100% of Allowed Charge Maximum benefit allowance of one pap smear per benefit period.	No Coverage
• Related Office Visit	100% of Allowed Charge	No Coverage
▪ Colorectal Cancer Screening for members age 45 and older		
• Fecal Occult Blood Testing (FOBT), Fecal Immunochemical Tests (FIT) – maximum benefit allowance of one test per benefit period; and	100% of Allowed Charge	No Coverage
• FIT DNA – maximum benefit allowance of one test every three years; or	100% of Allowed Charge	No Coverage
• Colonoscopy – maximum benefit allowance of one test every 10 years; or	100% of Allowed Charge	No Coverage
• Sigmoidoscopy – maximum benefit allowance of one test every five years.	100% of Allowed Charge	No Coverage
▪ Prostate Cancer Screening for members age 40 and older	100% of Allowed Charge	No Coverage
• Related Office Visit	100% of Allowed Charge	No Coverage
▪ Intensive Behavioral Interventions for Obesity	100% of Allowed Charge Maximum benefit allowances of 26 visits per member per benefit period.	No Coverage
▪ Nutritional Counseling	100% of Allowed Charge	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
• Hyperlipidemia	Maximum benefit allowance of four visits per member per benefit period.	
• Gestational Diabetes	Maximum benefit allowance of four visits per member per benefit period.	
• Diabetes Mellitus	Maximum benefit allowance of four visits per member per benefit period.	
• Hypertension	Maximum Benefit Allowance of two visits per member per benefit period.	
▪ Outpatient Nutritional Care Services (including Feeding and Eating Disorders)	100% of Allowed Charge Maximum benefit allowance of four office visits per member per benefit period for members diagnosed with PKU.	No Coverage
▪ Diabetes Education Services	100% of Allowed Charge	No Coverage
▪ Diabetes Prevention Program	100% of Allowed Charge	No Coverage
▪ Comprehensive Eye Examination with Dilation for Medical Conditions	100% of Allowed Charge Maximum benefit allowance of one examination per member per benefit period.	No Coverage
▪ Tobacco Cessation Counseling Services	100% of Allowed Charge	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Outpatient Therapy Services		
▪ Rehabilitative Therapy		
• Physical Therapy	100% of Allowed Charge	No Coverage
• Occupational Therapy	100% of Allowed Charge	No Coverage
• Speech Therapy	100% of Allowed Charge	No Coverage
▪ Habilitative Therapy		
• Physical Therapy	100% of Allowed Charge	No Coverage
• Occupational Therapy	100% of Allowed Charge	No Coverage
• Speech Therapy	100% of Allowed Charge	No Coverage
▪ Other Therapy Services		
• Respiratory Therapy Services	100% of Allowed Charge	No Coverage
• Cardiac Rehabilitation Service	100% of Allowed Charge	No Coverage
• Pulmonary Rehabilitation Services	100% of Allowed Charge	No Coverage
• Vision Therapy	100% of Allowed Charge	No Coverage
Chiropractic Services	Maximum benefit allowance of 20 visits per member per benefit period.	
▪ Home and Office Visits	100% of Allowed Charge	No Coverage
▪ Therapy and Manipulations	100% of Allowed Charge	No Coverage
▪ Diagnostic Services	100% of Allowed Charge	No Coverage
Maternity Services		
▪ Inpatient Hospital and Medical Services	100% of Allowed Charge	No Coverage
▪ Prenatal and Postnatal Care Services	100% of Allowed Charge	No Coverage
• Related Prenatal or Postnatal Office Visit	100% of Allowed Charge	No Coverage
▪ Lactation Counseling	100% of Allowed Charge	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Family Planning Services	100% of Allowed Charge	100% of Allowed Charge
Contraceptive Services	100% of Allowed Charge	100% of Allowed Charge
▪ Related Office Visit	100% of Allowed Charge	100% of Allowed Charge
Psychiatric and Substance Abuse Services		
▪ Psychiatric Services		
• Inpatient	100% of Allowed Charge Precertification may be required.	No Coverage
• Residential Treatment	100% of Allowed Charge Precertification is required.	No Coverage
• Partial Hospitalization	100% of Allowed Charge	No Coverage
• Intensive Outpatient Program	100% of Allowed Charge	No Coverage
• Outpatient		
– Home and office visits including assessment, counseling, Behavioral Modification Intervention for Autism Spectrum Disorder, including Applied Behavioral Analysis (ABA), treatment planning, coordination of care, psychotherapy and group therapy	100% of Allowed Charge Precertification may be required.	No Coverage
– Outpatient services including diagnostic testing, diagnostic procedures and treatment procedures	100% of Allowed Charge Precertification may be required.	No Coverage
▪ Substance Abuse Services		

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
• Inpatient	100% of Allowed Charge Precertification is required.	No Coverage
• Residential Treatment	100% of Allowed Charge Precertification is required.	No Coverage
• Partial Hospitalization	100% of Allowed Charge	No Coverage
• Intensive Outpatient Program	100% of Allowed Charge	No Coverage
• Outpatient		
– Home and office visits including assessment, counseling, treatment planning, coordination of care, psychotherapy and group therapy and opioid treatment program	100% of Allowed Charge Precertification may be required.	No Coverage
– Outpatient services including diagnostic testing, diagnostic procedures and treatment procedures	100% of Allowed Charge Precertification may be required.	No Coverage
Ambulance Services		
▪ Ground Ambulance	100% of Allowed Charge	No Coverage
▪ Air Ambulance	100% of Allowed Charge Precertification may be required.	No Coverage
Skilled Nursing Facility Services	100% of Allowed Charge Benefits are subject to a maximum benefit allowance of 30 days per member per benefit period.	No Coverage
Home Health Care Services	100% of Allowed Charge	No Coverage

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Hospice Services	100% of Allowed Charge	No Coverage
Private Duty Nursing Services	100% of Allowed Charge	No Coverage
Medical Supplies and Equipment ▪ Home medical equipment ▪ Orthotic devices ▪ Supplies for administration of prescription medications ▪ Oxygen equipment and supplies ▪ Ostomy supplies ▪ Prosthetic appliances and limbs	100% of Allowed Charge	No Coverage
▪ Hearing aids	Maximum benefit allowance per member of one hearing aid per ear every three years. Precertification is required.	
Breast Pumps	100% of Allowed Charge Benefits are available for the rental or purchase of one breast pump per pregnancy.	No Coverage
Telehealth	100% of Allowed Charge	No Coverage
Transportation Services	100% of Allowed Charge Approval may be required.	No Coverage

All non-emergency medical transportation must receive approval from BCBSND at least two business days in advance of the scheduled appointment. Members should call Member Services at 1-833-777-5779.

Meals and Lodging Services	100% of Allowed Charge Approval is required.	No Coverage

Members must receive approval from BCBSND for meals and lodging at least two business days in advance of the scheduled appointment. Benefits for meals and lodging are allowed only when medical services or transportation require a member to be away overnight. Members should call Member Services at 1-833-777-5779.

Outpatient Prescription Medications or Drugs
Retail outpatient pharmacy benefits are administered by the Department of Health and Human Services (DHHS) and not by BCBSND. Members will have a different identification card from the DHHS to use when filling retail outpatient prescriptions. Members or Providers should contact the DHHS with retail questions about pharmacy benefits at 1-800-755-2604 l TTY: 711.

Second Opinions
When requested, a second opinion is covered when the service is received from a network provider. If a network provider is not available, this service is covered by an out-of-network provider at no cost to the member. An authorized referral is required for out-of-network services using the Precertification request option in the Availity Essentials provider portals.

Referrals for Out-of-Network Services

Individuals enrolled in Medicaid Expansion are eligible for benefits when they receive healthcare services from a provider within the Medicaid Expansion network. If a member needs services from an out-of-network provider, such as a second opinion, a provider participating within the Medicaid Expansion network is responsible for submitting a referral request for that out-of-network service. This referral process does not apply to members who are a part of the CSP program. See section Coordinated Service Program (CSP) for more information on CSP referrals.

The following apply to referral requests for out-of-network services:

- The in-network provider must submit referral requests using the Precertification request option in the Availity Essentials provider portal.
- Referrals must be requested prior to the service being rendered. Retro referrals will not be accepted.
- The request will be reviewed by BCBSND clinical review staff who will review and send a response once the review is completed.
- Authorized referrals do not guarantee payment of benefits. Referrals must be for medically appropriate and necessary services and are subject to conditions, limitations, and exclusions of the member's benefit plan.

- In-network providers must not request referrals for services that are available through a network provider.

Referral Submission Within Availity Essentials

At this time the referral function in Availity Essentials is only used for the commercial BCBSND line of business. To submit a referral for a Medicaid Expansion member, utilize the Precertification request option as stated above. Required fields for authorized referrals within Availity Essentials include:

CPT Code

If the CPT is unknown, the CPT code 99199 can be used for these requests.

Diagnosis Code

The provider should submit an applicable diagnosis code.

Date Range

Enter appropriate start date. The date range will be reviewed by the Utilization Management area to establish the necessary amount of time.

Allowed Number of Visits

This will be reviewed by clinical review staff, and you will receive a response once the review is completed.

Documentation

Clinical documentation will need to be submitted with the request showing why the services cannot be performed by an in-network provider.

Services that Don't Need a Referral

The following services don't require a referral:

- Women's services to an obstetrician, gynecologist, or other out-of-network women's health specialist
- Pregnant women can receive routine obstetrics and gynecology care from their doctor or an in-network specialist. A referral isn't needed for maternity visits and pap tests.
- Services may be covered when provided by an out-of-network provider with approval.
- Family planning services.
- Care received from Indian Health Service (IHS), Indian Tribes, Tribal Organizations, Urban Indian Organizations or through referrals under Contract Health Services (CHS). Providers at these locations are considered in-network. For this same provider group of Indian Health Care Providers (IHCP), out-of-network providers can refer into a network provider.
- Emergency services are reimbursed at the in-network level; referrals are not required.

NOTE: More information regarding Emergency Room and inpatient admission notifications can be found under the Notification Responsibility section of this manual.

CONTRACTING AND CREDENTIALING

Responsibilities and Requirements of Network Providers

Participating providers in the Medicaid Expansion network are those physicians, allied health providers and facilities that have entered into a Provider Group Participation Agreement with BCBSND and the North Dakota Department of Health and Human Services. Detailed requirements are in the Credentialing and Recredentialing Policy.

Provider Group Participation Agreements

Your responsibilities as a participating provider are defined in your provider participation agreement(s). The provider has an obligation to ensure safety and quality of their patients, our members. BCBSND will take appropriate action when provider quality and safety issues are identified, and will act in accordance with the providers participation agreement and in line with the Credentialing and Recredentialing policy guidelines. This could result in immediate termination of your participation. Please refer to your agreement when you have a question about your participation.

As a participating provider, you also have the following responsibilities to our members – your patients:

Sign Base Agreement

Providers must sign the base Provider Group Participation Agreement before selecting specific networks. The base agreement requires providers to accept reimbursement for services provided under the terms of the member's benefit plan. If a provider doesn't sign a network exhibit, that does not preclude them from their roles and responsibilities within the Provider Group Participation Agreement.

Select Network Exhibits

The Provider Group Participation Agreement contains exhibits for various health products, including Medicaid Expansion, Federal Employee Program (FEP) and Preferred Blue PPO (BlueCard). The exhibits are used to determine network benefits for different plans.

Accept BCBSND's Payment as Payment in Full

BCBSND's payment for covered services is based on the lesser of the participating provider's charge or BCBSND's allowed amount. Providers may not collect from the member any amount over BCBSND's allowed amount. The provider remittance advice summarizes each claim and itemizes the allowed amount and other payment information.

Develop and Conduct Cultural Competency Training

To acknowledge the increasing diversity in your patients / our members, BCBSND expects participating providers to develop and conduct cultural competence training for all practitioners and employees.

This training should include, at a minimum, annual reminders about:

- Compliance with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000, et seq, which prohibits discrimination on the basis of race, color and national origin in programs that receive federal financial assistance
- Compliance in assisting members with accessing language services (providers may contact BCBSND for assistance)
- Compliance in providing services in a culturally sensitive manner

Avoid Discrimination

Network providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency, disabilities or diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity. Providers shall accommodate cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters.

Maintain Advance Directive Policies

Network providers must maintain written policies and procedures with respect to all members receiving care. Providers should:

- Provide written information to each member regarding their right to make decisions concerning a case, including the right to:
  - Accept or refuse medical or surgical treatment
  - Formulate advance directives
  - Access the provider's written policies about the implementation of those rights
- Document in the member's medical record whether the member has executed an advance directive and avoid conditioning care or otherwise discriminating against an individual based on an advance directive.
- Comply with state laws related to advance directives and educate staff and the community on advance directive issues.

Written information must be provided at the following times:

- When the member is admitted to the hospital
- Before the member comes under the care of the provider
- When a member begins hospice care
- When the member enrolls with a health maintenance organization

Distribute False Claims Act Information

BCBSND requires network providers to comply with False Claims Act policies and procedures. BCBSND uses all reasonable efforts, including provider attestations, to ensure network providers are disseminating False Claims Act policies and procedures to their employees and agents.

Review Change Notifications

BCBSND will notify participating providers at least 30 days before any material changes to the following:

- Contracting provisions
- Professional Fee Schedules
- Medical policies
- Reimbursement policies
- Institutional Fee Schedules

Have Full Discussions with Members

Regardless of any benefit or coverage exclusions or limitations associated with a benefit plan, providers shall not be prohibited from discussing fully with members any issues related to the member's health, including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSND or any other party.

Access and Availability Standards for Network Providers

Contracts with BCBSND require network providers – including primary care providers (PCPs) and Specialty Care Providers – to follow these access and availability standards for appointments:

- Primacy Care Providers (including OB/GYN and women's health specialists):
  - Emergency services available 24 hours a day, seven days a week (may be by telephone)
  - Within six weeks of the member's request for routine, non-urgent or preventative care appointments
  - Within 24 hours for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)
  - Non-urgent sick care within 72 hours, or sooner if the condition deteriorates into an urgent or emergency condition
  - Maintain a ratio of one full-time equivalent PCP for every 2,500 patients, including Medicaid Expansion members
  - < 30 miles of travel in urban areas
  - < 50 miles of travel in rural/frontier areas
- Maternity Providers:
  - Emergency services available immediately

- First trimester within 14 calendar days of first request
- Second trimester within seven calendar days of first request
- Third trimester within three calendar days of first request
- Initial high-risk pregnancy within three days of identification of high risk or immediately if an emergency exists
- < 30 miles of travel in urban areas
- < 50 miles of travel in rural/frontier areas

- Behavioral Health and/or Substance Use Disorder Providers
  - Immediate availability for life-threatening emergency services
  - Within six hours for non-life-threatening emergency services
  - Within 24 hours for urgent, symptomatic, but not life-threatening care
  - Within 10 working days for initial visits and routine care
  - Within 30 calendar days for follow-up routine care
  - For each behavioral health and substance use disorder practitioner, maintain a ratio of one full-time equivalent physician per 3,000 members
  - < 30 miles of travel in urban areas
  - < 50 miles of travel in rural/frontier areas
- High-Volume and High-Impact Specialty Providers:
  - High-volume specialties are specialties that are expected to treat a large number of members within a geographic area
  - Consultation within 30 calendar days of referral or as clinically indicated
  - For each high-volume and high-impact specialty, maintain a ratio of one full-time equivalent physician per 3,000 members
  - < 30 miles of travel in urban areas
  - < 50 miles of travel in rural/frontier areas
- Hospitals:
  - < 30 miles of travel in urban areas
  - < 50 miles of travel in rural/frontier areas
- Disability Access
  - Network providers must provide physical access, reasonable accommodations and accessible equipment for Medicaid Expansion members with physical or behavioral health disabilities.
- If BCBSND is unable to provide the necessary services to a member within their network, BCBSND will cover these services out-of-network for the member for as long as BCBSND's Provider Network is unable to provide the services. BCBSND coordinates authorization and

payments so the cost to the member is no greater than it would be if the services were furnished within the network.

- BCBSND ensures parity in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors in determining access to out-of-network providers for medical/surgical benefits.
- BCBSND ensures that network providers offer hours of operation to its members that are no less than the hours of operation offered to commercial members or that are comparable to traditional Medicaid, if the provider serves only Medicaid members.
- BCBSND ensures providers' after-hours answering machines instruct members to go to an emergency room or call 911 in the event of an emergency.
- BCBSND ensures providers provide after-hours availability to patients who need medical advice as specified in the Primary Care Physician (PCP) section of this manual.
- BCBSND collects data on which languages are spoken by providers and data on handicap accessibility through their credentialing and recredentialing applications. This information is shared in the Provider Directory.
- BCBSND ensures network providers have interpretation services available and these services are provided for both in-person and telephone communications to help members communicate with BCBSND and providers.
- Provider access and availability monitoring procedures include:
  - Access and availability are monitored through the complaints and grievance processes and the annual member satisfaction survey.
  - Improvement plans are implemented for areas that don't meet access and availability goals.
  - Benchmarks for access and availability are reviewed periodically to determine if goals are appropriate.
- After-hours answering machine messages are monitored as follows:
  - Annually, at a minimum, phone calls are made after hours to a random sample of health care providers to verify their answering machine message.
  - Reports regarding providers' after-hours answering machine messages and instructions in seeking emergency care are reported annually to the North Dakota Department of Health and Human Services.
  - Improvement plans are implemented for providers who don't comply with their after-hours answering machine messages.
- Languages spoken are monitored as follows:
  - BCBSND makes an annual comparison of the five most common languages spoken within our state to the languages spoken within our provider network.
  - Member access to providers is monitored through the complaints and grievance processes and the annual member satisfaction survey.

- Handicap accessibility is monitored as follows:
  - BCBSND makes annual outreach to providers through various survey methods to improve accuracy of the provider data, including whether the provider's office/facility has accommodations for people with physical or mental disabilities.
  - Handicapped accessibility is monitored through the complaints and grievance processes and the annual member satisfaction survey.

General	Behavioral/Mental Health and/or Substance Use Disorder	High-Volume and High-Impact Specialty
Emergency Services – available 24 hours a day, seven days a week	Emergency Services, Life Threatening – immediate	Consultation within one month of referral or as clinically indicated
Urgent Care – within 24 hours	Emergency Services, Non-Life Threatening – within six hours	
Non-Urgent Sick Care – within 72 hours, or sooner, if condition deteriorates into urgent or emergency condition	Urgent Care – within 24 hours Initial Visits, Routine Care – within 10 working days	
Routine, Non-Urgent or Preventative Care Visits – within six weeks of member's request	Follow-Up Visits, Routine Care – within 30 days	

Providers Must Follow Confidentiality Standards

Providers are obligated to protect the personal health information of their BCBSND members from unauthorized or inappropriate use as a requirement of their contract with BCBSND and in accordance with the highest standards of professionalism.

All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements with BCBSND.

Provider Directory Requirements

Names and details of all credentialed and participating providers are included in the provider directory.

BCBSND makes every effort to ensure information in the provider directory is current and accurate, based on the information provided to us.

Provider directory information includes information such as:

- Name and any group affiliation
- Street address(es)
- Telephone number(s)
- Website
- Specialty
- Medical school attended, graduation year and residency
- Board certifications
- Gender
- Languages spoken
- Whether the provider will accept new patients
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment

Updates Needed for the Provider Directory

Providers should validate their provider directory information following the process outlined on www.bcbsnd.com website https://www.bcbsnd.com/providers/news-resources/no-surprises-act.

Notify Provider Network if:

- Any contact information changes, including address, phone number or fax number
- New providers join your practice
- Providers leave your practice, including through retirement or termination
- A business or practice closes or merges
- Your National Provider Identifier (NPI) number changes
- Your status regarding accepting new patients changes
- The list of languages spoken in the office changes
- Patient gender or age restrictions change
- A provider's specialty or board certification has changed for any active service location
- A new tax ID number is obtained
- The address for a 1099 form changes

Submit Changes to Provider Network

Online: www.BCBSND.com/web/providers/forms

Email: prov.net@bcbsnd.com

Fax: 701-282-1910

Mail: BCBSND
ATTN: Provider Network
4510 13th Avenue South
Fargo, ND 58121

Primary Care Provider (PCP) Responsibilities

When individuals enroll in Medicaid Expansion, they are assigned a primary care provider (PCP). As a PCP, you should:

- Coordinate medical and behavioral health care service needs to ensure all medically necessary services are delivered in a timely manner.
- Refer patients to specialists, subspecialists, subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria.
- Coordinate with these other levels of medical care and follow up on individual patients.
- Maintain medical records of all services provided by you, records of referrals to other providers and documentation of follow-up and coordination of care.
- Develop a plan of care to address risks, medical needs and other responsibilities.
- Provide after-hours availability to patients who need medical advice. At a minimum, PCP offices should have a return call system that is staffed and monitored so Medicaid Expansion enrollees can connect to a medical practitioner within 30 minutes of their call.
- Maintain hospital admitting privileges or arrangements with a physician who has admitting privileges at a participating hospital.
- Work with BCBSND case managers to develop individualized plans of care for high-risk enrollees receiving case management services and participate on their case management team as needed.
- Encourage screening and referrals to ensure immediate access to services for the following:
  - Depression
  - Anxiety
  - Trauma/Adverse Childhood Experiences (ACEs)
  - Substance use/Screening Brief Intervention/Referral to Treatment (SBIRT) early detection
  - Developmental disorders and delays
  - Social-emotional health
  - Social determinants of health

Compliance with the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2)

Providers that treat or diagnose patients for Substance Use Disorders (SUD) or refer patients for treatment of SUD are subject to the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2) as a Part 2 Program. Part 2 is intended to protect patients who are receiving treatment for a SUD from adverse consequences of the disclosure of their records. BCBSND payment of any claim submitted for such services is contingent upon compliance with the following requirements:

- Obtain appropriate consent: Valid Provider consent form.
  - The Provider is prohibited by law from disclosing PII to BCBSND without obtaining patient's

consent. BCBSND is prohibited by law from using PII to pay any claim (or to process any other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains PII to BCBSND, the Provider represents and warrants that the Provider has first obtained patient consent in substantially the same form as the BCBSND PII Consent Form example, BCBSND reserves the right to deny payment of claims (and the right to refuse to process other information) if the Provider fails to obtain such consent.

- Provide the Part 2 Disclaimer: "42 CFR part 2 prohibits unauthorized disclosure of these records."
  - The Provider is prohibited by law from disclosing PII to BCBSND pursuant to patient's consent, unless it includes with the PII a specific statement to notify BCBSND that the information is subject to Substance Use Disorder confidentiality restrictions ("Part 2 Disclaimer"). Accordingly, the Provider shall include the Part 2 Disclaimer with any claim (or other record) that contains PII when submitting the claim (or other record) to BCBSND. The Provider shall include Part 2 Disclaimer with claims it submits to BCBSND in the following manner:
    - **837 Professional Claims:** – Electronic: Should use the NTE data segment Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier "ADD." Data element NTE02 should contain the Part 2 Disclaimer.
    - **837 Institutional Claims:** – Electronic: Should use the NTE data segment in Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier "ADD." Data element NTE02 should contain the Part 2 Disclaimer.
- Provide PII to BCBSND, upon request and as deemed reasonably necessary by BCBSND, to perform evaluations, audits or research. Definitions of the capitalized terms "Part 2 Program", "Patient Identifying Information" and "Substance Use Disorder" are consistent with the meanings provided in 42 C.F.R. § 2.11.

Documentation Requirements

Medical records require appropriate documentation that clearly identifies medical necessity for the services provided and must fully substantiate the ICD-10, CPT® and HCPCS® code(s) and modifier(s) being submitted on claims to receive accurate reimbursement.

Documentation must be complete and legible and include at a minimum the following:

- Name of patient and date of service
- Chief complaint or purpose for visit or service
- All services provided such as clinical assessment, examination, procedures performed, and equipment provided
- Treatment plans
- Orders for, intent of and results of all ordered diagnostic services
- National Drug Code (NDC) numbers on all drug codes and the use of rebatable NDC

numbers where applicable

- Include the following fields for each outpatient drug dispensed:
  - Total number of units of each dosage
  - Form
  - Strength
  - Package size by NDC
- The provider who is treating the patient must order all diagnostic services and must clearly document in the medical record his or her intent the specific test be performed. The provider who treats the patient is the provider who furnishes an evaluation and management service, treats the patient for a specific medical problem and uses the results in the management of the patient's specific medical problem. Tests not ordered by the treating provider are not reasonable and necessary.
- Refer to the American Medical Association (AMA) coding guidelines for more detail on what should or should not be documented in total time with a patient.
- Date and signature of the rendering provider

For providers who perform telehealth services, the following information is also necessary to include in the medical dictation when these services are provided. The below information should be included in the documentation each visit. Refer to any applicable telehealth policy as well.

- Documentation supporting medical necessity and appropriateness for the health service visit.
- Location of the individual and location of the provider.
- Mode of telehealth services provided, such as asynchronous (store-and-forward), synchronous (real time).
  - If synchronous telehealth was provided the provider must identify the originating facility name (the site that facilitated the telehealth service).
  - If digital online synchronous telehealth was provided the provider must specify that the visit was a digital online visit.

BCBSND requires the locations of the patient and provider during the telehealth service to be recorded in the documentation. To ensure provider safety, should the provider be working from their home office, BCBSND does not require the provider's home address to be included in the patient's medical record, though a notation is required to verify the place where the service was performed.

Documentation for non-emergency medical transporation (NEMT) is required. Medicaid Expansion transporation providers are responsible for keeping records for each member that is transported to a covered service. this documentation should be retained for at least five years from the date of the service on the claim and should include the following information:

- Member name

- Member ID (Medicaid expansion number)
- Member's pick-up address
- Date and time the member was picked up
- Drop off facility and address
- Date and time the member was brought back to their home
- Type of vehicle used for transport
- Mileage

Failure to meet these requirements may result in claim denial or claims returned for more information.

Diagnostic Imaging

Appropriate utilization and effective communication are critical components of diagnostic imaging. In addition to BCBSND following the ACR Practice Parameter for Communication of Diagnostic Imaging Findings as published in 2014, below are some tips to consider and remember when ordering, documenting and communicating any type of diagnostic imaging result:

- Quality patient care can only be achieved when study results are given in a timely manner to those responsible for the treatment decisions
- An official interpretation (final report) should be completed following any examination, procedure or consultation regardless of the performance site (hospital, physician office, mobile unit, imaging center, etc.)
- Final reports are the definitive means of communicating to referring physician(s)
- Documentation of radiological studies should be completed on the day the image is read
- Radiology reports become part of the patient's permanent medical record

Listed below are the required documentation components for radiology reports:

- Demographics:
  - Patient's name
  - Valid order from the referring provider for the specific test performed
  - Date and time of service
  - Name and type of examination
  - Facility or location where study was performed
  - Name and signature of interpreting provider
  - Inclusion of the following additional items is encouraged:
    - — Dictation date
    - — Date and time of transcription

  - Birth date and age
  - Gender
- Clinical Information:
  - Indication(s) for examination: Reason why the study is being performed and how the results will be used in the patient's plan of care
  - Procedures performed and materials used: Description of the studies and procedures performed and any contrast media (including concentration, volume and administration route), medications, catheters or devices used
  - Views taken findings:
    - Appropriate anatomic, pathologic and radiologic terminology should be used to describe findings
    - Indication of study quality, i.e., if results are unable to be obtained due to inadequacy of image(s)
    - Pertinent positive or negative findings
    - Impression (conclusion or diagnosis)
    - A precise diagnosis should be given when possible
    - If appropriate, a differential diagnosis should be rendered
    - Significant patient reaction or complication, if applicable
- If there may be the need for follow-up or additional studies, based on the outcome of the initial study, these should be indicated by the ordering provider as part of the original order when applicable.

Physical, Occupational and Speech Therapy

Providers should not bill for timed services if less than a total of eight minutes is spent with the patient. The following table represents appropriate billing.

Billed Units	Represented Minutes
One (1)	8-22
Two (2)	23-37
Three (3)	38-52
Four (4)	53-67
Five (5)	68-82
Six (6)	83-97

Evaluation and Management (E/M) Documentation Requirements

The American Medical Association (AMA) has made changes in the selection of E/M codes, which has been adopted by BCBSND. Based on the changes, E/M codes may be billed based on the level of Medical Decision Making (MDM) or total time for the encounter; with the exception if Emergency Room visits which may not be billed based on time. Providers must follow the appropriate E/M level selection based on the effective date for the below changes.

- 99202 – 99215 (Office Visits)

  - Effective January 1, 2021, may be billed based on the MDM or total time for the encounter.
- 99281-99285 (Emergency Room Visits)
  - Effective January 1, 2023, may be billed based on the level of MDM
- 99221-99223, 99231-99236, 99242-99245, 99252-99255, 99304-99310, 99315-99316, 99341-99345 and 99347-99350
  - Effective January 1, 2023, may be billed based on the MDM or total time for the encounter.

Selection of E/M codes for encounters prior to the above effective dates must follow the AMA guidance for the encounter dates. For more information reference the edition of the CPT manual based on the encounter date.

E/M Time Requirements

The definition of time is minimum time, not typical time, and represents total physician or Qualified Health Practitioner (QHP) time on the date of service (DOS). The time of clinical staff (e.g. nursing staff) cannot be included in total time for the DOS. The use of DOS time must be clearly documented in the record to support time was used to select code. This definition only applies when code selection is based on time and not MDM.

Medical Decision Making

The AMA continues to use the three MDM sub-components for code selection based on MDM. The subcomponents have been edited for appropriate code selection. For more information reference the current edition of the CPT manual.

E/M Documentation

The chief complaint and history for new and established patient E/M's do not need to be reentered in the medical record if information has already been entered by ancillary staff or the patient /member. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

When documenting the history or exam portion of an E/M service, if relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed.

All Previous documentation that is reviewed must include the date and time of the visit being reviewed, what information has specifically been reviewed and verified, and what, if anything, has changed per CPT guidelines. The documentation of the MDM must be specific to the current encounter and clearly documented to support E/M services billed based on the level of MDM.

Documentation Requests

Third-party Documentation

Upon request for a review, it is the billing provider's responsibility to obtain supporting documentation as needed from a referring provider (for example, provider order, notes to support medical necessity or other relevant information).

The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the billing provider is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested. Providers should submit adequate documentation to ensure claims are supported as billed.

Insufficient Documentation

Upon review, it may be determined that claims have insufficient documenation errors when the medical documenation submitted is inadequate to support payment for the services billed (that is, it could not be concluded tat some of the allowed services were actuallly provided, weree provided at the level billed, or were medically necessary). Insufficient documenation is also a determination when a specific documentation element that is required as a condition of payment is missing, such as a provider signature on an order, or a form that is required to be completed in its entirety.

Insufficient documentation errors identified may include, but are not limited to:

- Incomplete progress notes (for example, unsigned, undated, insufficient detail)
- Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures)
- No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services provided)

Medical Record Requests

Providers should maintain current, organized and well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members.

To ensure timely distribution and review of submitted medical records, they should include:

- First/last name
- Date of birth
- Benefit plan number
- Any other applicable identifiers (case number or claim number)
- Copy of medical record request letter from BCBSND. If you are unable to locate your Medical Records Request letter when mailing the records to BCBSND, use the Medical Records

Submission Form. Access the form at https://www.bcbsnd.com/providers/news-resources/forms-documents, under the Claims Processing section. When using this form, be sure to include the claim number that the records pertain to.

Medical Necessity Criteria

Medical necessity criteria are used to conduct clinical determinations. BCBSND reviews treatment for medical necessity in accordance with this definition:

- Medically appropriate and necessary: services, supplies or treatments provided by health care providers to treat an illness or injury that satisfies all the following criteria as determined by BCBSND:
  - Medically required and appropriate for the diagnosis and treatment of the member's illness or injury
  - Consistent with professionally recognized standards of health care
  - Does not involve excessive costs in comparison to alternative services effective for diagnosis and treatment of the member's illness or injury

BCBSND uses the InterQual Criteria and BCBSND Medical Policy available at https://www.bcbsnd.com/providers/policies-precertification to assist clinicians in making informed decisions. Additional evidence-based resources may be used when determining medical necessity.

Technology Assessment Evaluation Criteria

Providers may submit requests for BCBSND to review new technology for a coverage determination or development of a medical policy. Access the form at https://www.bcbsnd.com/providers/news-resources/forms-documents under New Technology.

BCBSND uses the following criteria for the evaluation of new technology:

1. The technology must have final approval from the appropriate government regulatory bodies.
   - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the technology.
   - Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.
   - The indications for which the technology is approved need not be the same as those which BCBSND is evaluating.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
   - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
   - The evidence should demonstrate the technology can measure or alter the physiological

changes related to a disease, injury, illness or condition. There should also be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

- Opinions and evaluations by national medical associations, consensus panels or other technology assessment evaluation bodies are evaluated according to the scientific quality of supporting evidence and rationale.

3. The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings. When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy criteria #3 and #4.

Medical Record Documentation Policy

To support quality member care and ensure our members are receiving medically necessary and appropriate care related to the purpose of their visit, BCBSND expects providers to submit documentation specific to the patient and specific to the individual encounter. Specific encounter documentation helps ensure BCBSND determine appropriate reimbursement and that reimbursement is not inflated by inappropriate or irrelevant information. It is not expected that every patient would have the same problems or symptoms or require the same examination and treatment. Documentation should support the individualized care each BCBSND member received.

BCBSND intends to reimburse providers for medically appropriate and necessary services, rendered to BCBSND members, that treat the condition or concern for which the member is seeking treatment and, for additional concerns or conditions identified during the visit.

Documentation without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining the service(s) provided for that visit are medically appropriate.

Amended Medical Records

Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical services.

DO

- Include the date of the late entry, addendum or correction.
- Note the reason for the correction.
- Include the signature of the person making the addition or change.

DON'T

- Delete or remove incorrect information from the record. Instead, draw a line through it or make another appropriate indication.

All medical record documentation must comply with BCBSND policies and support the services and diagnosis submitted on the claim form at the time of the original claim submission to BCBSND.

Corrections to the medical record prior to claim submission are considered when determining the validity of services billed. If changes appear in the record following a request for records, medical review or audit, only the original record is reviewed when making determinations.

Credentialing in Medicaid Expansion

To be a provider in North Dakota Medicaid Expansion, providers must become credentialed with BCBSND and the State of North Dakota.

Current BCBSND Providers

Providers who are participating with BCBSND, that also want to participate in the Medicaid Expansion network will need to sign an contract addendum. To request an addendum, send an email to ProviderContracting@bcbsnd.com.

New BCBSND Providers

Once enrolled with the State of North Dakota, providers can join the BCBSND network and become credentialed for Medicaid Expansion by applying. Visit https://www.bcbsnd.com/providers/become-a-new-provider/apply to apply to be a BCBSND participating provider.

Providers not Enrolled with North Dakota Medicaid

If you are not a current BCBSND provider and want to be credentialed for Medicaid Expansion, you will need to enroll with the State of North Dakota and BCBSND. Visit https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-provider-enrollment-information to apply to be a provider with the State of North Dakota.

Voluntary Termination

Providers wishing to voluntarily terminate participation with BCBSND Medicaid Expansion shall provide notice via email to providercontracting@bcbsnd.com. The effective date of such termination will be in accordance with the timeframes outlined in the termination provision found in the Provider's contract with BCBSND.

1915(i) Providers

The North Dakota Medicaid 1915(i) State Plan Amendment allows North Dakota Medicaid to pay for additional home- and community-based services to support individuals with behavioral health conditions. BCBSND partners with North Dakota Medicaid to administer claims for Medicaid Expansion members for these services. Coverage and payment are based on benefit plan and eligibility.

Providers who deliver home- and community-based services to members with behavioral health conditions can enroll as a North Dakota Medicaid 1915(i) provider with the State of North Dakota.

Providers should complete the following steps in addition to other requirements set by the State of North Dakota for this program. Enrollment with both the State of North Dakota and BCBSND is required.

- Enroll as a 1915(i) provider with the State of North Dakota. Visit https://www.hhs.nd.gov/1915i to learn how to become a provider, what services are included and what types of individuals are eligible for those services.
- After enrollment with the State of North Dakota, send an email to BCBSND at providercontracting@bcbsnd.com to enroll within the Medicaid Expansion network.
- Register for the Availity Essentials provider portal at https://www.availity.com/provider-portal-registration.
- Submit a precertification on behalf of the member through the Availity Essentials provider portal.
- Refer to this provider manual for claim submission processes and procedures.
- 1915(i) Providers will need to verify the member's benefit requirements for eligibility to receive 1915(i) services, a member may be eligible for Medicaid Expansion but not eligible for 1915(i) services. A member may lose eligibility for 1915(i) services during their treatment. It is the provider's responsibility to verify a member's 1915(i) eligibility by calling BCBSND at 701-282-1003 during normal business hours.

For additional questions refer to the following:

1915(i) Process Overview | DHS - Behavioral Health Division (nd.gov)

Non-Emergency Medical Transportation (NEMT) Providers

The North Dakota Medicaid Expansion program provides the opportunity to NEMT providers to coordinate non-emergency medical transportation to and from medical appointments for our North Dakota Medicaid Expansion members when no other transportation source is available. NEMT provider must be enrolled with the State of North Dakota, enrollment information can be

found here https://www.hhs.nd.gov/healthcare/medicaid/provider. For more information visit our provider webpage https://www.bcbsnd.com/providers/medicaid-expansion/medicaid-expansion-non-emergency-medical-transportation--nemt--p.

Meal and Lodging Providers

Providers of meals and lodging can become credentialed for Medicaid Expansion through the State of North Dakota. Visit https://www.hhs.nd.gov/healthcare/medicaid/provider to apply to be a provider with the State of North Dakota. Medicaid Expansion follows ND DHHS coding and billing located under the ND Medicaid Non-emergency Transportation Fee Schedule hyperlink found here https://www.hhs.nd.gov/medicaid-provider-information/medicaid-provider-fee-schedules.

Out-of-Network (OON) Providers

Medicaid Expansion members do not have coverage for services provided by out-of-network (OON) providers because OON providers do not have a contract with BCBSND.

Services received from an OON provider will not be covered unless one of the following exceptions exists:

- Emergency and Post-stabilization services
- Family planning services
- Women's routine and preventive health care services
- New members who receive covered services the first 30 days after enrolling in Medicaid Expansion
- New members who received maternity services prior to enrolling in Medicaid Expansion and need to continue the services
- An authorized referral is obtained from BCBSND when access to a network provider is not available or feasible
- Covered services received from an Indian Health Care Provider (IHCP)

If BCBSND authorizes services from an out-of-network provider, we will ensure:

- The service is provided by a qualified and clinically appropriate provider.
- The provider is located within the shortest travel time of the member's residence, taking into account the availability of public transportation to the location.
- The provider is licensed by the state of North Dakota or, if located in another state, the provider is licensed by that state.
- The provider is licensed and accredited by a state-approved accrediting organization, if required by state or federal requirements.
- Payments for covered services are made directly to the provider.
- Payment is accepted as payment in full.
- No charges are billed to the member. (Note: If the member knowingly chooses to seek services from an out-of-network provider, the member may be billed for all charges when

provided notice in advance.)

- Provider is participating with ND Medicaid.

Resources

Questions related to Availity Essentials:

- Phone: Availity Client Services at 1-800-282-4548
  - Monday through Friday, 7 a.m. - 7 p.m. CST
- Web: https://www.availity.com
  - Providers can register for an Availity Essentials account at https://www.availity.com/Essentials-Portal-Registration

Questions related to NPI and BCBSND participation:

- Phone: 1-800-756-2749
- Email: Provider Credentialing and Data Management at prov.net@bcbsnd.com

PROVIDER RESOURCES

Contact Information

Service/ Department	Email/website	Phone	Fax	Hours of Operation (CST)
Provider Services	N/A	1-833-777-5779	1-701-282-1888	8 a.m. to 6 p.m.
Member Services	N/A	1-833-777-5779	1-701-282-1888	8 a.m. to 6 p.m.
Availity Essentials	https://www.availity.com	1-800-282-4548	N/A	7 a.m. to 7 p.m.
Case Management	N/A	1-800-336-2488	1-701-282-1967	8 a.m. to 5 p.m.
Provider Credentialing and Data Management	Prov.net@bcbsnd.com	1-800-756-2749	1-701-282-1910	8 a.m. to 5 p.m.*
Utilization Management	N/A	1-800-952-8462	1-701-277-2971	8 a.m. to 5 p.m.*
Provider Relations	Prov.partners@bcbsnd.com	N/A	N/A	8 a.m. to 5 p.m.
Provider Contracting	ProviderContracting@bcbsnd.com	N/A	N/A	N/A
Pharmacy Management	dhsmed@nd.gov	1-701-328-7098	N/A	N/A

** After hours, leave a message on the confidential voicemail and your call will be returned the next business day*

Provider Relations Services

Provider Relations Partners and Provider Education Specialists assist providers and their office staff with complex claim situations and provide information about BCBSND's programs. For questions regarding the contents of this manual, please contact prov.partners@bcbsnd.com. Please do not contact the Provider Relations Partners with routine claim or benefit questions.

Provider HealthCare News

HealthCare News Weekly

Healthcare News Weekly is a weekly publication of the latest news and updates that may pertain to medical policy, coding and billing information, processing issues, system outage notifications and other important announcements from BCBSND.

To receive e-mail notification of HealthCare News, follow the below steps.

1. Go to www.BCBSND.com/providers
2. Click on "Provider Services", then "News & Resources"
3. Enter your email address in the "Stay updated on HealthCare News" section on the right-hand side
4. Click Subscribe
5. Upon submission, you will receive a confirmation on screen that you have successfully subscribed.

NOTE: If you do not receive your confirmation email or new article publications, check your spam folder. If nothing appears in your spam folder, contact the Customer Contact Center Provider Service department for troubleshooting assistance.

Quarterly Provider Insights

BCBSND produces Quarterly Provider Insights articles, which publish on a quarterly basis. The Insights will provide a company message, along with information regarding news and announcements, educational topics, and miscellaneous updates. This publication can be found under News & Resources, in the HealthCare News tab https://www.bcbsnd.com/providers/news-resources/healthcare-news.

Published HCN will be archived after one year. If the information within an aged article is still relevant, it will be placed elsewhere or republished.

Availity Essentials Provider Portal

Providers can submit and manage ND Medicaid Expansion claims on Availity Essentials, the same self-service provider portal used by BCBSND commercial plans.

Availity Essentials is a multi-payer site where providers can use a single user ID and password to work with ND Medicaid Expansion and other participating payers online. Availity Essentials is compliant with all HIPAA regulations and there is no cost for providers to register or use any of the online tools.

Note: If you do not receive your confirmation email or new article publications, check your spam folder. If nothing appears in your spam folder, contact the Customer Contact Center Provider Service department for troubleshooting assistance.

Features Provide Convenience to Providers

Through the Availity Essentials provider portal, providers can:

- Submit eligibility and benefits inquiries for ND Medicaid Expansion members
- Submit claims and review statuses
  - Submit claim transactions (837I & P), member eligibility (270), claim status (276), etc. 24 hours a day, seven days a week
- Correct and void claims
  - Make a correction to change the diagnosis code, change the date of service, update the charges, add services or remove a line of the claim
  - Void a claim submitted in error
- View electronic remittance advice (835)
  - Receive claim acknowledgment (277CA) and claim payment/remittance advice (835) transactions
- Request authorizations and referrals
  - A list of services requiring precertification is on our website at www.bcbsnd.com/providers under Policies and Precertifications
- Direct Messaging
  - Ask a claim question related to a claim denial or eligibility status
- Complete credentialing and recredentialing forms
- Submit and/or update an electronic funds transfers (EFT) request

You can find more information on Availity Essentials functionalities on the BCBSND webpage https://www.bcbsnd.com/providers/news-resources/availity-essentials and/or utilizing the Availity Essentials website directly at www.availity.com.

CARE COORDINATION PROGRAMS

Case Management

Because serious illness can have emotional impacts, BCBSND provides members with a voluntary case management program to provide effective and feasible alternatives. When people meet optimal levels of wellness and functional capability, it benefits our members and their support systems, the health care delivery systems and various reimbursement sources.

BCBSND's case management program is available at no additional cost to members.

Care Coordinators consist of Registered Nurses and Licensed Social Workers trained in the following areas:

- Motivational Interviewing
- Crucial Conversations
- Case Management and Utilization Management

Member assessments include:

- A comprehensive health screening
- Screening for depression and anxiety
- Assessment of the member's health engagement
- Medication reconciliation

Care coordination interventions include:

- Goal setting with members to achieve optimal health outcomes
- Motivational interviewing to assess barriers to change
- Assessment of the member's engagement in their health
- Providing education regarding health risks and needs assessment
- Collaboration or referral to a patient-centered medical home or primary care provider
- Transition of care planning for complex cases
- Coordination of local, regional and nationwide healthcare services
- Ongoing case management for complex and chronic cases
- Referrals to Disease Management for rare and complex disease management
- Assistance in making informed healthcare decisions
- Connect the members to the right resources within BCBSND to help them understand their benefits

A member or their authorized representative must agree to participate in the Case Management program. A referral to the program is required and is initiated by the individual member, their authorized representative or their health care provider. To initiate a referral to Case Management, contact BCBSND at 1-800-336-2488.

Prenatal Plus

BCBSND's Prenatal Plus Program, a maternity management program, will help pregnant members stay as healthy as they can by providing information and support during their pregnancy and delivery. Members can work one-on-one with a nurse case manager throughout their pregnancy and after their delivery to get the answers and services they need.

This program is confidential and available at no additional cost to members.

Moms-to-be receive the following:

- Prenatal care advice
- Guidelines for healthy lifestyle and pregnancy
- Help in preventing preterm labor

- Information on taking folic acid
- Help to quit smoking during pregnancy
- Education on the last weeks of pregnancy
- A checklist of what to take to the hospital
- Information on post-partum depression
- Educational content on breastfeeding
- Information about caring for a newborn

Members can sign up as soon as they know they are pregnant and can join anytime while pregnant. Members can call BCBSND at 1-833-777-5779 or enroll online through the member portal.

Disease Management

BCBSND's complex, chronic and rare disease management program is a system of coordinated care interventions and member communications for members with rare and complex diseases.

Conditions managed include:

- Seizure disorders
- Multiple Sclerosis
- Systemic Lupus Erythematosus
- Hemophilia Dermatomyositis
- Chronic Inflammatory Demyelinating
- Polyradiculoneuropathy
- Crohn's Disease
- Ulcerative Colitis
- Polymyositis
- Amyotrophic Lateral Sclerosis
- Rheumatoid Arthritis
- Cystic Fibrosis
- Scleroderma
- Parkinson's Disease
- Myasthenia Gravis

Nurse case managers work individually with members and their physicians to address the unique health care needs associated with high-cost, complex conditions. The nurses:

- Teach effective self-management techniques
- Help providers educate patients
- Promote adherence to treatment plans

Additionally, members receive condition-specific information and an extensive archive of health resources.

Utilization Management Program

Utilization Management (UM) processes are designed to evaluate the medical necessity and appropriateness of services before a member receives treatment. The authorization process ensures that members receive the highest level of benefits to which they are entitled and the most appropriate setting and level of care for a given medical condition.

BCBSND clinical staff review all pertinent information submitted by providers, then apply defined criteria to determine if a service is medically appropriate. If the information received from the provider varies from the defined criteria, clinical staff seek review from a BCBSND medical director or pharmacist, as appropriate.

Note: Precertification, Prior Approval and Preauthorization may be used interchangably, but refer to the same process.

Services Requiring Precertification

Medicaid Expansion members must obtain precertification before benefits are available for certain services. The BCBSND provider is responsible for all precertification requirements. Services not precertified prior to the claim submission can be denied as a benefit exclusion.

Visit www.bcbsnd.com/web/providers/precertification for the list of services and procedures that require precertification.

The following guidelines apply when submitting a precertification:

- Submit requests through the Availity Essentials provider portal at https://www.availity.com. Follow the steps in the Predictal process guide when submitting a precertification electronically at https://www.bcbsnd.com/content/dam/bcbsnd/documents/general/provider/predictal-resource-guide.pdf.
- Precertification's do not guarantee payment of benefits.
- Services must be medically appropriate and necessary and are subject to conditions, limitations and exclusions of the member's benefit plan.
- Precertification is not required for emergency admissions or post-stabilization care. *See below for ER admission notification procedure.*

Notification Responsibility

A member seeking services from a participating health care provider requiring either prior approval or precertification grants to that health care provider authority to act on behalf of the member as their authorized representative. As an authorized representative, the health care provider assumes responsibility to act on behalf of the member in pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. The member agrees that all information and notifications related to the Claim for Benefits requiring prior approval or precertification is to be directed solely to the authorized representative unless the member specifically requests that any notices or information also be delivered to the member.

Providers agree to abide by the following Utilization Management Program requirements in

accordance with the terms of the agreement and the member's benefit plan.

Emergency Room (ER) Admission Notification

We are required by the state of North Dakota to contact all Medicaid Expansion Members within 72 hours of being discharged from the Emergency Room (ER). Notice from Medicaid Expansion providers to BCBSND is requested when any Medicaid Expansion Member visits the ER and is discharged home. Notice should be sent utilizing the Medicaid Expansion ER Admission Notification form on the Medicaid Expansion Provider Resources page of the BCBSND website.

BCBSND is working to establish a mutually beneficial partnership with our members and providers to help improve adherence to the established treatment plan from the ER and improve member outcomes. Receiving the completed form gives us the ability to identify these ER discharges early, our BCBSND Case Management team can then assist in preventing potential unnecessary ER visits or admissions related to complications which is both beneficial to the member and providers.

Note: If admitted inpatient from the ER, you do not need to fill out the Medicaid Expansion ER Admission Notification form, instead submit a precertification request through Availity Essentials as noted below.

Inpatient Admission Notification

Providers are required to notify BCBSND within 24 hours of an emergency/post-stabilization or maternity inpatient admission. These should be submitted using the Precertification request function in Availity Essentials.

Inpatient Discharge Notification

Follow up calls to Medicaid Expansion members are attempted within seven days of discharge. This process helps improve adherence to the established treatment plan from an inpatient hospital stay. To assist with these calls, submit the discharge date and discharge instructions on all inpatient discharges. To add a discharge date and discharge instructions, modify the existing inpatient precertification admission request on your Availity Essentials dashboard. The information can also be faxed through the precertification fax line 1-701-277-2971 if you are unable to complete the request through Availity Essentials.

Precertification & Concurrent Review/Discharge Planning

Clinicians (Registered Nurses) complete initial reviews for services that require precertification in accordance with established clinical criteria. Please use this link https://www.bcbsnd.com/providers/policies-precertification/Precertification-for-Medicaid-Expansion to see the Services/Procedures requiring precertification.

No precertification is required when BCBSND is secondary to other insurance, unless other insurance benefits have been exhausted or care is non-covered. If the care is not covered by the primary plan please include notice of no benefits available from the primary plan. No precertification is required for maternity admissions that result in delivery.

Concurrent review is required for these services, extending beyond the initial precertification period, to ensure that ongoing treatment is appropriate and includes discharge planning.

Working in conjunction with the member and their providers, BCBSND staff supports discharge planning by providing information on benefits available for those services determined to be medically appropriate and necessary for the member's continued care and treatment.

Outpatient services authorized within a specified time frame (i.e. January 1 – January 10) are authorized during that time period only. Unused days due to weather, closure or sickness will not be extended past the approved date frame. Concurrent requests for additional days will be reviewed for medical necessity and appropriateness.

The procedure for submitting a precertification request to BCBSND is below. Please note that method you utilize can affect response time.

- Log into Availity and complete the request services and attach all records supporting the medical necessity of your request to.
  - Response to your request will be sent back via the Availity Essentials Dashboard, fax and letter.
- If you do not have access to Availity Essentials, providers can use one of the following forms found on the BCBSND website (www.bcbsnd.com/web/providers/forms) under Precertification:
  - Inpatient Authorization Request
  - Outpatient Authorization Request
  - ABA Service for Autism Spectrum Disorder Request – FEP only
  - Repetitive Transcranial Magnetic Stimulation (rTMS) authorization request

Note: The above forms were completed to obtain the most frequently asked for information in order to decrease requests being pended for additional demographic information.

- You can fax in your request and all records supporting the medical necessity of your request to 701-277-2971.
- If you do not have access to fax or Availity Essentials mail your request and all records supporting the medical necessity of your request to:

  BCBSND
  Attn: Utilization Management
  4510 13th Ave S
  Fargo ND 58121

  - Response to your request will be sent back via fax and letter.

**Requests for services that require colored photos should be sent via Availity Essentials or mail.

**Requests via fax or mail should utilize the appropriate authorization form(s) above and/or indicate on the documentation the member information, provider NPI/Address/Fax, timeframe of the request, diagnosis, and procedure codes (if an outpatient request) and contact information for questions.

Determination timeliness for initial determinations range up to 72 hours for urgent care or up to 15 days for non-urgent care. These timeframes may be extended when additional medical information is needed to complete the review or in extenuating circumstances.

The following definition is used to determine whether a Precertification, Prior Approval or Preauthorization is deemed "urgent" and subject to review within 72 hours:

The absence of treatment:

- Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or
- In the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

If the request does not meet the above definition, the request will be considered non-urgent and subject to the 15-day review guideline.

BCBSND is committed to maintain a streamlined process to ensure all requests are handled timely and in accordance with state and federal regulations. Availability of Providers and Members schedule alone does not meet the definition. Every effort will be made to complete the review as soon as possible.

Retrospective Utilization Management (UM)

Retrospective UM, prior to claim submission, is designed to review services already completed but prior to the claim being submitted to BCBSND. Requests will be reviewed per the normal UM process in accordance with the member's benefit plan and relevant medical policy. Medical records and pertinent information regarding the member's care should be submitted via Availity Essentials, fax, or mail. Up to 30 days is allowed for medical necessity review of retrospective requests. Please note, requests submitted after claim submission will not be reviewed and may be denied as a benefit exclusion.

Peer-to-Peer Process

The Peer-to-Peer process is an opportunity for the requesting/ordering provider to have a one-on-one conversation with a peer reviewer when a service has been denied as not medically necessary. The purpose is to further explain the adverse determination with a principal reason, clinical rationale and components of specific medical policy. The denial will not be over-turned because of the peer-to-peer conversation. When the provider has received additional clarification, they may either accept the adverse determination or proceed with a formal appeal. If the original BCBSND peer reviewer is not available, an alternate peer reviewer is made available.

Health care providers may contact BCBSND Provider Services at 1-833-777-5779 to request a Peer-to-Peer conversation, providing their telephone number and available times to be reached. A peer clinical reviewer will contact the health care provider, making two attempts within three business days or by scheduling a formal appointment within three business days of receiving the request. If these attempts are unsuccessful and the provider remains unavailable, the peer-to-peer conversation availability is considered met.

Failure to Comply with Utilization Management Requirements

The Plan may apply monetary penalties such as a reduction in payment, as a result of provider's failure to obtain Pre-service Review on services that require precertification.

Medical Policies

BCBSND medical policies are developed, reviewed and approved by the BCBSND Internal Medical Policy Committee, which includes clinical and coding staff with medical policy accountability.

The process of developing and maintaining medical policies and clinical review criteria helps with the following:

- Have reliable research performed before establishment of a policy
- Promote credibility to criteria developed internally
- Ensure criteria and medical policies are up to date and acceptable to practitioners
- Have an assessment tool by which commercially available criteria can be compared
- Maintain quality of criteria

Find current BCBSND medical policies at https://www.bcbsnd.com/providers/policies-precertification/medical-policy/disclaimer.

Retired Medical Policy

Policies may be retired for several reasons, including:

- Technology is obsolete or discarded
- Technology is the standard of care and details about its use are well known
- Costs of implementing the policy are too great
- An issue may be handled in other ways, such as payment

Draft Medical Policy

BCBSND strives to develop medical policies in an open, collaborative manner with providers. Comments may be submitted during the development phase of BCBSND medical policies. We especially value comments referencing an evidence-based evaluation process.

Review draft medical policies at www.BCBSND.com/web/providers/draft-medical-policy.

Mail comments to:
Blue Cross Blue Shield of North Dakota
Health Integration
4510 13th Avenue South
Fargo ND 58121

Notification of a draft policy will be done via HealthCare News. This is the same way providers are notified when a policy is new, or revised.

Medical Benefit Drug Medical Policy

The Department of Health and Human Services (DHHS) has a Preferred Drug List (PDL). This list contains clinic administered drugs requiring precertification. Some of these drugs have specific criteria outlined in the PDL while others utilize group criteria for approval. Refer to the Preferred Drug List for more information.

Additional clinic administered drugs may require precertification if developed, reviewed and approved by the BCBSND Internal Medical Policy Committee and the DHHS. Clinic administered drugs requiring precertification can be found on the Medicaid Expansion Restricted Use - Precertification drug list.

Approval for Meals, Lodging and Transportation

Benefits for meals and lodging may be allowed when medical/behavioral health services or transportation require a member to be away overnight. Transportation services for medical care may also be available through BCBSND if no other source is available. Meals, lodging, and transportation services require BCBSND review and approval in advance.

A member may choose to obtain covered services at a network (or preferred) provider outside the members community. If those services are available at a preferred provider within the community and the member chooses to use services elsewhere, transportation and lodging expenses are not covered and are the responsibility of the member, unless otherwise pre-approved by BCBSND. For more information on this as well as authorization requirements, how to submit claims, and more, visit our Medicaid Expansion NEMT provider web page. The web page can be located under the Resources section of the Medicaid Expansion tab, section titled Non-Emergency Medical Transportation (NEMT) Meals and Lodging Providers or by clicking here: https://www.bcbsnd. com/providers/medicaid-expansion/resources/medicaid-expansion-non-emergency-medical-transportation--nemt--p.

Pharmacy Benefits Administered Separately

Medicaid Expansion members have a different identification card for their retail pharmacy prescriptions because retail outpatient pharmacy benefits are administered by ND DHHS rather than BCBSND.

ND Medicaid covers outpatient prescription drugs when prescribed by an enrolled prescriber, using a tamper-resistant prescription pad and dispensed by an enrolled ND Medicaid provider. ND DHHS has a Preferred Drug List (PDL) providers must adhere to when prescribing drugs. Providers must access the Prescription Drug Monitoring Program (PDMP) patient history before prescribing controlled substances.

Providers can use the following resources for more information on the pharmacy program:

- Pharmacy Overview, Manual, and Tamper-Resistant Prescription Pad information: https://www.hhs.nd.gov/healthcare/medicaid/providers/pharmacy
- Coverage Rules on Medications: http://www.hidesigns.com/assets/files/ndmedicaid/2021/Coverage_Rules_on_Medications_2021v3.pdf
- Additional DHS training: https://www.hhs.nd.gov/healthcare/medicaid/provider/education-and-training

- Medicaid Expansion Restricted Use - Precertification Drug List (link provided when available).

340B Drug Pricing Program

Providers may not use drugs purchased under the 340B Drug Pricing Program enacted by the Veterans Health Care Act of 1992, Public Law 102-585, codified in Section 340B of the Public Health Services Act to provide any prescription drugs to these members.

Should a provider use 340B product, services must be submitted with the UD modifier and include the appropriate National Drug Code (NDC).

Pharmacist Administered Vaccines

Pharmacists who have received the required training and are credentialed and participating with BCBSND are authorized to administer vaccinations to members as appropriate. Proof of valid ND pharmacist license, pharmacist NPI and certificate of immunization training is required to become a credentialed and participating provider with BCBSND.

Pharmacist administered vaccinations must be submitted as medical claims using the pharmacist individual NPI as the rendering provider and the pharmacy NPI as the billing provider. Claims received with the pharmacy NPI listed as the rendering provider will be rejected.

Medication Therapy Management Services

Medication Therapy Management Services (MTMS) is provided by MTMS pharmacists through the medical benefit. This service is defined as an individual-specific medication evaluation based on a Medicaid Expansion member's chronic diseases and current medication list. MTMS are to be completed by a MTMS pharmacist provider face-to-face and will include a complete assessment and intervention if needed. The MTMS pharmacist provider is responsible for reviewing the individual's medication history, creating a medication profile and providing medication education which can include, but is not limited to, how to improve compliance with taking prescription medications and how to prevent medication side effects.

Prior to submitting MTMS claims to BCBSND Medicaid Expansion for procedure codes outline in the Medication Therapy Management Services (MTMS) (Medicaid Expansion) policy, the MTMS pharmacist:

- Must be employed and affiliated with a Pharmacy that is enrolled as a North Dakota Medicaid Provider https://www.hhs.nd.gov/healthcare/medicaid/provider/enrollment-information.
  - The Pharmacy must also be participating in the Medicaid Expansion network. If the pharmacy is not, email providercontracting@bcbsnd.com requesting to be set-up within the Medicaid Expansion network.
- The individual MTMS pharmacist must be credentialed https://www.bcbsnd.com/providers/credentialing/credentialing-applications.
  - Utilize the **Practitioner Credentialing Application**, if you are not yet credentialed and

need to be.

The MTMS pharmacist submitting a MTMS claim to BCBSND is required to use their individual NPI as the performing provider and the pharmacy NPI as the billing provider. Claims received with the pharmacy NPI listed as the performing provider will be rejected.

You can view the Medication Therapy Management Services (MTMS) (Medicaid Expansion) policy for additional criteria information by utilizing our policy search function https://www.bcbsnd.com/providers/policies-precertification/medical-policy/disclaimer.

Coordinated Services Program (CSP)

BCBSND will collaborate with enrolled members to ensure their healthcare services match their medical needs. If members are using health care services at a frequency or amount that is deemed excessive, improper, or incorrect, they may be placed in the Coordinated Services Program (CSP), so the health care services they receive do not exceed generally accepted medical standards.

The CSP reviews are done by BCBSND in consultation with the North Dakota Department of Health and Human Services. Members placed in the CSP will be designated one coordinated service medical prescriber and one pharmacy provider who will collaborate regularly with them to understand their health care needs and coordinate their care. The designated coordinated services medical prescriber can also refer members to prescribing specialists for additional care.

The following criteria are used to determine if the CSP is appropriate:

- Seriousness of incorrect, improper or excessive use of services
- Historical utilization of the member and
- Availability of a coordinated services physician
- External referrals

When a member is placed in the CSP, BCBSND provides written notice to the member, which includes:

- The reason why the member is being placed on the CSP
- The member's right to file an appeal
- The timeframe in which the member must file an appeal

Once a member has exhausted BCBSND's internal appeals process, the member has a right to a State Fair Hearing. BCBSND will notify the member of the timeframe in which to file a request. The CSP administered by BCBSND meets the requirements outlined in 42 CFR §431.54.

Services Obtained From A Non-Designated Prescriber

BCBSND will not make payment for medical care or services rendered to a CSP member by any prescriber other than the member's designated CSP prescriber, except for:

- Medical care rendered in a medical emergency; or
- Medical care rendered upon CSP provider referral and approved by BCBSND.
  - Only the member's designated CSP prescriber can authorize a referral to another

prescriber. Referrals must be medically necessary and submitted prior to the date of service. If additional visits from other prescribers are needed, the members primary designated CSP prescriber must initiate the referral. Utilize the Medical and Pharmacy Services Coordinated Services Program (CSP) Referral and Specialist Request Form for these referral requests.

- If a CSP prescriber is going to be absent from practice for an extended period, the CSP prescriber should refer the member to another prescriber to access necessary medical services.

Claims received for services rendered by the non-designated prescriber for a situation not outlined in the above bullet points, will be denied as member liable. The member or member's authorized representative has the right to appeal the claim(s) if they disagree.

REIMBURSEMENT AND BILLING GUIDELINES

Reimbursement Policies

Reimbursement policies are payment decisions subject to:

- Terms and conditions of the benefit plan, including specific exclusions and limitations, and
- Applicable state and federal laws.

BCBSND reimburses Medicaid Expansion providers based on the methodologies and rates outlined in annual Reimbursement Notices.

Additional considerations for reimbursement policies include:

- Specific product discounts or contractual arrangements are not reflected in the fee schedule.
- CPT and HCPCS codes not in the fee schedule are reimbursed by report.
- Codes not in the fee schedule are manually reviewed and payment is determined on an individual basis.
- The existence of a procedure code on the fee schedule does not guarantee that the code is valid or covered.
- Fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT codes.
- BCBSND's system will check procedure validity and reject any invalid codes.
- Some codes may represent services for which benefits are not available.

Any Coding and Reimbursement policies do not constitute plan authorization, nor are they an explanation of benefits.

Providers should contact Provider Service at 1-833-777-5779 for specific coverage or policy information.

Fee Schedules Are Confidential

Fee schedules are confidential and proprietary and for the exclusive use of BCBSND Medicaid Expansion providers.

Medicaid Expansion providers may only use or disclose the information for the following reasons:

- Practice management
- Billing activities
- Other business operations
- Disclosure to the North Dakota Insurance Commissioner
- Disclosure to ND DHHS

Other uses or redistribution of fee schedules without the written consent of BCBSND is prohibited.

National Correct Coding Initiative (NCCI) Edits

BCBSND Medicaid Expansion follows the Medicaid National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) and medically unlikely edits (MUE) edits effective for date(s) of service on or after July 1, 2022. Medicaid Expansion claims with date(s) of service prior to July 1, 2022, will continue to process against Medicare NCCI edits. Providers can find more information on the edits within the BCBSND Correct Coding Guidelines - Medicaid Expansion policy.

To learn more visit the Medicaid National Correct Coding Initiative website.

Encounter File

When a service is provided, a claim is billed and processed through BCBSND. Claims that are identified as not processed in accordance with the guidelines may result in a claim adjudication. There will be no specific ANSI rejection code for these claims as situations may vary. Providers are advised to follow standards processes for claim questions by utilizing Availity Essentials direct messaging or contacting the Customer Contact Center.

Not Otherwise Specified (NOS) and Not Otherwise Classified (NOC)

All Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that do not have a specific code description (i.e. Unlisted, Not Otherwise Specified (NOS), Not Otherwise Classified (NOC), Unclassified, etc.) will be rejected. This requirement doesn't apply to anesthesia services, codes 00100-01996.

How to submit required information for these codes:

- For electronic claim submission, information is placed in SV101-7 of the 2400 service line loop
- Examples of NOS/Unlisted or Unspecified Codes:
  - 83520 (Immunoassay, quantitative, not otherwise specified) – include a description

of the method or technique
  - 21499 (Unlisted musculoskeletal procedure, head) – include a description of the procedure performed
- In order for an accident-related dental claim to be processed under medical coverage, an accident date is required. If the accident date is not provided in the loops and segments listed below, the claim will not process.
  - Loop/Segment/Element for tooth number = 2400 SV101-7
  - Loop/Segment/Element for accident date = 2300 DTP03, with a qualifier of 439 in DTP01

Dental Services Performed by a Dentist or Oral Surgeon

The following services are allowed under Medical when performed by a dentist or oral surgeon and should be submitted on the CMS-1500 claim form.

- Services related to an Accidental
- Frenotomy/Frenectomy
- Oral Biopsy
- Oral Lesion Removal
- Oral Abscess Treatment

Professionals in Training

Professionals in training must be working towards and participating in a supervision plan to become a recognized, payable provider by Blue Cross Blue Shield of North Dakota (BCBSND). These professionals must practice under the direct supervision of a provider, as approved by the individual's board who is licensed, registered, or certified by the appropriate state agency and meets the credentialing criteria set forth by BCBSND. Direct supervision means the supervising provider must be present in the office suite and/or on a telehealth visit and immediately available to provide assistance or direction to the professional in training. Services must be billed using the supervising provider's NPI.

Professionals in training who are eligible and must bill under the supervising provider's NPI:

- Licensed Associate Professional Counselor (LAPC)
- Licensed Associate Marriage Family Therapist (LAMFT)
- Graduate Registered Nurse Anesthetists (GRNA)
- Post-doctoral Psychology Resident
- Psychiatry Resident in psychotherapy training under the direct supervision of a psychologist
- Resident Psychiatric Physicians in their 2nd year of training or greater that have met the specific supervision standards through their accrediting body

Professionals in training who are not eligible to bill:

- Resident Physicians
  - The attending/supervising physician must either be present while the substantial

elements of the history and examination are performed by the resident, or the attending/supervising physician must independently perform them. Billing occurs under the attending/supervising physician's NPI.

- The attending/supervising physician participates in the clinical decision making and formulation of the treatment plan.

Documentation by the attending/supervising physician needs to support this information.

Billing for Services Provided to Immediate Family Members

An immediate family member is a person who ordinarily resides in a provider's household or who is related to the provider, including but not limited to a provider's parent, sibling, child or spouse, whether such relationship is by blood or exists by law. This applies to providers treating themselves as well.

Health care providers may submit claims for the following types of services provided to immediate family members:

- Diagnostic Radiology (technical component only)
- Diagnostic Lab (technical component only)
- Nuclear Medicine Therapy (technical component only)
- Supplies

Health care providers may not submit claims for the following types of services provided to immediate family members:

- Medical office visits
- Medical hospital visits
- Routine surgery
- Maternity
- Consultations
- Anesthesia
- Assistant at surgery
- Therapy or manipulation services
- Professional component or interpretation of radiology, laboratory or other medical services

Provider-Based Status

BCBSND does not recognize Medicare's provider-based designation. Services provided to members in a clinic or office setting must be filed electronically (837P). The affiliated hospital may not separately bill for any portion of a service provided in the clinic.

Institution for Mental Diseases (IMD)

A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of Members with mental diseases, including medical attention, nursing care and related services. IMD is an exclusion under Medicaid Expansion and follows the guidance published by DHHS: https://www.hhs.nd.gov/sites/www/files/documents/

sud-housing-recovery-providers-policy.pdf.

Critical Access Hospital Status

Critical Access Hospital (CAH) status is a Medicare designation. According to Medicare's billing guidelines for CAHs, providers are not required to submit outpatient services using HCPCS. However, in situations where BCBSND is the primary payer, all of BCBSND billing and coding guidelines continue to apply. The appropriate HCPCS must be submitted with revenue codes for the claim to process correctly.

Rural Health Clinic

A Rural Health Clinic is a special Medicare designation. BCBSND receives Medicare cross-over claims submitted by rural health clinic providers, but that designation and billing should not be used on claims where BCBSND is the primary payer. In other words, there should be no electronic 837I claim submitted for services received in a rural health clinic where BCBSND is the primary payer under either the rural health clinic provider number or the acute hospital provider number. These services should be filed electronically (837P) using the provider's individual National Provider Identifier (NPI).

Incident to Billing

BCBSND does not recognize "incident to" billing, which is a Medicare billing policy with specific criteria for those situations.

Split/Share shared services

When a service is rendered and split or shared between providers, only one of the providers may bill Blue Cross Blue Shield of North Dakota (BCBSND) for split or shared services. BCBSND will only reimburse one of the billing providers for the services rendered. The provider which performed more than 50% of the time of the visit, or the provider which performed and documented in its entirety the medical decision-making portion of the note will be the determining factor for reimbursement.

The provider submitting the claim should append the FS (Split or Shared Evaluation and Management Visit) modifier to attest the service was split or shared.

Member-Demanded Services

Providers accept BCBSND payment for covered services as payment in full. Members should not be billed for any services, unless the member chooses to:

- Have a non-covered service or
- Receive covered services from an out-of-network provider

In both situations, the member must be notified in advance with an Advance Member Notice (AMN), also known as a waiver, agreeing to pay for the service.

Services relating to medical policies should be submitted with a GA modifier. All other services should be submitted with a GY modifier. The following applies to the use of these modifiers.

- Services submitted with the GA or GY modifier will be denied as member liable.
- Medical information will not be requested or reviewed prior to the denial.
- BCBSND will conduct routine audits of services billed with these modifiers, requesting chart notes (and signed AMNs, if applicable) to verify appropriate usage.
- Services billed inappropriately will be reprocessed as provider liable. Further actions may be taken if inappropriate usage continues.

When submitting an AMN form:

- Use the form found at https://www.bcbsnd.com/providers/news-resources/forms-documents, in the Claims Processing section.
- Do not use Medicare's form or other provider-designed waiver forms.
- The AMN must specifically identify the non-covered services, procedure codes and total financial liability. General notices will not be accepted.

AMNs cannot be required as a condition of providing covered services or be used to collect from members for failure to obtain precertification.

Trauma Activation

Inpatient trauma activation will not be paid outside of the Diagnosis Related Group (DRG) and will be considered a part of the DRG payment. Trauma activation for outpatient services will be reimbursed at a flat rate, which will be dependent upon the level of trauma designation by the American College of Surgeons or the State of North Dakota.

A trauma activation fee can be billed when activation of the designated trauma team occurs. The activation fee does not replace any emergency room charges the patient may incur. Providers must meet the minimum data element requirements for the North Dakota State Trauma Registry. There must be pre-hospital notification based on field triage or inter-hospital transfer to be eligible for submission of a trauma activation fee. A trauma activation fee is not allowed for patients who arrive without notification.

An additional payment per case will be made based on the trauma level designation. For outpatient services, trauma activation will be reimbursed the lesser of charges or fee schedule amount. The rates are not subject to the mid-tier, rural or western rural adjustment for outpatient services.

Providers must submit the claim with the appropriate trauma level revenue code for their trauma level designation to receive the additional payment. Outpatient claims must have G0390 and a line-item service date or the claim will be returned. The following chart identifies the appropriate billing requirements for trauma activation.

Billing for Trauma Activation on Electronic 837I

Revenue Code	Description	Units	HCPCS	Line-Item Date of Service

Outpatient	0681	Level I Trauma	1	G0390	Required
	0682	Level II Trauma	1	G0390	Required
	0683	Level III Trauma	1	G0390	Required
	0684	Level IV Trauma	1	G0390	Required
	0689	Other Trauma Response (Use for Level V Trauma)	1	G0390	Required

Inpatient Rehabilitation, Swing Bed and Transitional Care Unit Per-Diem Services – Hospital Billing

This section addresses all Inpatient non-Acute Per-Diem services, including Inpatient Rehabilitation (IP Rehab), Swing Bed (SWB) and Transitional Care Unit (TCU). Inpatient services delivered to patients will be reimbursed an all-inclusive per diem rate. The per diem rate includes all services normally used in a treatment program such as room and board, lab, X-ray, all therapies, diagnostic testing, services of social workers, licensed addiction counselors, nurses, physical, occupational and speech therapists and dietitians, etc.

The following services are reimbursable in addition to the per diem rate:

- Chemotherapy Agents
- Chemotherapy Administration
- Radioisotopes and Related Services
- Customized
- Prosthetic Devices
- CT Scans
- Cardiac Catheterization
- MRI's
- Radiation Therapy
- Angiography
- Outpatient Surgery
- EPO
- Preventive and Screening Services
- Blood Products
- Blood Storage and Processing
- Complex Medical Equipment (e.g. Specialized beds and mattresses and wound vacs when approved during precertification and submitted on revenue code 0946 or 0947)
- Cardiac Rehab

Billing Guidelines

Services should be billed using revenue codes to indicate the type of services provided. Items considered to be separately reimbursable should be billed where the services were rendered and submitted by the rendering provider on a separate outpatient claim.

Example: If the patient has a CT scan in the hospital outpatient setting, the CT scan should be billed on a separate UB-04 outpatient (TOB 13x) claim form with the appropriate HCPCS code(s) under the acute provider number. If the patient receives chemotherapy at the bedside in the TCU setting, these services should be billed on a separate UB-04 outpatient (TOB 13x) claim form with the appropriate HCPCS code(s) under the TCU provider number.

Therapists, social workers, and dietitians should not bill for services on the CMS-1500 claim form as these services are inherent to the treatment program and delivered during the inpatient stay. Psychologists and psychiatrists should bill on the CMS-1500 claim form for services that are medically appropriate and necessary.

All Patient Refined-Diagnosis Related Group (APR-DRG)

The APR-DRG classification system classifies patients into clinically meaningful groups that account for the severity of illness and risk of mortality. APR-DRG also help provide an accurate and consistent way to compare provider performance. BCBSND uses the APR-DRG classification system for all institutional inpatient acute medical surgical and behavioral health inpatient acute claims.

Coding Elements

The following discharge data elements are used for APR-DRG subclass assignment:

- Principal diagnosis coded in ICD-10-CM
- Principal procedure coded in ICD-10-PCS
- Secondary diagnoses coded in ICD-10-CM
- Secondary procedures coded in ICD-10-PCS
- Age
- Sex
- Birth weight (value or ICD-10-CM code)
- Admit date
- Discharge date
- Status of discharge
- Days on mechanical ventilator (value or ICD-10-CM code)

If claims are submitted without all this information, or at least the fields that are appropriate to the claim, the processing of the claim could be delayed or denied. APR-DRG payments are based on the date of discharge.

Note: Providers should list any diagnosis code(s) necessary to drive the SOI on a DRG claim within the first 25 diagnosis code fields on the UB-04 Claim Form. Diagnosis codes needed for correct DRG SOI not included in the first 25 diagnosis fields will result in the claim processing at a lesser DRG SOI.

Present on Admission (POA) Indicator

BCBSND requires all acute care hospitals to report Present on Admission (POA) indicators for each diagnosis code on inpatient claims. According to POA reporting guidelines, Present on Admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation or outpatient surgery) are considered as Present on Admission. POA indicators may affect payment for hospital-acquired conditions.

For guidance using POA indicators, refer to Appendix 1 of the ICD10-CM coding guidelines.

Transfer Cases

Transfers include any inpatient cases with a discharge status of a transfer to another short-term acute care facility (02, 05, 43, 65, 66, 70, 82, 85, 88, 93, 94 and 95). Transfer cases are paid on a per diem basis.

The APR-DRG per diem conversion is calculated as follows:

- Base Rate * APR-DRG weight/Network Average Length of Stay (LOS).

The transfer per diem payment is calculated as follows:

- Observed LOS for a transfer case * calculated per diem conversion. Final payment is the lesser of per diem or acute payment.

Example: DRG 53, Severity Level 2

- Regular Case Payment Base Rate ($12,011) * APR Weight (0.6423) = $7,715 Per Diem Payment [Acute Payment $7,715 / Network APR-DRG LOS (2.8 Days)] * Actual Transfer LOS (2 Days) = $5,511
- Lesser of Regular Case Payment (1) or Per Diem Payment (2) = $5,511

NOTE: LOS is calculated discharge date minus admit date plus one.

Outlier Cases

Outlier payments are designed to pay providers an additional amount, over and above the APR-DRG payment, for those cases that fall outside of pre-established thresholds.

Under the APR-DRG system, outlier payments are based on cost. The formula for determining outlier cases is as follows:

- If (Charge x Overall Hospital Ratio of Cost to Charges (RCC) > Outlier Cost Threshold) then Outlier.

Example: DRG 53, Severity Level 2

- Calculation of Case Cost:
  - Facility Charges ($37,500) * Overall Hospital RCC (0.7162) = $26,858
- Outlier Payment:
  - Case Cost ($26,858) – Outlier Cost Threshold ($21,808) = $5,050
- APR-DRG Case Rate:
  - Case Weight (0.6423) * Base Rate ($12,011) = $7,715
- Final Outlier Case Payment:
  - APR-DRG Case Rate ($7,715) + Outlier Payment ($5,050) = $12,765

Billing Guidelines

1. Submit claims electronically (837I) with Type of Bill (TOB) 111 (Hospital/Inpatient/Admit through Discharge Date Claim). Claims that are paid based on an APR-DRG are not eligible for interim billing.
2. Hospital APR-DRG payments include reimbursement for all services performed during an entire inpatient admission. Services incurred during an inpatient admission regardless of the place of service are part of the APR-DRG and should not be billed separately.
   - These services include but are not limited to outpatient procedures, diagnostic tests and lab tests.
   - Example: A patient who is an inpatient at Hospital A is brought to Hospital B for a CT scan that is not available at Hospital A. Hospital A submits a bill for the entire inpatient stay including the CT scan. Hospital A receives the entire APR-DRG payment and is responsible for reimbursing Hospital B for the CT scan.
3. Report appropriate ICD-10-CM diagnosis codes in Form Locator (FL) 67, 67 A-Q, 69 and 72 A-C.
   - 67: Principal diagnosis code. The 8th digit of the field (shaded area) is for the POA indicator.
   - 67 A-Q: Secondary diagnosis fields. The 8th digit of the field (shaded area) is for the POA indicator.
   - 69: Admitting diagnosis code.
   - 72 A-C: External cause of injury (ECI) code and POA indicator.
4. All acute care hospitals must report the POA indicator in FL 67, 67 A-Q in the shaded area corresponding to the 8th digit. The reporting options for all diagnoses are:
   - Y – Yes: Present at the time of admission.
   - N – No: Not present at the time of admission.
   - U – No: Information in the Record: Documentation is insufficient to determine if condition was present on admission or not.
   - W – Clinically Undetermined: Provider is unable to clinically determine whether condition was present on admission or not.

- Unreported/Not Used or "1": Exempt from POA reporting.

5. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E.
6. Report charges associated with each Revenue Code.

Note: The revenue codes listed below are not allowed on an inpatient APR-DRG claim. Claims will be returned if one of the following revenue codes is submitted:

- Rev Code 0273 – Take Home Supplies
- Rev Code 0274 – Prosthetic/Orthotic Devices
- Rev Code 029X – Durable Medical Equipment (Other than Rental)

Note: Durable medical equipment items used by the patient during their inpatient stay, such as special beds, are a part of the inpatient payment and should not be billed separately.

- Rev Code 051X – Clinic
- Rev Code 052X – Free Standing Clinic
- Rev Code 053X – Osteopathic Services
- Rev Code 054X – Ambulance
- Rev Code 0912 – Partial Hospitalization

7. Report the appropriate discharge status in FL 17.
8. The Statement Covers Period From date in FL6 ("From" Date) is different than the Admission Date in FL 12 ("Admit" Date). There are times when these dates may be the same, but there are situations when these dates may be different.
   - The Admit Date is the date that the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims. The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included on the claim. The "From" date should be the earliest date of service on the bill.
9. Day of discharge cannot be counted as a unit of service on the room and board Revenue Code on an inpatient hospital, swing bed or skilled nursing facility claim.
10. If the patient has a leave of absence (LOA) during the inpatient stay, the LOA day(s) must be identified with Revenue Code 018X and units equal to the number of LOA days. The following are a couple of examples on how to count LOA days:
    - If the patient leaves the hospital on Saturday afternoon and returns on Sunday afternoon, there is no LOA as the patient received services on both days.
    - If the patient leaves the hospital on Saturday afternoon and returns on Monday afternoon, one (1) LOA day should be billed.

Enhanced Ambulatory Patient Group (EAPG)

The EAPG classification methodology is used to explain the amount and type of resources used in a wide range of ambulatory visits. Individual services within the visit are assigned to individual EAPGs, which are organized by the EAPG logic to reflect the typical resources expended during the visit. BCBSND uses the EAPG classification system for hospital outpatient, ambulatory surgical center, partial psychiatric and partial substance abuse claims. Ambulance, home health and hospice services do not apply to EAPG classification. More information regarding EAPG's can be found on https://www.bcbsnd.com/providers/policies-precertification/coding-and-reimbursement/Enhanced-Ambulatory-Patient-Grouping.

Billing Guidelines

1. Submit claims electronically (837I) with outpatient TOB 131.
2. EAPG payments are based on visits.
   - A visit is all related services provided to one patient on one date of service.
   - BCBSND encourages providers to bill all related outpatient services for the same date of service on one claim.
   - Providers may bill multiple dates of service on one claim.
   - Multiple EAPGs are commonly assigned per visit and more than one EAPG may be payable within a visit.
3. Lessor of charge logic will apply to EAPG claims at the visit level.
4. Report appropriate ICD-10-CM diagnosis codes in FL 67, 67 A-Q, 69 and 72 A-C.
5. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E.

Report charges associated with each Revenue Code and CPT or HCPCS code as appropriate.

Significant Procedure Consolidation

When a patient has multiple significant procedures, some may require minimal additional time or resources. Significant procedure consolidation refers to the collapsing of multiple related significant procedure EAPGs into a single EAPG for the purpose of determining payment.

Same Significant Procedure (SSP) Consolidation

Same Significant Procedure (SSP) consolidation will occur when multiple occurrences of the same significant procedure EAPG are present on a claim. The highest weighted significant procedure EAPG will be paid in full and any subsequent occurrences of that same significant procedure EAPG will be consolidated and receive no payment. BCBSND applies this to significant procedure type two and diagnostic type 25.

Ancillary Packaging

Certain ancillary services will be packaged into the EAPG rate for a significant procedure or medical visit. The ancillary packaging list can be found with the EAPG fee schedule in the online fee schedule portal located at https://feeschedule.bcbsnd.com/FeeSchedule/FeeScheduleManagement/List

Ancillary Discounting

When multiple occurrences of the same ancillary EAPG are present on a claim, the additional ancillary EAPGs are discounted at 50%.

Provider Preventable Conditions

BCBSND does not pay any provider for a Provider Preventable Condition. Providers must comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. 447.26(d).

HOW TO FILE AND CORRECT CLAIMS

Claim Submission: Timeframes

All professional (837P) and institutional (837I) claims must be filed electronically to BCBSND Payer ID 55891 within the following timeframes:

- 180 calendar days of the date of service for Medicaid Expansion-only claims
- 180 calendar days from the enrollee's retroactive coverage notification
- 365 calendar days from the date of service for claims involving third-party liability
- Submit with Frequency Type 1: Initial Claim

Claims submitted outside of these timeframes will be denied unless BCBSND or its subcontractors created the error.

Tips:

- Submit North Dakota Department of Health and Human Services assigned taxonomy codes for billing and rendering provider.
  - Taxonomy Code Requirements for Behavioral Health Provider Services of Methadone and Opioid Clinic Providers who bill services for HCPCS code H0020 alcohol and/or drug services for Methadone and Opioid Clinic services must submit claims with the following taxonomy code 261QM2800X.
- Submit North Dakota Provider Medicaid ID
- A National Drug Code (NDC) is required for medical drug claims. Claims that do not meet this requirement will be denied.

- A claim should only be submitted with one Billing Provider and one Rendering provider. Availity Essentials may have the option to submit additional rendering NPI's on each claim line, but our system will not recognize that information for claims processing. A separate claim should be filed for any service(s) that are rendered by a different provider NPI.

If it has been longer than 30 days and a claim has not yet finalized, contact the Customer Contact Center by calling the number on the back of the member ID card for additonal details. Providers are also advised to contact the Customer Contact Center if they have questions regarding correction and/or void claim processing.

Coordination of Benefits

Coordination of Benefits (COB) occurs when a member is covered by two or more insurance plans. When COB is involved, claims should be filed with the primary insurance carrier first. When an Explanation of Benefits (EOB) is received from the primary carrier, the claim should be filed with the secondary carrier, including the primary carrier processing information.

When any of the below bulleted items are identified, the claim msubmitted to BCBSND may be denied:

- Primary EOB information is not entered on the claim
- Information on other insurance coverage cannot be verified
- The member does not respond to our request for additional information

Receiving COB information from members before their claims are filed may reduce processing and payment delays.

For member coverage under two BCBSND benefit plans, BCBSND will cross the primary claim over to the secondary coverage for processing. Therefore, providers should not submit a claim to the secondary benefit plan. claim adjustments in this scenario do not cross over. See Claim Corrections section for more details.

When a member has coverage under BCBSND and another insurance plan, claims should be submitted to the primary plan first. Once the claim to the primary plan has been processed, a second claim should be submitted to the secondary plan with a copy of the primary plan's EOB.

Coordination of Benefits (COB) Guidelines

In an effort to decrease the number of claims being reprocessed and to ensure accurate and timely reimbursement, the following claims submission guidelines must be followed:

- BCBSND will automatically process claim(s) for patients with multiple BCBSND coverages. Do not resubmit claims for the secondary plan.
- Primary insurance payment information amounts must be entered in loop 2430.
- submit the appropriate modifier(s) where applicable. The appropriate use of modifiers

will allow more claims to be paid without additional information. It will also prevent inappropriate denials for duplicate services. This is especially helpful when coordinating benefits for accident or injury care.

- If services are a result of an accident, include the accident datte an/or the occurance code on the claim.
- Indicate if services are a result of work or auto injury. If services are work related, you must submit the EOBs from the workers compensation carrier with the claim to BCBSND. If workers compensation paid the services in full, the claims and EOBs do not need to be submitted.
- Submit the diagnosis pertinent to that visit only.
- To avoid refunds and reprocessing, submit claims after all late charges and credits are included.
- Do not submit a new claim with other insurance carrier's payment if BCBSND has previously processed a claim for the services. An adjustment request should be submitted on the original claim.

Example

If a patient has workers compensation benefits for an injury to the left knee (LT) but requires a procedure done to the right (RT) knee not related to the workers compensation injury, the use of the LT and RT modifiers will indicate the services are different. This will prevent claims from being delayed for coordination of workers compensation benefits.

Coordination of Benefits (COB) Questionnaire

To streamline claims processing and reduce the number of denials related to Coordination of Benefits, a Coordination of Benefits (COB) questionnaire is available to you at www.bcbsnd.com under the Forms and Documents section. That will help you and your patients avoid potential claim issues.

When you see a Blue member and are aware that they might have other health insurance coverage, give a copy of the questionnaire to them during their visit. Providers should ensure that the form is completely filled out and at a minimum, includes: provider name, tax identification or NPI number, the policy holder's name, group number and identification number including the three-character prefix and the member's signature. Once the form is complete, providers have the choice to instruct the member to submit the form to their plan or the provider can submit the questionnaire to the local plan in which they provided services.

Coordination of Benefits (COB) Out of State Situations

Refer to the section BlueCard Program for Out of Area Services in this manual for BlueCard Out of State Information.

Subrogation/Accident/Workers' Compensation

A contract provision that allows health care insurers to recover all or a portion of claim payment(s) if the member is entitled to recover such amounts from a third party. The thrid party's liability insurance carrier normally makes these payments. A third party is another carrier, person or company that is legally liable for payment from the treatment of the claimant's illness or injury.

BCBSND follows a "pursue and pay" process for claims received with indication of a subrogation, accident, or workers' compensation. This means BCBSND will first do its due diligence in determining if the claim is related to an on-the-job accident and then pay the claim, or if a response is received by the member about an injury, claims will be processed according to the situation and benefits. If no response is received, the claim will be rejected as provider liable.

All claims submitted to BCBSND must indicate if work-related injuries or illnesses are involved and if the services are related to an accident. If you are unable to get the third-party information from a member, contact the BCBSND ME Contact Center.

Claim Corrections: Criteria

Claim corrections (also referred to as an adjustment) allows a provider to submit a replacement or void (cancellation) of an initial/original claim.

Claim corrections must be:

- Submitted on finalized claims only
- Submitted with appropriate frequency type
  - Frequency Type 7: Replacement claim
    - This is used to correct data on an initial claim, such as diagnosis code, date of service or the addition or removal of charges.
    - The original claim number assigned by BCBSND is required.
    - Frequency 7 claims must be submitted within 90 days from the initial/original claim remittance date, except for the following:
    - Coordination of Benefits
    - Workers Compensation
    - No-Fault
    - Subrogation
    - Third-Party Payers

Note: The above claim correction exceptions must be filed within 365 days from the date of service.

  - Frequency Type 8: Void/cancel claim

Claim Corrections: Process

1. Complete electronic claim corrections using the following steps:
2. Log in to the Availity Essentials provider portal at

https://apps.availity.com/availity/web/public.elegant.login

3. Select Claims & Payments from the menu
4. Under Claims, select the claim type: Professional or Facility
5. Input the claim information
6. Select the frequency type
7. Set payer control number by using claim number assigned by BCBSND
8. Click Submit

Tip: Submitting Billing Provider Updates

Billing provider updates require a frequency 8, followed by a frequency 1.

Tip: Submitting a Correction on an ME Secondary Claim

Claim adjustments when ME is secondary will not cross over like the initial (first) claim does. After the primary plan claim adjustment has finalized with new processing details, providers will need to submit the applicable frequency type to the secondary ME plans claim with the new details.

Tip: Submitting Claim Corrections Impacting Two Claims

When submitting a claim correction that impacts two claims, such as adding a modifier on one claim due to a reduction on another claim, use the following:

- Claim 1: Submit frequency 7 to correct data
- Claim 2: Submit frequency 7 to reprocess as a no-change correction

Tip: Input Member ID Numbers Precisely

Member ID numbers must be reported exactly as shown on the ID card. Do not add, omit or alter any characters. Member IDs are specific to the member and are not shared within a family.

Tip: Use Your National Provider Identifier (NPI)

Health care providers are assigned a National Provider Identifier (NPI) to meet Health Insurance Portability and Accountability Act (HIPAA) requirements. This allows providers to use just one identification number when filing claims with BCBSND and working with federal and state agencies.

Organizations submitting claims to BCBSND must use an organizational NPI and Tax Identification Number (TIN) where applicable. Each practitioner being credentialed or recredentialed must include their individual NPI on the application.

Learn who should apply for an NPI and how to obtain an NPI at https://www.bcbsnd.com/providers/credentialing/new-provider-tools. Click “Completing an NPI Application” to visit the National Plan & Provider Enumeration System (NPPES) website.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

Network providers must register to receive Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).

EFT is a provider service where BCBSND deposits payment directly into your checking account. A provider must be enrolled with ERA prior to setting up EFT.

ERA's will explain processing details once a claim has finalized. To assist in understanding the processing, providers should know the difference between certain reason codes:

- Claim Adjustment Reason Codes - known as CARC codes, which are used to describe why a claim or service line was paid differently than it was billed. Find more details on CARC codes here: https://x12.org/codes/claim-adjustment-reason-codes.
- Remittance Advice Remark Codes - also known as RARC or remark codes, are used to provide additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. This may not always appear on an ERA. Find more details on RARC codes here: https://x12.org/codes/remittance-advice-remark-codes.

Providers currently receiving ERA and EFT from BCBSND do not need to sign up again. Medicaid Expansion will be included on your existing enrollments. Please note, only one bank account can be used across all lines of business (Commercial or Medicaid Expansion plans).

Providers not enrolled in ERA or EFT can enroll through the Availity Essentials provider portal at https://www.availity.com/provider-portal-registration.

Overpayments and Recoupments

Identified Overpayments

In the event a provider identifies that BCBSND overpaid for services, providers should return identified overpayments to BCBSND within 60 calendar days after the overpayment was identified.

How to return identified overpayments:

- Submit a claim correction to void the claim (see Claim Corrections section)
- This will cause the overpayment amount to offset on future payments
- Return the check or write a separate check for the amount paid in error with the following information:
  - Remittance advice
  - Supporting documentation
  - Reason for refund

Send overpayments to:

BCBSND
Attn: Overpayment
4510 13th Avenue South

Fargo ND 58121

Payment Recoupments

BCBSND notifies providers in writing of its intent to recoup any payment. The notification includes:

- Patient's name, date of birth and Medicaid Expansion identification number
- Date(s) of health care services rendered
- A list of the specific claims and amounts subject to recoupment
- Specific reasons for making the recoupment for each claim

Overpayment Disputes

Providers may dispute a payment recoupment. They may submit a dispute request within 45 calendar days from the receipt of written notification of recoupment. The dispute request should include why the recoupment should not be done along with any supporting documentation. If a request isn't received within 45 calendar days, the amount is offset on future payments.

BCBSND reviews the dispute request and notifies providers of its determination and rationale in writing within 30 calendar days.

If a recoupment is valid, the provider must remit the amount to BCBSND or allow BCBSND to offset the amount on future payments.

Unsolicited Refunds

Unsolicted refunds refer to refunds that were not requested by BCBSND. Also referenced as a refund/return of overpayments.

Providers shall follow the proper claim correction or void process as permitted in the previous sections of this manual. If a provider cannot correct or void a claim for reasons such as the correction time frame has passed, the claim is purged from the BCBSND system, the (https://www.bcbsnd.com/content/dam/bcbsnd/documents/forms/providers/Unsolicited-Refunds-Form.pdf) form can be utilized. All fields of the form are to be filled out entirely.

If information is missing from the form, the request may not be completed.

This form is intended to be used as a last resort to refund or return money to BCBSND for an overpayment, not in conjunction or solely for a claim adjustment/void.

Third Party Liability

Some members enrolled in Medicaid Expansion may have additional sources of coverage for their health care services. In these cases that may involve Third-Party Liability (TPL), BCBSND has policies for pay and chase and cost avoidance.

- When BCBSND is aware of the probable existence of TPL at the time a claim is filed, BCBSND will reject the claim and return it to the provider for a determination of the amount of liability.
- When BCBSND learns the member has other health coverage that precludes eligibility

for Medicaid Expansion, BCBSND may hold the claim while the state determines the member's eligibility.

BCBSND must pay the provider's claim first and then seek reimbursement from the liable third party:

- Upon expiration of state's 45-day review period, BCBSND will either pay or reject the claim based on the information provided in the most recent eligibility transmission file.
  - If the member's eligibility has not been terminated, BCBSND may continue to hold claims to follow the provider agreements as well as applicable laws and regulations.
- If the probable existence of TPL cannot be established or third-party benefits are not available to pay the member's medical expenses when the claim is filed, BCBSND will pay the claim pursuant to its payment schedule.
  - If BCBSND later determines that TPL exists, BCBSND will seek reimbursement from the third party within 60 calendar days of discovery of the TPL.
- BCBSND has 120 calendar days from the date of adjudication of a claim that is subject to TPL to attempt recovery of the costs for services that should have been paid through a third party.
  - After 365 days from adjudication of a claim, BCBSND loses all rights to pursue or collect any recoveries subject to TPL; the state then has the sole authority to recover the costs.

Guidelines for Procedure, Diagnosis and Add-on Codes

The following code sets must be used and coded to the highest level of specificity:

- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
- International Classification of Diseases, Tenth Revision, Procedure Classification System (ICD-10-PCS)

Code sets are:

- Billed based on the definitions, units and parenthetical information as identified by the American Medical Association (AMA) for CPT and the Centers for Medicare & Medicaid Services (CMS) for HCPCS
- Updated based on release of new codes by the owners of the code sets (AMA, CMS, etc.)
- Cannot be used prior to their effective date or after their termed date

BCBSND follows these coding guidelines unless otherwise identified in our policies. Participating providers should follow the coding guidelines published in these codes sets when submitting claims to BCBSND for processing.

ICD-10-CM (Diagnosis Codes)

Always report the primary diagnosis code on the claim form. Principal Diagnosis – "Reason for service or procedure."

- Report up to 12 diagnosis codes on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- All ICD-10 codes start with an alpha character.
- Some three-character code groupings stand alone as the valid code for the condition.
- Do not add zeros to make codes seven characters long.

ICD-10-PCS (Procedure Code Structure)

- ICD-10-PCS codes are only used for inpatient hospital claims.
- ICD-10 PCS is comprised of seven alphanumeric characters.
- Each character contains up to 34 possible values, which represent a specific option for the general character definition.
- The 10 digits 0-9 and 24 letters A-H, J-N and P-Z may be used in each character.
- The letters O and I are not used to avoid confusion with the digits 0 and 1.

Add-on Codes

"Add-on" codes describe procedures or services that are always performed in addition to the primary procedure or service. They describe additional intra-service work associated with the primary procedure or service. Such services would never be reported using stand-alone codes.

Additional or supplemental procedures are designated as "add-on" codes and identified in CPT with a + symbol. Add-on codes can also be identified by specific language in the code descriptor, such as "each additional" or "(List separately in addition to primary procedure)."

Only codes with the add-on code designation (i.e., preceded by a + symbol, include descriptive language in the code descriptor are considered add-on codes.

Codes that precede or follow a designated add-on code are not automatically considered add-on codes. Add-on codes are exempt from the multiple procedure concept and therefore, modifier '-51' cannot be appended to these codes.

The following criteria are used to identify add-on codes in CPT:

- The service or procedure can never serve as a stand-alone code and must be reported in conjunction with another primary service or procedure.
- The service or procedure is commonly carried out in addition to the primary service or procedure performed. If not commonly performed in addition to the primary service or

procedure, it is then defined as a stand-alone code, and when performed in addition to another procedure, the modifier -51 should be appended.

- The service or procedure must be performed by the same physician.
- The add-on code describes additional anatomic sites where the same procedure is performed (e.g., reoperation, additional digit[s], lesion[s], neurorrhaphy[s], vertebral segment[s], tendon[s], and joint[s]).
- The add-on code describes a special circumstance under which a specific service or procedure is performed in conjunction with the primary procedure.
- The add-on code describes an additional segment of time in a time-based code (e.g., each additional 30 minutes).

Trailing – T Codes

The AMA developed CPT Category III codes to track the utilization of emerging technologies, services and procedures. The existence of any CPT Category III codes does not establish a service or procedure as safe, effective or applicable to the clinical practice of medicine.

BCBSND considers all CPT Category III codes not covered unless a BCBSND medical policy specifically extending coverage to a particular CPT Category III code has been published.

Claims submitted with CPT Category III codes that do not have a medical policy will be denied as investigational.

If a provider believes that a CPT Category III code should qualify for coverage (e.g., the service has been proven safe and effective as well as reasonable and necessary), a request for review through the BCBSND medical policy development process may be initiated by submitting the BCBSND Technology Assessment Evaluation form. Refer to section Technology Assessment Evaluation Criteria in this manual for more information on this form.

Copies of the clinical references and peer-reviewed specialty guidelines must be submitted with the Technology Assessment Evaluation form.

Modifiers

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

To ensure you receive the most accurate payment for services rendered, use the appropriate modifiers when filing the claim. Append applicable modifier(s). If necessary, please submit medical records with your claim to support the use of a modifier.

Please use the following tips to avoid the possibility of rejected claims:

- Indicate the valid modifier.
- List up to four modifiers per CPT and/or HCPCS code.
- Do not use other descriptions in this section of the claim form. In some cases, the system may read the description as a set of modifiers, and this could result in lower payment.

- Avoid excessive spaces between each modifier.
- Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion.

If you have questions about billing with modifiers, call Provider Service at 1-833-777-5779, Monday through Friday, 8 a.m. to 6 p.m. CST.

BlueCard® Program for Out of Area Services

The BlueCard Program links participating providers and the independent BCBS Plans across the country and abroad with a single electronic network for claims processing. The program allows BCBS participating providers in every state to submit claims for members who are enrolled through another Blues Plan to their local BCBS Plan.

Blue Cross and Blue Shield Plans currently administer Medicaid programs in various states as a Managed Care Organization (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan.

How to Identify BCBSND Medicaid Expansion Members

The Prefix

The three-character prefix of the member's identification number is the key element used to identify and correctly route a claim. For BCBSND Medicaid Expansion members the prefix will be YME.

The Identification (ID) Card

Members enrolled in a BCBSND Medicaid Expansion product are issued a BCBSND plan ID card. BCBSND ID cards for Medicaid members:

- Will indicate on the top right-hand side, that the member is enrolled in a Medicaid Expansion product.
- Will not include a suitcase logo.
- Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness.

How the Program Works

Provider's rendering services should always submit an eligibility inquiry. It is important to have all members show their most recent identification cards for an accurate response for their current plan.

1. You may verify the member's coverage by:
    a. Using the Availity Essentials portal Eligibility and Benefits transaction; or
    b. Calling BlueCard Eligibility at 800- 676-BLUE (2583).
        i. An operator will ask you for the prefix on the member's ID card and will connect you to the appropriate membership and coverage unit at the member's plan.
2. If you are unable to locate a prefix on the member's ID card, check for a Customer Service phone number on the back of the ID card to further verify.
3. After you provide services to a BCBSND Medicaid Expansion member, file the claim in accordance with your contractual agreement.

Reminder: The claim must be filed using the prefix and identification number located on the patient's ID card.

4. Once the claim is received, it is electronically routed to the member's BCBS Plan.
5. The member's plan adjudicates the claim, either approving or denying payment.
6. BCBSND reconciles payment and forwards it to the provider according to your payment cycle. The member's BCBS plan sends a detailed Explanation of Benefits (EOB) report to the member.

Out-of-Network Services

Medicaid Expansion members have limited out-of-network benefits. A prior authorized referral is required for services provided by a provider not participating with the BCBSND Medicaid Expansion network. Refer to the **Referrals for Out-of-Network Services** section for more detail.

Note: BCBSND does not require out-of-state out-of-network providers to be participating with their local Medicaid. However, participation with ND Medicaid is required to see a BCBSND Medicaid Expansion member.

For details regarding precertification, refer to the **Utilization Management Program** section of this manual.

Provider Enrollment Requirements

Some states such as North Dakota require that out-of-state providers enroll in their state's Medicaid program to be reimbursed.

If a provider is required to enroll in another state's Medicaid program, the provider should receive notification upon submitting an eligibility or benefit inquiry. Providers should check enrollment requirements in that state's Medicaid program before submitting the claim.

If a provider submits a claim without enrolling with Medicaid, their claims will be denied, and they will receive a non-covered provider liable denial on the provider remittance.

Claim Submission

Claims for all BCBSND Medicaid Expansion members should be submitted to your local BCBS Plan, unless noted otherwise. If a member has other primary insurance coverage, file according to the primary insurance plan's guidelines. More information regarding Medicaid Expansion claim filing guidelines and exceptions can be found in section Claim Submission: Timeframes in this manual.

After services are provided to a BCBS member, file the claim according to your contractual arrangements. If you contract directly with the member's BCBSND plan, file the claim directly to BCBSND.

An out-of-state provider billing for services rendered to a BCBSND Medicaid Expansion member will be reimbursed according to the BCBSND fee schedule, unless stated otherwise. Out-of-state providers must accept the allowed amount applied. Billing Medicaid Expansion members for the difference between the allowance amount and charges for covered services is prohibited. If you provide services that are not covered by BCBSND Medicaid Expansion to a Medicaid Expansion member, reimbursement will not be made. You may only bill a member for non-covered services if you have obtained written approval from the member in advance of the services being rendered, such as an AMN; see Member-Demanded Services section for more details.

Ancillary Claims Filing Instructions

Ancillary claims for Independent Clinical Laboratory, Durable (Home) Medical Equipment (DME) and medical supplies are filed to the Local Plan whose service area the ancillary services were provided.

- Independent Clinical Laboratory- the Local Plan is determined by which service area the referring provider is located.
- DME- the Local Plan is determined by which service area the equipment was shipped to or purchased at from a retail store.

Contiguous Counties

Contiguous county rules determine which plan a provider should file to if they are participating with one or both plans.

For providers located in counties of states that border North Dakota (Minnesota, Montana and South Dakota) the claims filing rules are:

- If a member has insurance coverage with BCBSND and receives services from a health care provider located in a bordering county, which is participating with BCBSND, the provider must follow these contiguous county guidelines.
- If a health care provider in a bordering county is not participating with BCBSND but is participating with the Blue Cross Blue Shield plan where the provider is located and provides services to a member with coverage from BCBSND, the provider must file claims to the local

Blue Cross Blue Shield plan.

Contiguous county filing examples are given below. In most cases you will file claims to the Host (local) plan. Exceptions to situations like example number four or ancillary scenarios may apply.

Example 1:

An out-of-state-Host plan provider renders care to a BCBSND-Home Plan's member in the Host Plan's service area.

- No other Plan serves the area, and the area is not contiguous with the Home Plan's service area.
- Provider files the claim with the Host (local) Plan.
- Claim is considered a BlueCard claim.

Example 2:

Provider has an office in two different plans' service areas and has local and contiguous county contract with both plans.

- Dr. Smith has an office in ND and an office in MN in an area contiguous to ND.
- Dr. Smith has a contract with ND and MN and a contiguous county contract with ND.
- Dr. Smith sees a BCBSND Medicaid Expansion patient in his ND office and the member resides in ND; a claim should be filed to ND.
- Dr. Smith sees a BCBSND Medicaid Expansion patient in his MN contiguous county office, the member resides in ND, a claim should be filed to ND.

Example 3:

Provider located in one service area, does not have a contract with the plan in this service area, and has a contiguous county contract with another plan.

- Dr. Smith, located in MN, and does not have a contract with MN.
- Dr. Smith has a contiguous area contract with ND.
- Dr. Smith sees a BCBSND Medicaid Expansion patient in his MN office, the member resides in ND, a claim should be filed to ND.

Example 4:

A non-participating provider renders care to another Control/Home Plan's member in the Par/ Host Plan's service area.

- Provider files the claim with the local plan.
- Claim must be processed through BlueCard program.

APPEALS, GRIEVANCES AND DISPUTES

Appeal Process

Appeals Must Be Made Within 60 Days

An individual enrolled in Medicaid Expansion who receives an Adverse Benefit Determination has the opportunity for **one level** of appeal. Appeal requests can be submitted verbally or in writing to BCBSND within 60 calendar days from the date of the written notice of Adverse Benefit Determination from BCBSND.

Verbal requests must be followed by a written, signed appeal, except for expedited appeals.

Submitting an Appeal

Phone: 1-833-777-5779

Fax: 701-277-2209

Online: https://www.bcbsnd.com/providers/eligibility-claims/provider-appeal

Mail: BCBSND Medicaid Expansion
Attn: Appeals, Grievances, Complaints
PO Box 1570
Fargo, ND 58107-1570

BCBSND acknowledges appeal requests, verbally or in writing, and provides the following:

- An explanation of the process that will be followed to resolve the appeal, and
- Information about a member's right to present evidence and testimony and make legal and factual arguments, in person and in writing.

Standard Pre-Service Appeals

An standard pre-service appeal may be filed directly by a member or from a provider acting on behalf of the member as an authorized representative. Members seeking covered services that require precertification grant to that provider the authority to act on behalf of the member as the member's Authorized Representative. As an Authorized Representative, the provider assumes responsibility to act on behalf of the member in pursuing a claim for benefits or appeal of an Adverse Benefit Determination.

A notice of resolution is provided to affected parties as expeditiously as the member's health condition requires or within 30 calendar days from the day BCBSND receives a standard pre-service appeal, with a possible 14-day timeline extension.

Expedited Pre-Service Appeals

An expedited pre-service appeal review may be requested if BCBSND, the member or the authorized representative indicates the timeline for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function. Pre-service expedited appeals may be filed directly by a member or

from a provider acting on behalf of the member as an authorized representative. Members seeking covered services that require precertification grant to that provider the authority to act on behalf of the member as the member's Authorized Representative. As an Authorized Representative, the provider assumes responsibility to act on behalf of the member in pursuing a claim for benefits or appeal of an Adverse Benefit Determination.

Retrospective Review Claim for Benefits Inquiry

A retrospective review claim for benefits inquiry is defined as a request, either verbal or written, for a medical review of services that is subject to a member obtaining approval in advance of obtaining the benefit or service — but advance approval was not obtained before services were provided to the member. Determinations regarding retrospective review claim for benefits are based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

The provider is responsible for providing BCBSND with a retrospective review claim for benefits within 60 calendar days after the date the benefits or services offered under their benefit plan were incurred. A notice of resolution is provided to affected parties within 30 calendar days from the day BCBSND receives a standard appeal, with a possible 14-day timeline extension.

Post Service Appeals

Post service appeals can be filed by the provider. A notice of resolution is provided to affected parties within 30 calendar days from the day BCBSND receives a standard appeal, with a possible 14-day timeline extension.

Timeline Extensions Available for Standard and Expedited Appeals

The timeline for resolving standard or expedited appeals and providing notice may be extended by up to 14 calendar days if:

- The member requests the extension
- BCBSND requires additional information and the delay is in the member's interest

If BCBSND extends the timeframe, and the extension was not requested by the member, BCBSND shall:

- Give the member prompt verbal notice of the delay,
- Within two calendar days, provide the member written notice of the reason for the delay, including the right to file a grievance if the member disagrees with the decision, and
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the new deadline.

If BCBSND fails to adhere to the appeal process notice and timing requirements, the member will have exhausted the BCBSND appeal process and may initiate a State Fair Hearing.

Information Considered in Appeals

Before and during the appeal process, BCBSND provides the member, the provider and authorized representative with the opportunity to examine the member's case file, including medical records and other documents considered or generated by BCBSND in connection with the appeal of the Adverse Benefit Determination.

This information is provided free of charge in advance of the 30 calendar days of BCBSND's receipt of the appeal for standard appeals or in advance of the three days of BCBSND's receipt of the appeal for expedited appeals to provide enough time for review.

Timeframes for Appeal Resolution and Notification

Appeal Type	Response Timeframe
Standard Pre-Service	Written response within 30 days
Expedited Pre-Service	Verbal response within 72 hours, followed by written response within 3 days
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post Service	Written response within 30 days

Notice of Appeal Resolution

The notice of appeal resolution is sent to affected parties and will include the following:

- The results of the appeal resolution process and the date it was completed
- For appeals not resolved wholly in favor of the member, BCBSND will include the following:
  - The right to request a State Fair Hearing and how to do so, including the specific timeframe for the filing.
  - The right to request continuation of the disputed services if the appeal decision is to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider and the original period covered by the original authorization has not expired.
- How to request continuation of disputed services
- A statement that the member may be liable for the cost of disputed services provided if the State Fair Hearing decision upholds BCBSND's Adverse Benefit Determination

In the case of an expedited appeal, in addition to providing written notice, BCBSND shall make reasonable efforts to provide verbal notice of the resolution.

Appeal Decision-Makers

BCBSND individuals who make appeal decisions:

- Are not involved in a previous review or decision
- Are not subordinates of someone involved in a previous review or decision

- Are health care professionals with appropriate clinical expertise in treating the member's condition or disease if deciding the following:
  - An appeal of a denial that is based on lack of medical necessity
  - An appeal that involves clinical issues
  - A grievance regarding the denial of an expedited appeal resolution
- Consider all comments, documents, records and other information submitted by the member or their representative without regard to whether the information was submitted or considered in the initial Adverse Benefit Determination

Continuation of Services

The member's benefits are maintained while an appeal is in process if all of the following apply:

- The member files the request for an appeal within 60 calendar days following the date on the Adverse Benefit Determination notice.
- The appeal involves the termination, suspension or reduction of a previously authorized service.
- The member's services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The request for continuation of benefits is filed on or before the later of the following:
  - Within 10 calendar days of BCBSND sending the notice of the Adverse Benefit Determination or
  - The intended effective date of the BCBSND's proposed Adverse Benefit Determination.

If, at the member's request, BCBSND continues or reinstates the member's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal or request for State Fair Hearing.
- The member does not request a State Fair Hearing and continuation of benefits within 10 calendar days from the date that BCBSND sends the notice of Adverse Appeal resolution.
- A State Fair Hearing decision adverse to the member is issued.

BCBSND may recover the cost of continued services furnished to the enrolled member while the appeal or State Fair Hearing was pending if the final resolution of the appeal or State Fair Hearing upholds BCBSND's Adverse Benefit Determination.

BCBSND pays for disputed services received by the member while the appeal was pending when BCBSND or the State Fair Hearing officer reverses a decision to deny authorization of the services.

Process for State Fair Hearings

A member, or other party to the appeal who has completed BCBSND's appeal process, may request a State Fair Hearing after receiving a notice of the appeal resolution indicating that

BCBSND is upholding, in whole or in part, the Adverse Benefit Determination, or after BCBSND fails to adhere to the notice and timing requirements for appeals.

The member or other party has 120 calendar days from the date of BCBSND's notice of resolution to request a State Fair Hearing.

BCBSND attends the State Fair Hearings as scheduled and supplies the necessary witnesses and evidentiary materials.

BCBSND submits an evidence packet to the state and member, free of charge, within 10 business days from the time BCBSND receives notification of the hearing. The evidence packet is submitted according to any prehearing instructions and includes all necessary documents, including the statement of matters or denial letter as well as any medical records and other documents considered by BCBSND and supporting the Adverse Benefit Determination and appeal resolution.

Within two business days of notification of the State Fair Hearing request, BCBSND provides the corresponding notice of Adverse Benefit Determination and the notice of appeal resolution that relate to the State Fair Hearing request to the state.

The member's benefits are maintained while the State Fair Hearing is pending, if the member files for continuation of benefits within 10 calendar days after BCBSND sends the notice of appeal resolution that is not wholly in the member's favor.

BCBSND complies with all terms and conditions set forth in any orders and instructions issued by an administrative law judge.

If, at the member's request, BCBSND continues or reinstates the benefits while the State Fair Hearing is pending, the benefits shall continue until one of the following occurs:

- The member withdraws the State Fair Hearing request or
- The State Fair Hearing officer issues a hearing decision adverse to the member.

If BCBSND's action is reversed by the administrative law judge and services were not furnished while the plan appeal was pending, BCBSND will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when BCBSND receives the notice reversing the determination.

Grievance Process Available to Members

If an individual enrolled in Medicaid Expansion or that member's authorized representative is dissatisfied on any matter other than an Adverse Benefit Determination, they may express that dissatisfaction by filing a verbal or written grievance with BCBSND at any time.

Submitting a Grievance

Phone: 1-833-777-5779

Fax: 701-277-2209

Mail: BCBSND Medicaid Expansion
Attn: Appeals, Grievances, Complaints
PO Box 1570

Fargo, ND 58107-1570

Grievance Timelines

The timeline for the grievance process is as follows:

- BCBSND acknowledges receipt of the grievance within five business days.
- BCBSND provides a written determination of the grievance as expeditiously as the member's health condition requires, but no later than 90 calendar days after receipt of the grievance.
- BCBSND may extend this time period an additional 14 days if:
  - The member or their authorized representative requests the extension or BCBSND demonstrates a need for additional information and the delay is in the interest of the member.
- If BCBSND extends the time period for a grievance determination, the member or their authorized representative is notified of the delay. The member receives a verbal notice of the delay by the end of business day and a written notice within two calendar days.

Provider Dispute Process

A provider dispute, also known as a complaint, is a written or verbal disagreement with an administrative or claim matter.

Submitting a Dispute

Phone: 1-833-777-5779

Fax: 701-277-2209

Online: https://www.bcbsnd.com/providers/news-resources/forms-documents/medicaid-expansion-provider-dispute-form

BCBSND staff handle provider complaints by gathering pertinent facts from all parties, investigating each one and ensuring any corrective action is completed.

Timeline for an Administrative Non-Claim Complaint

Administrative complaints can include disputes related to policies, procedures, or any aspect of an administrative function.

Providers must submit any non-claim complaints within 45 calendar days of the date the issue occurred.

BCBSND staff must:

- Acknowledge receipt and give an expected resolution date within three business days
- Provide a written status update every 15 calendar days
- Resolve the complaint within 90 calendar days with written notice of the disposition and the basis of the resolution within three business days of the resolution

Timeline for Claim Complaints

Claim complaints may consist of proposed actions, claim and billing disputes or service authorizations.

Providers must submit any claim complaints within 90 calendar days of the date of final determination.

BCBSND staff must:

- Acknowledge receipt and give an expected resolution date within three business days
- Resolve within 60 calendar days with written notice of the disposition and the basis of the resolution within three business days of resolution

Payment Integrity Program

The enhanced BCBSND Payment Integrity Program expands the current program capabilities and will include several additional reviews during and after the claims processing cycle to safeguard members' health care dollars.

Find out more details on these strategies, how to navigate the review, as well as next steps on our website: https://www.bcbsnd.com/providers/eligibility-claims/payment-integrity-program.

Cotiviti disputes are considered reconsiderations, not an appeal. Appeals are adverse benefit determinations (ABD), hence the term and title ABD. Cotiviti findings are not benefit related; they are findings resulting in a payment determination. Rejects are for coding and reimbursement issues that address improper payments.

Note, the process for review may differ than the above outlined appeals process. Below will provide additional clarity.

Retrospective Claim Audits (Post Pay)

- Clinical Chart Validation (CCV) - Review of medical records
  - Reconsideration must be submitted within 60 days from the date of the audit determination letter. See the Cotiviti letter for next steps.
- Retrospective Claims Accuracy (RCA) - Claim originally overpaid
  - Reconsideration must be submitted within 45 days from the date of the audit determination letter. See the Cotiviti letter for next steps.
- Coordination of Benefits Validation (COB) - Coordination of benefits
  - This will follow standard BCBSND processes and will not come from Cotiviti.
- Evaluation & Management (E/M)
  - Reconsideration must be submitted within 60 days from the date of the audit determination letter.

Prospective Claims (Pre-Pay)

- Payment Policy Management (PPM) - Coding and reimbursement issues
- Coding Validation (CV) - Clinical Coding review (a subset of PPM)
  - Prospective request timelines following BCBSND standard appeal timelines and will utilize the BCBSND Appeal form. For more information on the appeals timelines, see the Appeals section above.

Per the Appeals section above, only one level appeal is allowed. However, with payment Integrity, two levels of reconsiderations are allowed. The first one must be submitted within 60 days. The timeframe in which the second reconsideration will be noted within the determination letter of the first reconsideration.

If a provider utilizes the two levels of reconsiderations, there are no additional reconsiderations available.

If a request is received from a provider on behalf of the member, it will be changed to a provider on behalf of self, and this process does not allow for member reconsiderations.

Special Investigations Unit (SIU) and Provider Audit

BCBSND established the Special Investigations Unit (SIU) and Provider Audit department to ensure claims paid by BCBSND are free from coding or billing errors, and services provided are medically appropriate, necessary and delivered in accordance with the member's benefit plan, accepted medical practice standards, and BCBSND policies. These processes ensure fair and equitable coding and billing practices as well as protect our members. The SIU and Provider Audit department is committed to protecting our members' interest through education, deterrence, detection and investigation of healthcare fraud, waste and abuse (FWA).

Objectives

- Identify claims at risk for inaccurate coding or billing
- Identify claims at risk of not meeting medical policy guidelines
- Proactively analyze trends to identify aberrant providers and members
- Identify and monitor coding variations between facilities and providers
- Review claims and corresponding medical records for appropriate coding based on nationally accepted coding guidelines, national coverage standards and BCBSND policy
- Identify incorrect code assignments that affect payment to the provider.
- Inform providers of review findings
- Provide education based on findings to promote consistency in code utilization among providers
- Assure identified or reported concerns of FWA are investigated and resolved timely and appropriately
- Implement corrective actions to prevent recurrence of FWA

Provider Audit and SIU Process

Audit Process:

Claims are analyzed for appropriate submission and payment.

Claims identified as potentially at risk of inappropriate submission, coding, or payment are selected for additional review.

Medical records and any additional information, if required, are requested from the provider or facility via certified letter or fax with an identified due date.

- If the requested information is not received by the due date, all claims associated with the requested information are denied and not eligible for reconsideration.

Claims, medical records and other supplied information are reviewed by a coding or medical professional for compliance

- CPT®
- HCPCS®
- ICD-CM
- ICD-PCS
- CPT® Assistant
- Coding Clinic
- BCBSND policy
- Other nationally accepted coding guidelines

If applicable, the claim may be reviewed for medical necessity by an appropriate medical professional.

Results of audit findings are communicated via a letter to the provider and/or other designated contact, or via a written memorandum provided during an onsite visit. The process for correcting any identified errors via an adjustment request is outlined in the letter or memorandum. The provider will have 30 days to submit an adjustment request (If applicable), or to request a reconsideration. Adjustment requests that are not supported by submitted documentation will result in the claim or claim line(s) being denied.

Should a provider fail to respond within the 30-day timeframe, in fairness to all providers, the provider has waived any opportunity for reconsideration or adjustment, and identified claims or claim line(s) will be denied.

Reconsideration Process

If the provider disagrees with any findings, they may request a reconsideration. The reconsideration process is an opportunity for providers to request reconsideration of findings made as a result of an original audit conducted by SIU and Provider Audit. This process applies only to findings communicated by the SIU and Provider Audit department.

The provider must submit a written request. This request must include any additional

information, any medical records not previously supplied, and the rationale for the request within the deadline communicated in the notification of audit findings. Please send the request to:

Manager SIU and Provider Audit
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo ND 58121

The request will be reviewed by a different coding or medical professional not involved with the original audit. BCBSND will respond to the provider within 45 days of the receipt date of the request with a determination unless otherwise communicated. If, after review, the initial audit finding is upheld, the claim line(s) will be denied.

This is the final level of reconsideration or review. No further adjustment or reconsideration of the claims will occur.

Self-Audit

If during an audit significant errors are identified, a provider may be required to complete a self-audit. If required:

The provider will be provided with a list of all claims subject to the self-audit.

The provider will have the opportunity to review their medical record documentation.

- If the provider finds upon their review that the documentation supports the service billed, they must supply the supporting documentation in compliance with the instructions in the letter or memorandum.
- If, upon review, it is identified that a more appropriate code should have been billed; the provider will send the corrected claim information via an adjustment request and submit this information along with all supporting documentation.
- If it is determined the service(s) should not have been billed, the provider may submit corrected information indicating such or not respond. All claims without supporting documentation supplied by the deadline will be denied as indicated in the communication.
- Submitted documentation will be reviewed by a coding or medical professional. Documentation submitted without an adjustment request will be considered a reconsideration.
- Claims found to be appropriately supported by the documentation will remain paid.
- Claims submitted for correction will be corrected via an adjustment request if the documentation supports the requested change.
- Any claims or correction requests found not supported by documentation supplied will be denied and this will be communicated back to the provider. No further opportunity for reconsideration or adjustment is available.

Claims with no documentation supplied will be denied. No further opportunity for review of records not initially submitted is available.

Results of the self-audit will be communicated back to the provider, including any further

corrective actions to be implemented.

DEFINITIONS

Terms and definitions may not apply to all benefit plans. Please contact Provider Services at 1-833-777-5779 for plan-specific information.

1915(i) Services
Services allowed as part of North Dakota's Medicaid plan under 1915(i) for eligible members. 1915(i) services include care coordination, training and supports for unpaid caregivers, peer support, non-medical transportation, community transition services, benefits planning services, supported education, pre-vocational training, supported employment and housing supports.

Affiliation
A clinic or group of independent physicians chosen by enrolled members on the benefit plan from which they will receive health care services. Also referred to as the member's network.

Affordable Care Act (ACA)
The ACA is legislation (Public Law 111-148) signed by President Barack Obama on March 23, 2010. It is also referred to as the health care reform law or Obamacare.

Allowed Charge
The maximum amount payable to a provider for a procedure or service. When seeking services from a BCBSND participating provider, the allowed charge (and any cost-sharing amounts) is accepted as payment in full for covered services.

Ancillary Services
All hospital services for a patient other than room and board and professional services. Laboratory tests and X-rays are examples of ancillary services.

Authorized Referral
If a level or type of service is not available within the Medicaid Expansion network, an authorized referral is required to be submitted by a network provider for benefits at the in-network level.

Benefit Period
A specified period of time when benefits are available for covered services under a benefit plan. A claim is considered for payment only if the date of service or supply are within the benefit period. All benefits are determined on a calendar year benefit period (January 1 through December 31).

Chiropractic Maintenance Care
Elective health care that is typically long-term, by definition not therapeutically necessary, but provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration, or it may be initiated with patients without symptoms in order to promote health and prevent future problems.

Claim
Information provided by a provider or a member to establish that services were provided. Providers submit the claim to BCBSND on the member's behalf.

Claim Number
The number assigned to a claim for services when it is entered into the claims processing system.

Claim Status
"Processed claims" are claims that have been successfully processed through BCBSND's system. "In process claims" are claims that haven't completed the processing cycle.

Covered Services
Medically appropriate and necessary services and supplies for which benefits are available when provided by a provider.

Explanation of Benefits (EOB)
A document sent to the member by BCBSND after a claim for services has been processed. An EOB includes the member's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by the benefit plan, non-covered services and the amount that is the plan holder's responsibility. This document should be carefully reviewed and kept with other important records.

Identification Card (ID Card)
A card issued by BCBSND to the plan holder as evidence of membership. The card includes the plan holder's name, benefit plan number and primary care provider.

In-Network Services
Services a member receives from a provider within the Medicaid Expansion network. Members must obtain all medical services from this network.

Medically Appropriate and Necessary
A term used to describe those services, supplies or treatments provided by a provider to treat an illness or injury that satisfies the following criteria as determined by BCBSND:

- The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of a member's illness or injury.
- The services, supplies or treatments are consistent with professionally recognized standards of health care.
- The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the member's illness or injury.

Member
Any individual enrolled in the Medicaid Expansion program.

National Provider Identifier (NPI)
A 10-digit number unique to each provider that is issued by the Centers of Medicare & Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Network
A clinic or group of independent physicians. They have agreed to accept BCBSND negotiated rates as payment in full. See also In-Network Services and Out-of-Network Services.

Network Provider
Health care providers contracted with BCBSND for the ND Medicaid Expansion Network, enrolled with the State of North Dakota Medicaid Program and located within the service area. Network providers include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Indian Health Care Providers (IHCP).

Online Explanation of Benefits (EOB)
An online Explanation of Benefits (EOB) is a document that members can view or print from claim detail on the website after a claim for services has been processed. It includes the member's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by the benefit plan, non-covered services, cost-sharing amounts and the amount that is the plan holder's responsibility.

Out-of-Network Services
Services that members receive from a provider outside the member's chosen network. Out-of-network services are not covered unless an approved referral is obtained.

Precertification
Also known as prior approval or prior authorization. The process of the member's provider submitting information to BCBSND providing evidence of the medical appropriateness of specified services to BCBSND in order to receive benefits for such service. This information should be submitted in writing from the member's provider. Eligibility for service benefits requiring precertification is contingent upon compliance with the provisions of a member's benefit plan. Precertification does not guaranteee payment of benefits. BCBSND reserves the right to deny benefits if prior approval is not obtained before services are rendered.

Prescriber
A physician or other person licensed, registered, or otherwise permitted under their licensure to prescribe prescriptions for drugs to patients.

Primary Care Provider (PCP)
A group of in-network physicians, nurse practitioners or physician assistants who accept primary responsibility for the management of a member's health care. The primary care provider is the member's point of access for preventive care or an illness and may treat the member directly, refer the member to a specialist (secondary/tertiary care), or admit the member to a hospital.

Provider
A hospital, clinic, physician or other facility that provides health care services.

Service Date
The date on which services were provided to the member.