BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

Medicaid Expansion Provider Manual

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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 as an organization does not specifically reward providers or other individuals for issuing denials of coverage. Utilization Management (UM) decision making is based only on appropriateness of care, service and existence of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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 833-777-5779.

Members’ rights and responsibilities

We understand the importance of keeping our members' rights and responsibilities one of our top priorities. We rely on our provider community to uphold the same standards. Listed below are the members’ rights and responsibilities as outlined in the member benefit book.

Members have the right to:

- Receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sexual orientation or sex.
- Be treated respectfully and with consideration for your personal dignity and privacy.
- Privacy of your personal health information that BCBSND maintains in accordance with federal and state laws.
- Request and receive a copy of your medical records in the possession of BCBSND and request that they be amended or corrected in accordance with the federal law.
- Be informed about your health condition and receive information regarding available treatment options and alternatives, in a manner appropriate to your condition and ability to understand, regardless of cost or benefit coverage.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Make recommendations regarding this Member rights and responsibilities statement.
- Use the Grievance and appeal process for complaints, comments and timely resolution of disputes. You may do so by contacting BCBSND Member Services at the telephone number on the back of your Identification Card.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Be free to exercise all rights and that by exercising those rights, you shall not be adversely treated by the North Dakota Department of Health & Human Services, BCBSND or its Network Providers.
- Receive information about BCBSND, its products and services, its Network Providers and your rights and responsibilities, in accordance with 42 CFR §438.10.
- Request assistance with effective communication including written information in other formats and written and oral translation services.

Members have the responsibility to:

- Know your health plan benefits and the requirements for accessing and receiving benefits under this Benefit Plan.
- Notify the North Dakota Department of Health & Human Services within 10 days at toll-free (844) 854-4825|ND Relay TTY: (800) 366-6888 (toll-free) if you change your name, address or telephone number.
- Notify the North Dakota Department of Health & Human Services of any changes of eligibility that may affect your membership or access to services.
- Provide the necessary information to your Health Care Providers to determine appropriate care.
- Follow the treatment plan prescribed by your Health Care Provider.
- Timely provide BCBSND the necessary information to process your claims and provide you with the benefits available to you under this Benefit Plan.

BCBSND accreditation

BCBSND holds full URAC accreditation for the Medicaid Health Plan. 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
- Population health (includes Care Management)

BCBSND also holds URAC Mental Health and Substance Use Disorder (MH/SUD) Parity Accreditation for Medicaid. URAC's MH/SUD Parity Accreditation is designed to validate that health plans and related organizations comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and relevant state parity laws:

- Ensuring Compliance
- Promoting Equity
- Risk Mitigation
- Driving Quality and Consistency

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

Eligibility coverage and benefits

The North Dakota Department of Health and Human Services (NDDHHS) 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.

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

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

A list of our covered services can be found on our website at https://medicaid.BCBSND.com/content/dam/medicaid/documents/Medicaid-Expansion-Certificate-of-Insurance.pdf. Note, this is not a guarantee of payment. If you have questions regarding eligibility and/or benefits, call Provider Service at 833-777-5779.

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.

Availity is an independent company providing provider portal services on behalf of BCBSND.

Referrals for out-of-network services

Individuals enrolled in Medicaid Expansion are eligible for benefits when they receive health care 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, use the precertification request option as stated above. Required fields for authorized referrals within Availity Essentials include:

Current Procedural Terminology code

If the Current Procedural Terminology (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 an 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 smears
- 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

Note: More information regarding emergency room (ER) 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 NDDHHS. Detailed requirements are in the Credentialing and Recredentialing Policy.

Provider Group Participation Agreement(s)

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.

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 any amount over BCBSND's allowed amount from the member. 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, unless noted otherwise:

- Contracting provisions
- Professional fee schedules – 60 days
- Medical policies
- Reimbursement policies
- Institutional fee schedules – 60 days

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.

Provider access and availability standards

- BCBSND's standards are designed to ensure that all covered services provided by primary care and specialty care providers, including additional or supplemental services contracted for or on behalf of the member, are available and accessible 24 hours a day, seven days a week, when medically necessary.
- BCBSND will ensure that provider after-hours answering machines instruct members to go to an ER or call 911 in the event of an emergency.
- Network Providers must follow the recommended access standards and appointment availability.
- BCBSND shall ensure 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 in accordance with 42 C.F.R. §438.910(d)(3).
- BCBSND shall meet and require its Network Providers to meet North Dakota standards for timely access to care and services as specified in this policy, taking into account the urgency of the need for services [42 C.F.R. §438.206(c)(1)(i)].
- If BCBSND is unable to provide the necessary services to a Member within their Network, BCBSND shall adequately and timely cover these services Out-of-Network for the Member for as long as BCBSND's Provider Network is unable to provide the services. BCBSND shall ensure coordination with respect to authorization and payment issues in these circumstances to ensure that the cost to the Member is no greater than it would be if the services were furnished within the Network.

Access standards

- Disability access
  - Network providers must provide physical access, reasonable accommodations and accessible equipment for members with physical or behavioral health disabilities.
  - Access information should be displayed on the provider's website.

- Emergency or life-threatening events
  - Network providers must provide after-hours answering machines that instruct members to go to an ER or call 911 or 988 in the event of an emergency.
- Nonemergency or non-life-threatening events
  - Network providers must provide after-hours availability to patients who need medical advice.
  - At a minimum, the PCP office shall have a return call system staffed and monitored to ensure that the member is connected to a designated medical Practitioner within thirty (30) minutes of the call.
- Limited language proficiency
  - Network providers shall deliver services that respect and understand the cultural and language needs of all members. This includes helping people who don't speak English well, come from different cultural and ethnic backgrounds, have disabilities, or identify with any gender or sexual orientation. Providers should also make sure to meet the language needs of members, including offering sign language interpreters.
  - Network providers must have interpretation services available.
  - Interpretation services are provided for both in-person and telephone communications to ensure that a member is able to communicate with providers.

Availability standards

BCBSND will follow the recommended appointment availability and access standards for Primary Care and Specialty Care Practitioners:

- Primary Care Practitioners
  - Identified as General/Family Practice (includes OB/GYN and women's health specialties) and Internal Medicine
  - Emergency services: Available 24 hours a day, seven (7) days a week (may be by telephone)
  - Routine, non-urgent or preventative care appointments:15 business days of member request
  - Urgent, symptomatic but not life-threatening care (care that can be treated in the doctor's office): Within 24 hours
  - Non-urgent sick care: Within 72 hours, or sooner if condition deteriorates into urgent or emergency condition
- Behavioral Health and/or Substance Use Disorder (SUD) providers:
  - Emergency services non-life threatening: Within 6 hours
  - Non-urgent: Within 10 business days
  - Emergency services: Available 24 hours a day, seven (7) days a week (may be by telephone)
  - Follow up for routine care: within 30 business days
- High Volume and High Impact Specialty Providers:
  - High volume specialties defined as "specialties that are expected to treat a large number of members within a geographic area"
  - High Impact Specialties defined as "practitioner types that treat conditions that have high mortality and morbidity rates and where treatment requires significant resources"
  - Consultation within 30 business days

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 important 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 at 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 Ave. S.
Fargo, ND 58121

PCP responsibilities

When individuals enroll in Medicaid Expansion, they are assigned a 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 care managers to develop individualized plans of care for high-risk enrollees receiving care management services and participate on their care 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 drivers 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. For purposes of this Provider Manual, the capitalized terms "Part 2 Program," "Part 2 Records" and "Substance Use Disorder" shall have the meanings provided in 42 C.F.R. § 2.11.

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 Part 2 Records to BCBSND without obtaining patient consent. BCBSND will require all Part 2 Programs (including non-participating providers) to obtain consent for BCBSND's treatment, payment and health care operations.

BCBSND is prohibited by law from using any Part 2 Records 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 Part 2 Records to BCBSND, the Provider certifies and warrants that the Provider has first obtained patient consent in substantially the same form as the BCBSND 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. The BCBSND Consent Form includes all the necessary components and can be used by Providers as needed. In the event of an audit, this specific BCBSND Consent Form would not need to be used, however all the components of this BCBSND Consent Form would need to be included and specifically state **"42 CFR part 2 prohibits unauthorized use or disclosure of these records."** The BCBSND Consent Form can be found at: https://www.bcbsnd.com/content/dam/bcbsnd/documents/forms/providers/Confidentiality-of-Substance-Use-Disorder-Consent.pdf.

The Provider will not submit a claim containing Part 2 Records unless and until the patient has provided consent (i) for the Provider to use and disclose the Part 2 Records for treatment, payment and health care operations and (ii) for BCBSND to use and redisclose the Part 2 Records for treatment, payment and health care operations, as permitted by 42 C.F.R. § 2.33. The patient consent should be substantially in the form as the BCBSND Consent Form, as provided above. The Provider acknowledges and agrees that: (a) BCBSND will assume any claim or other information it receives from the Provider that contains Part 2 Records has been disclosed pursuant to patient consent as specified above; and (b) BCBSND reserves the right to deny payment of provider's claims (and the right to refuse to process other information) in the event that provider fails to obtain consent as described herein.

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 Healthcare Common Procedure Coding System (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 birth on each page of documentation
- Date of service
- Date and signature of the ordering and/or rendering provider
- 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.
  - All time-based codes should include enough documentation to support time spent rendering the service. BCBSND prefers providers use start and stop time to ensure accurate reflection of the service duration.

For providers who perform telehealth services, the following information is also necessary to include in the medical dictation when these services are provided. The information below 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) or 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 transportation (NEMT) is required. Medicaid Expansion transportation providers are responsible for keeping records for each member that is transported to a covered service. This documentation should be retained for at least seven 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 – starting and ending mileage of the trip
- Member signature

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

Diagnostic imaging

Appropriate use 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
    - Date of birth 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 (8) 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

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 documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, it could not be concluded that some of the allowed services were actually provided, were provided at the level billed or were medically necessary). Insufficient documentation 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 (e.g., unsigned, undated, insufficient detail)
- Unauthenticated medical records (e.g., 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 (e.g., 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 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.

In alignment with National Committee for Quality Assurance (NCQA), BCBSND expects providers to participate in data exchange activities and maintain documentation that reflects coordination of care across settings. This includes responding to medical record requests that support our audit processes and organization's process for evaluating continuity and coordination of care.

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, 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 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 a 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 time frames 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. Enrollment with both the State of North Dakota and BCBSND is required.

Providers should refer to https://www.bcbsnd.com/providers/medicaid-expansion/resources/medicaid-expansion-1915-i-providers for more information on the program and requirements to get started.

For additional questions, refer to the following:
1915(i) Process Overview | DHS - Behavioral Health Division (nd.gov)

Non-Emergency Medical Transportation providers

The North Dakota Medicaid Expansion program provides the opportunity to Non-Emergency Medical Transportation (NEMT) providers to coordinate nonemergency medical transportation to and from medical appointments for our North Dakota Medicaid Expansion members when no other transportation source is available. NEMT providers 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 at 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 NDDHHS 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 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 OON 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 OON 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 – Friday, 7 a.m. to 7 p.m. (CT)
- **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:

- **Email:** Provider Credentialing and Data Management at prov.net@bcbsnd.com

Provider resources

Contact information

Service/ Department	Email/website	Phone	Fax	Hours of Operation (CT)
Provider Services	N/A	1-833-777-5779	1-701-282-1888	8 a.m. to 5 p.m.
Member Services	N/A	1-833-777-5779	1-701-282-1888	8 a.m. to 5 p.m.
Availity Essentials	https://www.availity.com	1-800-282-4548	N/A	7 a.m. to 7 p.m.
Care 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	N/A	N/A	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 (HCN) Weekly
HCN 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 email notification of HCN releases, 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 publication 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 Health Insurance Portability and Accountability Act (HIPAA) regulations, and there is no cost for providers to register or use any of the online tools.

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 or 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 transfer (EFT) request

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

Care coordination programs

Care management

Because serious illness can have emotional impacts, BCBSND provides members with a voluntary care 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.

Enrollment in Care Management is voluntary, at no additional cost to the member. A referral to the program is initiated by the individual member, their authorized representative or their health care provider. Find out more information by reviewing https://www.bcbsnd.com/providers/medicaid-expansion/arkos-health-care-management.

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 (ALS)
- 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 interchangeably 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.
- Precertifications 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.
  Read further 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.

Note: If a member's admission date gets moved to a future date, a provider must notify our UM team of the new admission date. This can be done by phone (800-952-8462) or fax (701-277-2971). Include the authorization approval number and the new date.

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.

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 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 using 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 Care 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 (7) 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 instructions on all inpatient discharges if you provide services in any of these settings: inpatient rehab, inpatient hospital, long-term acute care, skilled nursing facilities and residential treatment centers.

The information below can be faxed through the prior authorization fax line (701-277-2971):

- The prior authorization number of the approved stay, when applicable
- Member name, date of birth and BCBSND member ID (UMI)
- Discharge date
- Discharge notes, including any after-care appointments

Precertification and 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 the 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. Jan. 1 – Jan. 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 use can affect response time.

- Log in to Availity, complete the request services and attach all records supporting the medical necessity of your request.
  - 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

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 use the appropriate authorization form(s) above and/ or indicate on the documentation the member information, provider NPI/Address/Fax, time frame of the request, diagnosis, procedure codes (if an outpatient request) and contact information for questions.

Determination timelines for initial determinations range up to 72 hours for urgent care or up to 15 days for non-urgent care. These time frames 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, it 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 maintaining a streamlined process to ensure all requests are handled timely and in accordance with state and federal regulations. Availability of providers' and members' schedules alone does not meet the definition. Every effort will be made to complete the review as soon as possible.

Retrospective Utilization Management

Retrospective Utilization Management (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 overturned 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 Service at 1-833-777-5779 to request a peer-to-peer conversation by 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 UM requirements

The plan may apply monetary penalties, such as a reduction in payment, as a result of the 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.

Please note, the medical policies located in HealthCare News may be outdated and replaced by subsequent medical policy determinations or more updated medical policies appearing online. If you find a discrepancy with a policy and have additional questions, email medicalpolicy@bcbsnd.com.

Viewing versions of a medical policy

When viewing a BCBSND policy you may notice 3 tabs at the top:
- **Current tab**: The current version available for use
- **Draft tab**: Upcoming versions with a future effective date
- **Archive tab**: Previous version of a policy for prior dates of service

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

Medical Policy Development, Adoption and Reviewing Form

BCBSND strives to develop medical policies in an open, collaborative manner with providers. We especially value comments referencing an evidence-based evaluation process. BCBSND created a form that allows practitioners with relevant clinical expertise to provide input and feedback on the development, adoption and application of UM criteria for medical policy. It is located on the Forms and Documents page at https://www.bcbsnd.com/providers/news-resources/forms-documents.

Medical benefit drug medical policy

The NDDHHS 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 use group criteria for approval. Refer to the PDL for more information.

Additional clinic-administered drugs may require precertification if developed, reviewed and approved by the BCBSND Internal Medical Policy Committee and the NDDHHS. 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 member's 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 webpage. The webpage 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 NDDHHS 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. NDDHHS has a 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 DHHS training: https://www.hhs.nd.gov/healthcare/medicaid/provider/education-and-training
- Medicaid Expansion Restricted Use - Precertification Drug List (https://www.bcbsnd.com/me-restricted-drug-list).

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) are 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 outlined 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.
- Must be credentialed.
  - For individual pharmacists, use 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 using our policy search function at https://www.BCBSND.com/providers/policies-precertification/medical-policy/disclaimer.

Coordinated Services Program

BCBSND will collaborate with enrolled members to ensure their health care 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 NDDHHS. Members placed in the CSP will be designated one coordinated service medical prescriber and one pharmacy provider. They 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 use of the member
- 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 time frame 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 time frame 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
- 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 member's primary designated CSP prescriber must initiate the referral. Use 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
- 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 833-777-5779 for specific coverage or policy information.

Fee schedules are confidential

Fee schedules are confidential, 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 NDDHHS

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

National Correct Coding Initiative edits

BCBSND Medicaid Expansion follows the 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 NCCI 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 American National Standards Institute (ANSI) rejection code for these claims as situations may vary. Providers are advised to follow standards processes for claim questions by using Availity Essentials direct messaging or contacting the Customer Contact Center.

Not Otherwise Specified and Not Otherwise Classified

All CPT and 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 include:
  - 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 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 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 second 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.

Note: This list is subject to change. Provider types not listed above should not bill under a supervising provider's NPI. Correct credentialing paperwork needs to be completed accordingly.

Billing for self-services or services provided to immediate family members

No benefits are available for self-services and services provided by a Health Care Provider who is a member of the member's immediate family. Immediate Family Member is defined as “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.

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

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. Institution for Mental Diseases (IMD) is an exclusion under Medicaid Expansion and follows the guidance published on the NDDHHS website: https://www.hhs.nd.gov/sites/www/files/documents/medicaid-policies/institutions-for-mental-disease.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's 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 crossover 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 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 BCBSND for split or shared services. BCBSND will only reimburse one of the billing providers for the services rendered. The provider that performed more than 50% of the time of the visit, or the provider that performed and documented in its entirety the medical decision-making portion of the note will be the determining factor for reimbursement.

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
- 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

Home infusion therapy

Home infusion therapy services include the provision of nutrients, antibiotics and other drugs and fluids administered intravenously, including all medically appropriate and necessary supplies. A home infusion therapy provider provides these services to members or their families who have been trained in the administration of these services.

Home infusion therapy providers must have a separately signed participation agreement and a separate National Provider Identifier (NPI). A home infusion provider is not the same as a home health agency.

Reimbursement is based on the lesser of the provider's billed charges or the payment system in effect at the time services are incurred. For additional information, refer to the fee schedule portal for up-to-date reimbursement notices.

For Specialty Pharmacy claim submissions, the ordering physician's location will dictate the service area as to where the provider should file the claim. When submitting a Specialty Pharmacy infusion claim, the physician's name and NPI, who ordered the service is required. This information should be placed in the referring provider section.

- For electronic claims, this information should be added in the Referring Provider details section.

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
- MRIs
- Radiation therapy
- Angiography
- Outpatient surgery
- Erythropoietin (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
- Dialysis services

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

The All Patient Refined-Diagnosis Related Group (APR-DRG) classification system classifies patients into clinically meaningful groups that account for the severity of illness and risk of mortality. APR-DRG also helps 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)
- Admission 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 severity of illness (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 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 POA. 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 preestablished 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

The Enhanced Ambulatory Patient Group (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.

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).

Electronic Visit Verification

Home health providers who deliver in-home services to Medicaid Expansion members need to use Electronic Visit Verification (EVV) to track member visits. BCBSND has partnered with Sandata, a company that has technology which allows providers with third-party EVV systems to share data about member visits with us, which is called the Sandata Aggregator. Home health providers need to register prior to seeing members. Click here to register: https://sandata.zendesk.com/hc/en-us.

How to file and correct claims

Claim submission: time frames

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

- 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 time frames will be denied unless BCBSND or its subcontractors created the error.

Tips

- Submit NDDHHS-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 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 NPIs 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 additional 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 submitted 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 the 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.

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 date and/or the occurrence 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.

COB questionnaire

To streamline claims processing and reduce the number of denials related to COBs, a 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.

COB out-of-state situations

Refer to the section BlueCard Program for out-of-area situations 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 third 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) allow 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 type 7 claims must be submitted within 90 days from the initial/original claim remittance date, except for the following:
  - COB
  - 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://essentials.availity.com/static/public/onb/onboarding-ui-apps/availity-fr-ui/#/login
3. Select "Claims & Payments" from the menu
4. Under Claims, select 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 type 8, followed by a frequency type 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 type 7 to correct data
- Claim 2: Submit frequency type 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 NPI

Health care providers are assigned an NPI to meet 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 and Electronic Funds Transfer

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.

ERAs 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 - also known as CARC codes. These 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. These are used to provide additional explanations 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 Ave. S.
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

Unsolicited 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 used. 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.

Trailing – T Codes

The AMA developed CPT Category III codes to track the use 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 833-777-5779, Monday – Friday, 8 a.m. to 6 p.m. (CT).

BlueCard® Program for out-of-area services

The BlueCard Program links participating providers and the independent Blue Cross Blue Shield (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.

BCBS 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 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
    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 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 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: Time frames 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 that participates 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 BCBS plan where the provider is located and provides services to a member with coverage from BCBSND, the provider must file claims to the local BCBS 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 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 and 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, 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 and the member resides in ND; a claim should be filed to ND.

Example 4:
A nonparticipating 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: 833-777-5779. Provider Service can also assist with appeal questions at this number.

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
- Information about a member's right to present evidence and testimony and make legal and factual arguments, in person and in writing.

Provider BlueCard Claim Appeal Form

Use this form to request a formal reconsideration of a claim previously adjudicated by BCBSND. The form and more information can be found on https://www.bcbsnd.com/providers/news-resources/forms-documents.

Note: This form or our standard appeal form can be used.

Standard pre-service appeals

A 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 time frame, 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.
- 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, 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.

Time frames for appeal resolution and notification

Appeal type	Response time frame
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 time frame 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
  - 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 is 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 relates 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.
- 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: 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: 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 and 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 use 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 time frame in which the second reconsideration will be noted within the determination letter of the first reconsideration.

If a provider uses 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.

Quality Management

The Quality Management Department provides for planned, systematic activities and processes to monitor and evaluate patient care and services for the primary purpose of assisting providers to improve quality. Quality management includes activities to identify and resolve issues that affect the quality of patient care and services and measure improvements in medical outcomes as a result of treatments provided. If you have a concern with the quality of patient care or services, please contact: QualityManagement@bcbsnd.com.

Patient experience surveys

A Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered on an annual basis to identify opportunities for improvement in patient care and services. Also, a behavioral health member satisfaction survey is administered on an annual basis to members to obtain comprehensive feedback regarding their experiences with behavioral health care experiences. Member satisfaction is evaluated for services provided by BCBSND, hospitals, individual physicians and other providers. Survey results are analyzed and reviewed for trends and opportunities for improvement.

Quality measures

BCBSND measures, analyzes and reports results of quality measures. Quality measures include, but are not limited to, Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). Data is collected though claims, medical record review and the CAHPS survey. The data will be reported in accordance with NCQA, URAC, CMS and Blue Cross Blue Shield Association (BCBSA) requirements. Results of the measures are benchmarked against established goals and monitored for any trends.

Special Investigations Unit 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 health care 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 use 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 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 time frame, 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 to the SIU and Provider Audit department.
  - 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 Service at 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.

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 (Jan. 1 through Dec. 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 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 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 guarantee 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.