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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

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. If this manual’s information conflicts with a Participation Agreement or a member’s benefit plan, the Participation Agreement or benefit plan controls.

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

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

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

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

ELIGIBILITY COVERAGE AND BENEFITS

The North Dakota Department of Human Services (NDDHS) 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.

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

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

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

Provider of Service:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital and Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Inpatient Medical Care Visits</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Transitional Care Unit Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Ancillary Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Inpatient Consultations</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Concurrent Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Inpatient and Outpatient Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Professional Health Care Provider Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Assistant Surgeon Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Ambulatory Surgical Facility Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Hospital Ancillary Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Anesthesia Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

Benefits are subject to a lifetime maximum of one operative procedure per member when precertification is received from BCBSND.

Covered services must be received from a surgical facility approved by BCBSND.
## Provider of Service:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplant Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient and Outpatient Hospital and Medical Services</td>
<td>100% of Allowed Charge when precertification is received from BCBSND. Covered services must be received from a transplant facility approved by BCBSND.</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Transportation Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Maximum benefit allowance of $1,000 per transplant procedure.</td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Benefits are subject to a lifetime maximum of two surgical procedures per member and a maximum benefit allowance of one splint per member per benefit period.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospital and Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home and Office Visits</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Diagnostic Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Emergency Services</td>
<td>100% of Allowed Charge for emergency room facility fee billed by a hospital.</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Charge for office or emergency room visit billed by a professional health care provider.</td>
<td></td>
</tr>
</tbody>
</table>
Provider of Service:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Services at Urgent Care Center or Facility</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Accidental Injury</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>- Dental Anesthesia and Hospitalization</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Precertification is required.</td>
<td></td>
</tr>
<tr>
<td>Second Opinions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diagnostic Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>- Related Office Visit</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Home Infusion Therapy Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) – Foods and food products for the dietary treatment of members born after 12/31/62 with phenylketonuria</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Amino Acid-Based Elemental Oral Formulas</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Wellness Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A health care provider will counsel members as to how often preventive services are needed based on the age, gender and medical status of the member.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Screening Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Routine Physical Examination (Office Visit)</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>
Provider of Service:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus, Tetanus, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.

- Routine Diagnostic Screenings:
  - Lipid disorders screening once every five years
  - Osteoporosis screening for female members once every two years
  - Sexually Transmitted Disease (STD) screening
  - Diabetes screening
  - Hepatitis C Virus (HCV) screening
  - Lung cancer screening for members age 50 and older with a smoking history of 20 packs per year
  - Hepatitis B Virus (HBV) screening for members at high risk

- Tuberculosis screening

  100% of Allowed Charge

  No Coverage
## Provider of Service:

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nutritional Counseling</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Hyperlipidemia</td>
<td>Maximum benefit allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of four visits per member per benefit period.</td>
<td></td>
</tr>
<tr>
<td>• Gestational Diabetes</td>
<td>Maximum benefit allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of four visits per member per benefit period.</td>
<td></td>
</tr>
<tr>
<td>• Diabetes Mellitus</td>
<td>Maximum benefit allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of four visits per member per benefit period.</td>
<td></td>
</tr>
<tr>
<td>• Hypertension</td>
<td>Maximum Benefit Allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of two visits per member per benefit period.</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Nutritional Care Services (including</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Eating Disorders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum benefit allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of four office visits per member per</td>
<td></td>
</tr>
<tr>
<td></td>
<td>benefit period for members diagnosed with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PKU.</td>
<td></td>
</tr>
<tr>
<td>• Diabetes Education Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Diabetes Prevention Program</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Dilated Eye Examination (for diabetes-related</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>diagnosis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tobacco Cessation Counseling Services</td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Medicaid Expansion Provider Manual
### Provider of Service:

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>100% of Allowed Charge</td>
<td>100% of Allowed Charge</td>
</tr>
<tr>
<td><strong>Contraceptive Services</strong></td>
<td>100% of Allowed Charge</td>
<td>100% of Allowed Charge</td>
</tr>
<tr>
<td>- Related Office Visit</td>
<td>100% of Allowed Charge</td>
<td>100% of Allowed Charge</td>
</tr>
</tbody>
</table>

### Psychiatric and Substance Abuse Services

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

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice Services</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Private Duty Nursing Services</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Medical Supplies and Equipment</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td>▪ Home medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Orthotic devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Supplies for administration of prescription medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Oxygen equipment and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Ostomy supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Prosthetic appliances and limbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Hearing aids</td>
<td>Maximum benefit allowance per member of one hearing aid per ear every three years. Precertification is required.</td>
<td></td>
</tr>
<tr>
<td><strong>Breast Pumps</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Benefits are available for the rental or purchase of one breast pump per pregnancy.</td>
<td></td>
</tr>
<tr>
<td><strong>Telehealth</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Transportation Services</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Approval may be required.</td>
<td></td>
</tr>
<tr>
<td>All non-emergency medical transportation must receive approval from BCBSND at least two business days in advance of the scheduled appointment. Members should call Member Services at 1-833-777-5779.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meals and Lodging Services</strong></td>
<td>100% of Allowed Charge</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Approval is required.</td>
<td></td>
</tr>
</tbody>
</table>
Members must receive approval from BCBSND for meals and lodging at least two business days in advance of the scheduled appointment. Benefits for meals and lodging are allowed only when medical services or transportation require a member to be away overnight. Members should call Member Services at 1-833-777-5779.

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

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

**Referrals for Out-of-Network Services**
Individuals enrolled in Medicaid Expansion are eligible for benefits when they receive healthcare services from a provider within the Medicaid Expansion network. If a member needs services from an out-of-network provider, such as a second opinion, a provider participating within the Medicaid Expansion network is responsible for submitting a referral request for that out-of-network service.

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.
- The request will be reviewed by BCBSND clinical review staff who will review and send a response once the review is completed.
- Authorized referrals do not guarantee payment of benefits. Referrals must be for medically appropriate and necessary services and are subject to conditions, limitations, and exclusions of the member’s benefit plan.
- In-network providers must not request referrals for services that are available through a network provider.
Referral Submission Within Availity Essentials
At this time the referral function in Availity Essentials is only used for the commercial BCBSND line of business. To submit a referral for a Medicaid Expansion member, utilize the Precertification request option as stated above. Required fields for authorized referrals within Availity Essentials include:

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

Diagnosis Code
The provider should submit an applicable diagnosis code.

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

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

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

Services that Don’t Need a Referral
The following services don’t require a referral:

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

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

Responsibilities and Requirements of Network Providers

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

Provider Group Participation Agreements

Your responsibilities as a participating provider are defined in your provider participation agreement(s). Please refer to your agreement when you have a question about your participation. As a participating provider, you also have the following responsibilities to our members – your patients:

Sign Base Agreement

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

Select Network Exhibits

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

Accept BCBSND’s Payment as Payment in Full

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

Develop and Conduct Cultural Competency Training

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

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

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

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

**Maintain Advance Directive Policies**
Network providers must maintain written policies and procedures with respect to all members receiving care. Providers should:

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

Written information must be provided at the following times:

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

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

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

• Contracting provisions
Have Full Discussions with Members

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

Access and Availability Standards for Network Providers

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

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

- Maternity Providers:
  - Emergency services available immediately
  - First trimester within 14 calendar days of first request
  - Second trimester within seven calendar days of first request
  - Third trimester within three calendar days of first request
  - Initial high-risk pregnancy within three days of identification of high risk or immediately if an emergency exists
  - < 30 miles of travel in urban areas
- < 50 miles of travel in rural/frontier areas
- Behavioral Health and/or Substance Use Disorder Providers
  - Immediate availability for life-threatening emergency services
  - Within six hours for non-life-threatening emergency services
  - Within 24 hours for urgent, symptomatic, but not life-threatening care
  - Within 10 working days for initial visits and routine care
  - Within 30 calendar days for follow-up routine care
  - For each behavioral health and substance use disorder practitioner, maintain a ratio of one full-time equivalent physician per 3,000 members
- < 30 miles of travel in urban areas
- < 50 miles of travel in rural/frontier areas
- High-Volume and High-Impact Specialty Providers:
  - High-volume specialties are specialties that are expected to treat a large number of members within a geographic area
  - Consultation within 30 calendar days of referral or as clinically indicated
  - For each high-volume and high-impact specialty, maintain a ratio of one full-time equivalent physician per 3,000 members
- < 30 miles of travel in urban areas
- < 50 miles of travel in rural/frontier areas
- Hospitals:
  - < 30 miles of travel in urban areas
  - < 50 miles of travel in rural/frontier areas
- Disability Access
  - Network providers must provide physical access, reasonable accommodations and accessible equipment for Medicaid Expansion members with physical or behavioral health disabilities.
- If BCBSND is unable to provide the necessary services to a member within their network, BCBSND will cover these services out-of-network for the member for as long as BCBSND’s Provider Network is unable to provide the services. BCBSND coordinates authorization and payments so the cost to the member is no greater than it would be if the services were furnished within the network.
- BCBSND ensures parity in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors in determining access to out-of-network providers for medical/surgical benefits.
BCBSND ensures that network providers offer hours of operation to its members that are no less than the hours of operation offered to commercial members or that are comparable to traditional Medicaid, if the provider serves only Medicaid members.

BCBSND ensures providers’ after-hours answering machines instruct members to go to an emergency room or call 911 in the event of an emergency.

BCBSND ensures providers provide after-hours availability to patients who need medical advice as specified in the Primary Care Physician (PCP) section of this manual.

BCBSND collects data on which languages are spoken by providers and data on handicap accessibility through their credentialing and recredentialing applications. This information is shared in the Provider Directory.

BCBSND ensures network providers have interpretation services available and these services are provided for both in-person and telephone communications to help members communicate with BCBSND and providers.

Provider access and availability monitoring procedures include:

- Access and availability are monitored through the complaints and grievance processes and the annual member satisfaction survey.
- Improvement plans are implemented for areas that don't meet access and availability goals.
- Benchmarks for access and availability are reviewed periodically to determine if goals are appropriate.

After-hours answering machine messages are monitored as follows:

- Annually, at a minimum, phone calls are made after hours to a random sample of health care providers to verify their answering machine message.
- Reports regarding providers’ after-hours answering machine messages and instructions in seeking emergency care are reported annually to the North Dakota Department of Human Services.
- Improvement plans are implemented for providers who don’t comply with their after-hours answering machine messages.

Languages spoken are monitored as follows:

- BCBSND makes an annual comparison of the five most common languages spoken within our state to the languages spoken within our provider network.
- Member access to providers is monitored through the complaints and grievance processes and the annual member satisfaction survey.

Handicap accessibility is monitored as follows:

- BCBSND makes annual outreach to providers through various survey methods to improve accuracy of the provider data, including whether the provider’s office/facility has accommodations for people with physical or mental disabilities.
- Handicapped accessibility is monitored through the complaints and grievance processes and the annual member satisfaction survey.
<table>
<thead>
<tr>
<th>General</th>
<th>Behavioral/Mental Health and/or Substance Use Disorder</th>
<th>High-Volume and High-Impact Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services – available 24 hours a day, seven days a week</td>
<td>Emergency Services, Life Threatening – immediate</td>
<td>Consultation within one month of referral or as clinically indicated</td>
</tr>
<tr>
<td>Urgent Care – within 24 hours</td>
<td>Emergency Services, Non-Life Threatening – within six hours</td>
<td></td>
</tr>
<tr>
<td>Non-Urgent Sick Care – within 72 hours, or sooner, if condition deteriorates into urgent or emergency condition</td>
<td>Urgent Care – within 24 hours Initial Visits, Routine Care – within 10 working days</td>
<td></td>
</tr>
<tr>
<td>Routine, Non-Urgent or Preventative Care Visits – within six weeks of member’s request</td>
<td>Follow-Up Visits, Routine Care – within 30 days</td>
<td></td>
</tr>
</tbody>
</table>

Providers Must Follow Confidentiality Standards

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

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

Provider Directory Requirements

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

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

Provider directory information includes information such as:

- Name and any group affiliation
- Street address(es)
- Telephone number(s)
- Website
- Specialty
- Medical school attended, graduation year and residency
Updates Needed for the Provider Directory

Providers should validate their provider directory information semi-annually.

Notify Provider Network if:

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

Submit Changes to Provider Network

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

Email:  prov.net@bcbsnd.com

Fax:  701-282-1910

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

Primary Care Provider (PCP) Responsibilities

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

- Coordinate medical and behavioral health care service needs to ensure all medically necessary services are delivered in a timely manner.
- Refer patients to specialists, subspecialists, subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria.
Coordinate with these other levels of medical care and follow up on individual patients.

Maintain medical records of all services provided by you, records of referrals to other providers and documentation of follow-up and coordination of care.

Develop a plan of care to address risks, medical needs and other responsibilities.

Provide after-hours availability to patients who need medical advice. At a minimum, PCP offices should have a return call system that is staffed and monitored so Medicaid Expansion enrollees can connect to a medical practitioner within 30 minutes of their call.

Maintain hospital admitting privileges or arrangements with a physician who has admitting privileges at a participating hospital.

Work with BCBSND case managers to develop individualized plans of care for high-risk enrollees receiving case management services and participate on their case management team as needed.

Encourage screening and referrals to ensure immediate access to services for the following:

- Depression
- Anxiety
- Trauma/Adverse Childhood Experiences (ACEs)
- Substance use/Screening Brief Intervention/Referral to Treatment (SBIRT) early detection
- Developmental disorders and delays
- Social-emotional health
- Social determinants of health

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

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

- Obtain appropriate consent: Valid Provider consent form.

  The Provider is prohibited by law from disclosing PII to BCBSND without obtaining patient’s consent. BCBSND is prohibited by law from using PII to pay any claim (or to process any other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains PII to BCBSND, the Provider represents and warrants that the Provider has first obtained patient consent in substantially the same form as the BCBSND PII Consent Form example, BCBSND reserves the right to deny payment of claims (and the right to refuse to process other information) if the Provider fails to obtain such consent.
• Provide the Part 2 Disclaimer: “42 CFR part 2 prohibits unauthorized disclosure of these records.”

• The Provider is prohibited by law from disclosing PII to BCBSND pursuant to patient's consent, unless it includes with the PII a specific statement to notify BCBSND that the information is subject to Substance Use Disorder confidentiality restrictions (“Part 2 Disclaimer”). Accordingly, the Provider shall include the Part 2 Disclaimer with any claim (or other record) that contains PII when submitting the claim (or other record) to BCBSND. The Provider shall include Part 2 Disclaimer with claims it submits to BCBSND in the following manner:

  — **837 Professional Claims:** – Electronic: Should use the NTE data segment Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier “ADD.” Data element NTE02 should contain the Part 2 Disclaimer.

  — **837 Institutional Claims:** – Electronic: Should use the NTE data segment in Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier “ADD.” Data element NTE02 should contain the Part 2 Disclaimer.

• Provide PII to BCBSND, upon request and as deemed reasonably necessary by BCBSND, to perform evaluations, audits or research. Definitions of the capitalized terms “Part 2 Program”, “Patient Identifying Information” and “Substance Use Disorder” are consistent with the meanings provided in 42 C.F.R. § 2.11.

**Documentation Requirements**

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

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

• Name of patient and date of service
• Chief complaint or purpose for visit or service
• All services provided such as clinical assessment, examination, procedures performed, and equipment provided
• Treatment plans
• Orders for, intent of and results of all ordered diagnostic services
• National Drug Code (NDC) numbers on all drug codes and the use of rebatable NDC numbers where applicable
• Include the following fields for each outpatient drug dispensed:
  • Total number of units of each dosage
  • Form
  • Strength
  • Package size by NDC
• The provider who is treating the patient must order all diagnostic services and must clearly document in the medical record his or her intent the specific test be performed.
The provider who treats the patient is the provider who furnishes an evaluation and management service, treats the patient for a specific medical problem and uses the results in the management of the patient’s specific medical problem. Tests not ordered by the treating provider are not reasonable and necessary.

- Date and signature of the rendering provider

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

**Diagnostic Imaging**

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

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

Listed below are the required documentation components for radiology reports:

- **Demographics:**
  - Patient’s name
  - Valid order from the referring provider for the specific test performed
  - Date and time of service
  - Name and type of examination
  - Facility or location where study was performed
  - Name and signature of interpreting provider
  - Inclusion of the following additional items is encouraged:
    - Dictation date
    - Date and time of transcription
    - Birth date and age
    - Gender
- **Clinical Information:**
  - Indication(s) for examination: Reason why the study is being performed and how the
results will be used in the patient’s plan of care

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

Physical, Occupational and Speech Therapy

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

<table>
<thead>
<tr>
<th>Billed Units</th>
<th>Represented Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>One (1)</td>
<td>8-22</td>
</tr>
<tr>
<td>Two (2)</td>
<td>23-37</td>
</tr>
<tr>
<td>Three (3)</td>
<td>38-52</td>
</tr>
<tr>
<td>Four (4)</td>
<td>53-67</td>
</tr>
<tr>
<td>Five (5)</td>
<td>68-82</td>
</tr>
<tr>
<td>Six (6)</td>
<td>83-97</td>
</tr>
</tbody>
</table>

Evaluation and Management (E/M) Documentation Requirements

Office Visit E/M Codes

Effective January 1, 2021, CPT codes 99202-99215 are billed based on medical decision making (MDM) or total time for the encounter.

- Definition of time is minimum time, not typical time, and represents total physician or qualified health practitioner (QHP) time on the date of service (DOS)
- Time of clinical staff (e.g. nursing staff) cannot be included in total time for the DOS
- DOS time must be clearly documented in the record to support time was used to select code
- This definition only applies when code selection is based on time and not MDM
The AMA continues to use the three MDM sub-components for code assignment. The subcomponents have been edited for appropriate code selection. For more information reference the current edition of the CPT® manual.

All Other E/M Codes

Chief Complaint and History

- New and established patient E/M's do not need to be reentered in the medical record if information has already been entered by ancillary staff or the patient/member
- Practitioner may indicate in the medical record information was reviewed and verified

History and Exam

The defined list of required elements need not be re-recorded if there is evidence that the practitioner reviewed the previous information and updated it as needed.

- Relevant information should already be in the medical record
- Practitioners may focus documentation on what has changed since the last visit, or on pertinent items that have not changed

Previous Documentation

All Previous documentation reviewed must include:

- Date and time of the visit being reviewed
- What information has specifically been reviewed and verified
- What, if anything, has changed per CPT guidelines, for E/M codes other than 99202-99215

Established patients are required to meet two of the three key components of history, examination and MDM to determine the level of E/M service billed. BCBSND requires that one of the two levels used to determine the level of service is the MDM component. The documentation of the MDM must be specific to the current encounter.

Medical Record Requests

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

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

- First/last name
- Date of birth
- Benefit plan number
- Any other applicable identifiers (case number or claim number)
- Copy of medical record request letter from BCBSND. If you are unable to locate your Medical Records Request letter when mailing the records to BCBSND, use the Medical Records Submission Form. Access the form at https://www.bcbsnd.com/providers/news-resources/forms-documents, under the Claims Processing section. When using this form, be sure to include the claim number that the records pertain to.
Medical Necessity Criteria

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

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

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

Technology Assessment Evaluation Criteria

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

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

1. The technology must have final approval from the appropriate government regulatory bodies.
   - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the technology.
   - Any approval that is granted as an interim step in the U.S. Food and Drug Administration’s or any other federal governmental body’s regulatory process is not sufficient.
   - The indications for which the technology is approved need not be the same as those which BCBSND is evaluating.

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
   - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
   - The evidence should demonstrate the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. There should also be evidence or a convincing argument based on established medical facts that such measurement or
alteration affects health outcomes.

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

3. The technology must improve the net health outcome. The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

4. The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as or more than established alternatives.

5. The improvement must be attainable outside the investigational settings. When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy criteria #3 and #4.

**Medical Record Documentation Policy**

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

BCBSND intends to reimburse providers for medically appropriate and necessary services, rendered to BCBSND members, that treat the condition or concern for which the member is seeking treatment and, for additional concerns or conditions identified during the visit. Documentation without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining the service(s) provided for that visit are medically appropriate.

**Amended Medical Records**

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

**DO**

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

**DON’T**

- Delete or remove incorrect information from the record. Instead, draw a line through it or make another appropriate indication.
All medical record documentation must comply with BCBSND policies and support the services and diagnosis submitted on the claim form at the time of the original claim submission to BCBSND. Corrections to the medical record prior to claim submission are considered when determining the validity of services billed. If changes appear in the record following a request for records, medical review or audit, only the original record is reviewed when making determinations.

**Credentialing in Medicaid Expansion**

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

**Current BCBSND Providers**

The Provider Network team will reach out to current BCBSND providers to assist them in becoming credentialed for Medicaid Expansion, which includes signing an addendum to their current contract. To request an addendum, send an email to ProviderContracting@bcbsnd.com.

**New BCBSND Providers**

Providers can join the BCBSND network and become credentialed for Medicaid Expansion by applying to become a BCBSND provider. Visit [https://www.bcbsnd.com/providers/become-a-new-provider/apply](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.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html](https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-enroll-app.html) to apply to be a provider with the State of North Dakota.

**1915(i) Providers**

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

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

Providers should complete the following steps in addition to other requirements set by the State of North Dakota for this program.

- Enroll as a 1915(i) provider with the State of North Dakota. Visit [https://www.behavioralhealth.nd.gov/1915i](https://www.behavioralhealth.nd.gov/1915i) to learn how to become a provider, what services are included and what types of individuals are eligible for those services.
- Register for the Availity Essentials provider portal at
Submit a precertification on behalf of the member through the Availity Essentials provider portal.

- Refer to this provider manual for claim submission processes and procedures.
- 1915(i) Providers will need to verify the member’s benefit requirements for eligibility to receive 1915(i) services. A member may be eligible for Medicaid Expansion but not eligible for 1915(i) services. A member may lose eligibility for 1915(i) services during their treatment. It is the provider’s responsibility to verify a member’s 1915(i) eligibility by calling BCBSND at 701-282-1003 during normal business hours.

For additional questions refer to the following:

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

**Non-Emergency Medical Transportation (NEMT) Providers**

The ND Medicaid Expansion program provides the opportunity to NEMT providers to coordinate non-emergency medical transportation to and from medical appointments for our ND Medicaid Expansion members when no other transportation source is available. For more information visit our provider webpage [https://www.bcbsnd.com/providers/medicaid-expansion/medicaid-expansion-non-emergency-medical-transportation--nemt--p](https://www.bcbsnd.com/providers/medicaid-expansion/medicaid-expansion-non-emergency-medical-transportation--nemt--p).

**Meal and Lodging Providers**


**Out-of-Network (OON) Providers**

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

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

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

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

Resources
Questions related to Availity Essentials:
- Phone: Availity Client Services at 1-800-282-4548
  - Monday through Friday, 7 a.m. - 6:30 p.m. CST
- Web: https://www.availity.com
  - Providers can register for an Availity Essentials account at https://www.availity.com/Essentials-Portal-Registration

Questions related to NPI and BCBSND participation:
- Phone: 1-800-756-2749
- Email: Provider Networks at prov.net@bcbsnd.com
PROVIDER RESOURCES

Contact Information

<table>
<thead>
<tr>
<th>Service/Department</th>
<th>Email/website</th>
<th>Phone</th>
<th>Fax</th>
<th>Hours of Operation (CST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>N/A</td>
<td>1-833-777-5779</td>
<td>TBD</td>
<td>8 a.m. to 6 p.m.</td>
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<tr>
<td>Member Services</td>
<td>N/A</td>
<td>1-833-777-5779</td>
<td>TBD</td>
<td>8 a.m. to 6 p.m.</td>
</tr>
<tr>
<td>Availity Essentials</td>
<td><a href="https://www.availity.com">https://www.availity.com</a></td>
<td>1-800-282-4548</td>
<td>N/A</td>
<td>7 a.m. to 6:30 p.m.</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>N/A</td>
<td>1-800-952-8462</td>
<td>1-701-277-2253</td>
<td>8 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Case Management</td>
<td>N/A</td>
<td>1-800-336-2488</td>
<td>1-701-277-2253</td>
<td>8 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Provider Credentialing</td>
<td><a href="mailto:Prov.net@bcbsnd.com">Prov.net@bcbsnd.com</a></td>
<td>1-800-756-2749</td>
<td>1-701-282-1910</td>
<td>8 a.m. to 5 p.m.*</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>N/A</td>
<td>1-800-952-8462</td>
<td>1-701-277-2971</td>
<td>8 a.m. to 5 p.m.*</td>
</tr>
<tr>
<td>Provider Relations</td>
<td><a href="mailto:Prov.partners@bcbsnd.com">Prov.partners@bcbsnd.com</a></td>
<td>N/A</td>
<td>N/A</td>
<td>8 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Pharmacy Management</td>
<td><a href="mailto:dhsmed@nd.gov">dhsmed@nd.gov</a></td>
<td>1-701-328-7098</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

Availity Essentials Provider Portal

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

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

Features Provide Convenience to Providers

Through the Availity Essentials provider portal, providers can:

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

CARE COORDINATION PROGRAMS

Case Management

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

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

Care Coordinators consist of Registered Nurses and Licensed Social Workers trained in the following areas:
  • Motivational Interviewing
  • Crucial Conversations
  • Case Management and Utilization Management

Member assessments include:
  • A comprehensive health screening
  • Screening for depression and anxiety
  • Assessment of the member’s health engagement
  • Medication reconciliation

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

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

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

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

Moms-to-be receive the following:
• Prenatal care advice
• Guidelines for healthy lifestyle and pregnancy
• Help in preventing preterm labor
• Information on taking folic acid
• Help to quit smoking during pregnancy
• Education on the last weeks of pregnancy
• A checklist of what to take to the hospital
• Information on post-partum depression
• Educational content on breastfeeding
• Information about caring for a newborn

Members can sign up as soon as they know they are pregnant and can join anytime while pregnant. Members can call BCBSND at 1-800-342-4718 or enroll online through the member portal.

Disease Management
BCBSND’s complex, chronic and rare disease management program is a system of coordinated care interventions and member communications for members with rare and complex diseases.
Conditions managed include:

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

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

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

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

**Utilization Management Program**

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

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

**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 will be denied.

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:

▪ 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. See below for ER admission notification procedure.

Notification Responsibility

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

Providers agree to abide by the following Utilization Management Program requirements in accordance with the terms of the agreement and the member’s benefit plan.

Emergency Room (ER) Admission Notification

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

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

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

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

Inpatient Discharge Notification

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

Precertification & Concurrent Review/Discharge Planning

Clinicians (Registered Nurses and Licensed Clinical Social Workers) complete initial reviews for services that require precertification in accordance with established clinical criteria.

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

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

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

This process is as follows:

Retrospective Utilization Management (UM)

Retrospective UM is designed to review post service requests in accordance with the member’s benefit plan. Medical records and pertinent information regarding the member’s care will be reviewed (with input by peer clinical reviewers when necessary) against available benefits and to determine the level of coverage for the service. This review may consider such factors as the medical necessity of services provided, whether the claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment. Up to 30 days is allowed for medical necessity review of retrospective requests.
Peer-to-Peer Process
The Peer-to-Peer process is an opportunity for the requesting/ordering provider to have a one-on-one conversation with a peer reviewer when a service has been denied as not medically necessary. The purpose is to further explain the adverse determination with a principal reason, clinical rationale and components of specific medical policy. The denial will not be over-turned because of the peer-to-peer conversation. When the provider has received additional clarification, they may either accept the adverse determination or proceed with a formal appeal. If the original BCBSND peer reviewer is not available, an alternate peer reviewer is made available.

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

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


Retired Medical Policy
Policies may be retired for several reasons, including:

- Technology is obsolete or discarded
- Technology is the standard of care and details about its use are well known
- Costs of implementing the policy are too great
- An issue may be handled in other ways, such as payment
Draft Medical Policy
BCBSND strives to develop medical policies in an open, collaborative manner with providers. Comments may be submitted during the development phase of BCBSND medical policies. We especially value comments referencing an evidence-based evaluation process.

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

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

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

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

Approval for Meals, Lodging and Transportation

Meals and Lodging
Benefits for meals and lodging may be allowed when medical/behavioral health services or transportation require a member to be away overnight. Members must receive approval from BCBSND for meals and lodging at least two business days before the scheduled appointment. Members will not be reimbursed by BCBSND for benefit payments made by the member directly to the provider of services. Members can call BCBSND Member Services 1-833-777-5779, Monday through Friday, 8 a.m. to 6 p.m. CST.

Transportation
Transportation for medical care may be available through BCBSND if no other source is available. Members must receive approval from BCBSND for all non-emergency transportation at least two business days before the scheduled appointment. This includes travel to and
from medical checkups. Transportation by ambulance is paid for by BCBSND when used for emergency care. Ambulance transportation is also paid in non-emergency situations when a precertification is obtained from BCBSND. Members will not be reimbursed by BCBSND for benefit payments made by the member directly to the provider of services. Members can call BCBSND Member Services 1-833-777-5779, Monday through Friday, 8 a.m. to 6 p.m. CST.

For more information visit our Medicaid Expansion provider webpage https://www.bcbsnd.com/providers/medicaid-expansion.

**Pharmacy Benefits Administered Separately**

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

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

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

- Pharmacy Overview: [https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-pharmacy.html](https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-pharmacy.html)
- Pharmacy Manual: [www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html](www.nd.gov/dhs/services/medicalserv/medicaid/provider-all.html)
- Tamper-Resistant Prescription Pads: [https://www.nd.gov/dhs/services/medicalserv/medicaid/pharmacy-trpp.html](https://www.nd.gov/dhs/services/medicalserv/medicaid/pharmacy-trpp.html)
- Additional DHS training: [https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-training.html](https://www.nd.gov/dhs/services/medicalserv/medicaid/provider-training.html)
- Medicaid Expansion Restricted Use - Precertification Drug List (link provided when available).

**340B Drug Pricing Program**

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

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

**Pharmacist Administered Vaccines**

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

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

**Coordinated Services Program (CSP)**

BCBSND will work with enrolled members to ensure their healthcare services match their medical needs.

If members are using health care services at a frequency or amount that is not medically appropriate and necessary, they may be placed in a CSP so the health care services they receive don’t exceed generally accepted medical standards. The review is done by BCBSND in consultation with the North Dakota Department of Human Services.

The following criteria are used to determine if the CSP is appropriate:
- Seriousness of incorrect, improper or excessive use of services
- Historical utilization of the member and
- Availability of a coordinated services physician

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 and
- The timeframe in which the member has to file an appeal

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

**REIMBURSEMENT AND BILLING GUIDELINES**

**Reimbursement Policies**

Reimbursement policies are payment decisions subject to:
- Terms and conditions of the benefit plan, including specific exclusions and limitations, and
- Applicable state and federal laws.

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

Additional considerations for reimbursement policies include:
- Specific product discounts or contractual arrangements are not reflected in the fee schedule.
- CPT and HCPCS codes not in the fee schedule are reimbursed by report.
- Codes not in the fee schedule are manually reviewed and payment is determined on an
individual basis.

- The existence of a procedure code on the fee schedule does not guarantee that the code is valid or covered.
- Fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT codes.
- BCBSND's system will check procedure validity and reject any invalid codes.
- Some codes may represent services for which benefits are not available.

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

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

Fee Schedules Are Confidential

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

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

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

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

National Correct Coding Initiative (NCCI) Edits

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

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

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

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

- For electronic claim submission, information is placed in SV101-7 of the 2400 service line loop
- Examples of NOS/Unlisted or Unspecified Codes:
  - 83520 (Immunoassay, quantitative, not otherwise specified) – include a description of the method or technique
  - 21499 (Unlisted musculoskeletal procedure, head) – include a description of the procedure performed
- In order for an accident-related dental claim to be processed under medical coverage, an accident date is required. If the accident date is not provided in the loops and segments listed below, the claim will not process.
  - Loop/Segment/Element for tooth number = 2400 SV101-7
  - Loop/Segment/Element for accident date = 2300 DTP03, with a qualifier of 439 in DTP01

Professionals in Training

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

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

- Licensed Associate Professional Counselor (LAPC)
- Licensed Associate Marriage Family Therapist (LAMFT)
- Graduate Registered Nurse Anesthetists (GRNA)
- Post-doctoral Psychology Resident
- Psychiatry Resident in psychotherapy training under the direct supervision of a psychologist
- Resident Psychiatric Physicians in their 2nd year of training or greater that have met the specific supervision standards through their accrediting body
Professionals in training who are not eligible to bill:

- Resident Physicians
  - The attending/supervising physician must either be present while the substantial elements of the history and examination are performed by the resident, or the attending/supervising physician must independently perform them. Billing occurs under the attending/supervising physician's NPI.
  - The attending/supervising physician participates in the clinical decision making and formulation of the treatment plan.

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

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

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

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

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

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

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

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

Rural Health Clinic

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

Incident to Billing

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

Member-Demanded Services

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

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

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

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

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

When submitting an AMN form:

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

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

**Trauma Activation**

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

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

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

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

### Billing for Trauma Activation on Electronic 837I

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Units</th>
<th>HCPCS</th>
<th>Line-Item Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0681</td>
<td>Level I Trauma</td>
<td>1</td>
<td>G0390</td>
<td>Required</td>
</tr>
<tr>
<td>0682</td>
<td>Level II Trauma</td>
<td>1</td>
<td>G0390</td>
<td>Required</td>
</tr>
<tr>
<td>0683</td>
<td>Level III Trauma</td>
<td>1</td>
<td>G0390</td>
<td>Required</td>
</tr>
<tr>
<td>0684</td>
<td>Level IV Trauma</td>
<td>1</td>
<td>G0390</td>
<td>Required</td>
</tr>
<tr>
<td>0689</td>
<td>Other Trauma Response</td>
<td>1</td>
<td>G0390</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>(Use for Level V Trauma)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Swing Bed – Hospital Billing**

Inpatient services delivered to swing bed patients will be reimbursed an all-inclusive per diem rate. The per diem rate includes all services normally used in a swing bed treatment program, such as room and board, lab, X-ray, all therapies, diagnostic testing, services of social workers, licensed addiction counselors, nurses, dieticians, and physical, occupational and speech therapy.
The following services are reimbursable in addition to the swing bed per diem rate:

- Chemotherapy agents
- Chemotherapy administration
- Radioisotopes and related services
- Customized prosthetic devices
- Computed tomography (CT) scans
- Cardiac catheterization
- Magnetic resonance imaging (MRIs)
- Radiation therapy
- Angiography
- Outpatient surgery
- EPO
- Preventive and screening services
- Blood products
- Blood storage and processing
- Complex medical equipment (e.g. specialized beds and mattresses and wound vacs when approved during precertification and submitted on revenue code 0946 or 0947)
- Cardiac rehab

Note: Reimbursement will be based on the lesser of charges or the outpatient fee schedule amount.

**Billing Guidelines**

Traditional revenue codes should be used to indicate the type of services provided. Items considered to be separately reimbursable should be billed where the services were rendered.

For example, if the patient has a CT scan in the hospital outpatient setting, the CT scan should be billed on a separate electronically 837I outpatient (TOB 13x) claim form under the provider number. If the patient receives chemotherapy at the bedside in the TCU setting, these services should be billed with the appropriate HCPCS code(s) and include all other TCU services on the same electronic 837I under the same TCU provider number.

HCPCS are required on the separately reimbursable items listed above when submitted on the same claim as all other TCU services. Reimbursement will be limited to the per diem rate when HCPCS are not submitted.

Therapists, social workers and dietitians should not bill for services electronically (837P) when these services are inherent to the treatment program and delivered during the inpatient TCU stay. Psychologists and psychiatrists should bill electronically (837P) for services that are medically appropriate and necessary.
**Inpatient Transitional Care Unit – Hospital Billing**

Inpatient services delivered to Transitional Care Unit (TCU) patients will be reimbursed an all-inclusive per diem rate. The per diem rate includes all services normally used in a TCU treatment program such as room and board, lab, X-ray, all therapies, diagnostic testing, services of social workers, licensed addiction counselors, nurses, dieticians, and physical, occupational and speech therapists, etc.

The following services are reimbursable in addition to the TCU per diem rate. Reimbursement will be based on the lesser of charges or the outpatient fee schedule amount.

- Chemotherapy agents
- Chemotherapy administration
- Radioisotopes and related services
- Customized prosthetic devices
- Computed tomography (CT) scans
- Cardiac Catheterization
- Magnetic resonance imaging (MRIs)
- Radiation therapy
- Angiography
- Outpatient surgery
- EPO
- Preventive and screening services
- Blood products
- Blood storage and processing
- Complex medical equipment (e.g. specialized beds and mattresses and wound vats when approved during precertification and submitted on revenue code 0946 or 0947)
- Cardiac rehab

**Billing Guidelines**

Traditional revenue codes should be used to indicate the type of services provided. Items considered to be separately reimbursable should be billed where the services were rendered.

For example, if the patient has a CT scan in the hospital outpatient setting, the CT scan should be billed on a separate electronically 837I outpatient (TOB 13x) claim form under the provider number. If the patient receives chemotherapy at the bedside in the TCU setting, these services should be billed with the appropriate HCPCS code(s) and include all other TCU services on the same 837I claim form under the same TCU provider number.

HCPCS are required on the separately reimbursable items listed above when submitted on the same claim as all other TCU services. Reimbursement will be limited to the per diem rate when HCPCS are not submitted.

Therapists, social workers and dieticians should not bill for services filed electronically (837P) when these services are inherent to the treatment program and delivered during the inpatient
TCU stay. Psychologists and psychiatrists should bill filed electronically (837P) for services that are medically appropriate and necessary.

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

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

**Coding Elements**

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

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

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

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

**Present on Admission (POA) Indicator**

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

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

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

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

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

The transfer per diem payment is calculated as follows:

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

Example: DRG 53, Severity Level 2

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

▪ Lesser of Regular Case Payment (1) or Per Diem Payment (2) = $5,511

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

Outlier Cases

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

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

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

Example: DRG 53, Severity Level 2

▪ Calculation of Case Cost:
  • Facility Charges ($37,500) * Overall Hospital RCC (0.7162) = $26,858

▪ Outlier Payment:
  • Case Cost ($26,858) – Outlier Cost Threshold ($21,808) = $5,050

▪ APR-DRG Case Rate:
  • Case Weight (0.6423) * Base Rate ($12,011) = $7,715

▪ Final Outlier Case Payment:
  • APR-DRG Case Rate ($7,715) + Outlier Payment ($5,050) = $12,765
Billing Guidelines

1. Submit claims electronically (837I) with Type of Bill (TOB) 111 (Hospital/Inpatient/Admit through Discharge Date Claim). Claims that are paid based on an APR-DRG are not eligible for interim billing.

2. Hospital APR-DRG payments include reimbursement for all services performed during an entire inpatient admission. Services incurred during an inpatient admission regardless of the place of service are part of the APR-DRG and should not be billed separately.
   • These services include but are not limited to outpatient procedures, diagnostic tests and lab tests.
   • Example: A patient who is an inpatient at Hospital A is brought to Hospital B for a CT scan that is not available at Hospital A. Hospital A submits a bill for the entire inpatient stay including the CT scan. Hospital A receives the entire APR-DRG payment and is responsible for reimbursing Hospital B for the CT scan.

3. Report appropriate ICD-10-CM diagnosis codes in Form Locator (FL) 67, 67 A-Q, 69 and 72 A-C.
   • 67: Principal diagnosis code. The 8th digit of the field (shaded area) is for the POA indicator.
   • 67 A-Q: Secondary diagnosis fields. The 8th digit of the field (shaded area) is for the POA indicator.
   • 69: Admitting diagnosis code.
   • 72 A-C: External cause of injury (ECI) code and POA indicator.

4. All acute care hospitals must report the POA indicator in FL 67, 67 A-Q in the shaded area corresponding to the 8th digit. The reporting options for all diagnoses are:
   • Y – Yes: Present at the time of admission.
   • N – No: Not present at the time of admission.
   • U – No: Information in the Record: Documentation is insufficient to determine if condition was present on admission or not.
   • W – Clinically Undetermined: Provider is unable to clinically determine whether condition was present on admission or not.
   • Unreported/Not Used or “1”: Exempt from POA reporting.

5. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E.


Note: The revenue codes listed below are not allowed on an inpatient APR-DRG claim. Claims will be returned if one of the following revenue codes is submitted:
   • Rev Code 0273 – Take Home Supplies
• Rev Code 0274 – Prosthetic/Orthotic Devices
• Rev Code 029X – Durable Medical Equipment (Other than Rental)

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

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

7. Report the appropriate discharge status in FL 17.

8. The Statement Covers Period From date in FL6 (“From” Date) is different than the Admission Date in FL 12 (“Admit” Date). There are times when these dates may be the same, but there are situations when these dates may be different.

• The Admit Date is the date that the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims. The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included on the claim. The “From” date should be the earliest date of service on the bill.

9. Day of discharge cannot be counted as a unit of service on the room and board Revenue Code on an inpatient hospital, swing bed or skilled nursing facility claim.

10. If the patient has a leave of absence (LOA) during the inpatient stay, the LOA day(s) must be identified with Revenue Code 018X and units equal to the number of LOA days. The following are a couple of examples on how to count LOA days:

• If the patient leaves the hospital on Saturday afternoon and returns on Sunday afternoon, there is no LOA as the patient received services on both days.
• If the patient leaves the hospital on Saturday afternoon and returns on Monday afternoon, one (1) LOA day should be billed.

**Enhanced Ambulatory Patient Group (EAPG)**

The EAPG classification methodology is used to explain the amount and type of resources used in a wide range of ambulatory visits. Individual services within the visit are assigned to individual EAPGs, which are organized by the EAPG logic to reflect the typical resources expended during the visit located at [https://feeschedule.bcbsnd.com/FeeSchedule/FeeScheduleManagement/List](https://feeschedule.bcbsnd.com/FeeSchedule/FeeScheduleManagement/List). Reimbursement is calculated by taking a base rate and multiplying it by the EAPG assigned weight. 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.
Billing Guidelines
1. Submit claims electronically (837I) with outpatient TOB 131.
2. EAPG payments are based on visits.
   - A visit is all related services provided to one patient on one date of service.
   - BCBSND encourages providers to bill all related outpatient services for the same date of service on one claim.
   - Providers may bill multiple dates of service on one claim.
   - Multiple EAPGs are commonly assigned per visit and more than one EAPG may be payable within a visit.
3. Lessor of charge logic will apply to EAPG claims at the visit level.
4. Report appropriate ICD-10-CM diagnosis codes in FL 67, 67 A-Q, 69 and 72 A-C.
5. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E.
Report charges associated with each Revenue Code and CPT or HCPCS code as appropriate.

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

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

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

Ancillary Discounting
When multiple occurrences of the same ancillary EAPG are present on a claim, the additional ancillary EAPGs are discounted at 50%.
Provider Preventable Conditions
BCBSND does not pay any provider for a Provider Preventable Condition. Providers must comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. 447.26(d).

HOW TO FILE AND CORRECT CLAIMS

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

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

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

Tips:
▪ Submit North Dakota Department of Health assigned taxonomy codes for billing and rendering provider.
▪ Submit North Dakota Medicaid ID
▪ A National Drug Code (NDC) is required for medical drug claims. Claims that do not meet this requirement will be denied.

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

Claim corrections must be:

▪ Finalized
▪ 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 8: Void/cancel claim
▪ Submitted within 90 days from the initial/original claim processing date, except for the following:
  ▪ Coordination of Benefits
Claim Corrections: Process

1. Complete electronic claim corrections using the following steps:
3. Select Claims & Payments from the menu
4. Under Claims, select the claim type: Professional or Facility
5. Input the claim information
6. Select the frequency type
   - Replacement of Prior Claim
   - Void/Cancel of Prior Claim
7. Set payer control number by using claim number assigned by BCBSND
8. Click Submit

Tip: Submitting Billing Provider Updates
Billing provider updates require a frequency 8, followed by a frequency 1.

Tip: Submitting Claim Corrections Impacting Two Claims
When submitting a claim correction that impacts two claims, such as adding a modifier on one claim due to a reduction on another claim, use the following:

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

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

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

Organizations submitting claims to BCBSND must use an organizational NPI and Tax Identification Number (TIN) where applicable. Each practitioner being credentialed or recredentialed must include their individual NPI on the application.
Learn who should apply for an NPI and how to obtain an NPI at [https://www.bcbsnd.com/providers/credentialing/new-provider-tools](https://www.bcbsnd.com/providers/credentialing/new-provider-tools). Click “Completing an NPI Application” to visit the National Plan & Provider Enumeration System (NPPES) website.

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

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

Providers currently receiving ERA and EFT from BCBSND do not need to sign up again. Medicaid Expansion will be included on your existing enrollments.

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

**Overpayments and Recoupments**

**Identified Overpayments**

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

How to return identified overpayments:

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

Send overpayments to:

BCBSND
Attn: Overpayment
4510 13th Avenue South
Fargo ND 58121

**Payment Recoupments**

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

- Patient’s name, date of birth and Medicaid Expansion identification number
- Date(s) of health care services rendered
- A list of the specific claims and amounts subject to recoupment
- Specific reasons for making the recoupment for each claim
Overpayment Disputes
Providers may dispute a payment recoupment. They may submit a dispute request within 45 calendar days from the receipt of written notification of recoupment. The dispute request should include why the recoupment should not be done along with any supporting documentation. If a request isn’t received within 45 calendar days, the amount is offset on future payments.

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

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

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:
- 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 code sets when submitting claims to BCBSND for processing.

ICD-10-CM (Diagnosis Codes)
Always report the primary diagnosis code on the claim form. Principal Diagnosis – “Reason for service or procedure.”
- Report up to 12 diagnosis codes on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- All ICD-10 codes start with an alpha character.
- Some three-character code groupings stand alone as the valid code for the condition.
- Do not add zeros to make codes seven characters long.

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

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

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

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

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

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

▪ The service or procedure can never serve as a stand-alone code and must be reported in conjunction with another primary service or procedure.
▪ The service or procedure is commonly carried out in addition to the primary service or procedure performed. If not commonly performed in addition to the primary service or procedure, it is then defined as a stand-alone code, and when performed in addition to another procedure, the modifier -51 should be appended.
▪ The service or procedure must be performed by the same physician.
▪ The add-on code describes additional anatomic sites where the same procedure is performed (e.g., reoperation, additional digit[s], lesion[s], neurorrhaphy[s], vertebral segment[s], tendon[s], and joint[s]).
▪ The add-on code describes a special circumstance under which a specific service or procedure is performed in conjunction with the primary procedure.
▪ The add-on code describes an additional segment of time in a time-based code (e.g., each additional 30 minutes).

**Trailing – T Codes**

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

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

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

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

Copies of the clinical references and peer-reviewed specialty guidelines must be submitted with the Technology Assessment Evaluation form.
Modifiers
A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

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

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

▪ Indicate the valid modifier.
▪ List up to four modifiers per CPT and/or HCPCS code.
▪ Do not use other descriptions in this section of the claim form. In some cases, the system may read the description as a set of modifiers, and this could result in lower payment.
▪ Avoid excessive spaces between each modifier.
▪ Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion.

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

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

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

How to Identify BCBSND Medicaid Expansion Members
The Prefix
The three-character prefix of the member’s identification number is the key element used to identify and correctly route a claim. For BCBSND Medicaid Expansion members the prefix will be YME.
The Identification (ID) Card

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

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

How the Program Works

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

1. You may verify the member’s coverage by:
   a. Using the Availity Essentials portal Eligibility and Benefits transaction; or
   b. Calling BlueCard Eligibility at 800-676-BLUE (2583).
      i. An operator will ask you for the prefix on the member’s ID card and will connect you to the appropriate membership and coverage unit at the member’s plan.
      1. 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.

2. 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.

3. Once the claim is received, it is electronically routed to the member’s BCBS Plan.

4. The member’s plan adjudicates the claim, either approving or denying payment.

5. BCBSND reconciles payment and forwards it to the provider according to your payment cycle. The member’s BCBS plan sends a detailed Explanation of Benefits (EOB) report to the member.

Out-of-Network Services

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

Note: BCBSND does not require out-of-state out-of-network providers to be participating with their local Medicaid. However, participation with ND Medicaid is required to see a BCBSND
Medicaid Expansion member.
For details regarding precertification, refer to the **Utilization Management Program** section of this manual.

**Provider Enrollment Requirements**

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

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

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

**Claim Submission**

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

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

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

**Ancillary Claims Filing Instructions**

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

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

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

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

- If a member has insurance coverage with BCBSND and receives services from a health care provider located in a bordering county, which is participating with BCBSND, the provider must follow these contiguous county guidelines.

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

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

Example 1:

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

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

Example 2:

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

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

Example 3:

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

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

Example 4:
A non-participating provider renders care to another Control/Home Plan's member in the Par/Host Plan's service area.
▪ Provider files the claim with the local plan.
▪ Claim must be processed through BlueCard program.

APPEALS, GRIEVANCES AND COMPLAINTS

Appeal Process

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

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

Submitting an Appeal
Phone: 1-833-777-5779
Fax: 701-277-2209
Mail: BCBSND Medicaid Expansion
Attn: Appeals, Grievances, Complaints
PO Box 1570
Fargo, ND 58107-1570

BCBSND acknowledges appeal requests, verbally or in writing, and provides the following:
▪ An explanation of the process that will be followed to resolve the appeal, and
▪ Information about a member’s right to present evidence and testimony and make legal and factual arguments, in person and in writing.

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

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

**Expedited Pre-Service Appeals**

An expedited pre-service appeal review may be requested if BCBSND, the member or the authorized representative indicates the timeline for a standard resolution could seriously jeopardize the member’s life, physical or mental health, or ability to attain, maintain or regain maximum function. Pre-service expedited appeals may be filed directly by a member or from a provider acting on behalf of the member as an authorized representative. Members seeking covered services that require precertification grant to that provider the authority to act on behalf of the member as the member’s Authorized Representative. As an Authorized Representative, the provider assumes responsibility to act on behalf of the member in pursuing a claim for benefits or appeal of an Adverse Benefit Determination.

**Post Service Appeals**

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

**Timeline Extensions Available for Standard and Expedited Appeals**

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

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

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

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

If BCBSND fails to adhere to the appeal process notice and timing requirements, the member will have exhausted the BCBSND appeal process and may initiate a State Fair Hearing.
Information Considered in Appeals
Before and during the appeal process, BCBSND provides the member, the provider and authorized representative with the opportunity to examine the member’s case file, including medical records and other documents considered or generated by BCBSND in connection with the appeal of the Adverse Benefit Determination.

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

Timeframes for Appeal Resolution and Notification

<table>
<thead>
<tr>
<th>Appeal Type</th>
<th>Response Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Pre-Service</td>
<td>Written response within 30 days</td>
</tr>
<tr>
<td>Expedited Pre-Service</td>
<td>Verbal response within 72 hours, followed by written response within 3 days</td>
</tr>
<tr>
<td>Post Service</td>
<td>Written response within 30 days</td>
</tr>
</tbody>
</table>

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

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

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

Appeal Decision-Makers
BCBSND individuals who make appeal decisions:

- Are not involved in a previous review or decision
- Are not subordinates of someone involved in a previous review or decision
- Are health care professionals with appropriate clinical expertise in treating the member’s condition or disease if deciding the following:
• An appeal of a denial that is based on lack of medical necessity
• An appeal that involves clinical issues
• A grievance regarding the denial of an expedited appeal resolution
• Consider all comments, documents, records and other information submitted by the member or their representative without regard to whether the information was submitted or considered in the initial Adverse Benefit Determination

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

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

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

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

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

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

Process for State Fair Hearings
A member, or other party to the appeal who has completed BCBSND’s appeal process, may request a State Fair Hearing after receiving a notice of the appeal resolution indicating that BCBSND is upholding, in whole or in part, the Adverse Benefit Determination, or after BCBSND fails to adhere to the notice and timing requirements for appeals.
The member or other party has 120 calendar days from the date of BCBSND's notice of resolution to request a State Fair Hearing.

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

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

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

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

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

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

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

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

**Grievance Process Available to Members**

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

**Submitting a Grievance**

**Phone:** 1-833-777-5779  
**Fax:** 701-277-2209  
**Mail:** BCBSND Medicaid Expansion
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 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 Complaint Process
A provider complaint is a written or verbal dispute about an administrative or claim matter. No form is required to submit a written complaint.

Submitting a Complaint
Phone: 1-833-777-5779
Fax: 701-277-2209
Mail: BCBSND Medicaid Expansion
Attn: Appeals, Grievances, Complaints
PO Box 1570
Fargo, ND 58107-1570

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

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

**Objectives**

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

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 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 is outlined in the letter or memorandum. The provider will have 30 days to correct any identified errors (If applicable), or to request a reconsideration.
Should a provider fail to respond within the 30-day timeframe, in fairness to all providers, the provider has waived any opportunity for reconsideration or adjustment.

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. BCBSND will respond to the provider within 45 days of the receipt date of the request with a determination unless otherwise communicated.

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 and submit this information along with all supporting documentation.
- If it is determined the service(s) should not have been billed, the provider may submit corrected information indicating such or not respond. All claims without supporting documentation supplied by the deadline will be denied as indicated in the communication.
- Submitted documentation will be reviewed by a coding or medical professional. This is considered a reconsideration.
- Claims found to be appropriately supported by the documentation will remain paid.
- Claims submitted for correction will be corrected 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.

**DRG Coding Audit**

**Audit Processes**

Inpatient claims are extracted in an edit process based on the quarter the claims were paid.
The Reimbursement Coding Coordinator selects those claims identified as having one or more edits for review.

The Reimbursement Coding Coordinator follows appropriate ICD-10 coding conventions and guidelines, UHDDS guidelines, Coding Clinic, and BCBSND policy when conducting coding reviews.

The BCBSND Medical Directors provide input for cases where insufficient or conflicting medical record documentation may exist.

Results of review findings are provided to the facility’s Medical Record Department or other designated contact on a quarterly basis. BCBSND provides Individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.

Providers have 45 days following notification to request a reconsideration or if in agreement, request an adjustment.

The DRG Reconsideration Process is available to providers and consists of two levels of reconsideration.

**DRG Audit Reconsideration Process**

The reconsideration process allows providers to request a reconsideration on claim decisions made as a result of a DRG Coding Audit. This process applies only to the DRG Coding Audits.

**First Level of Reconsideration**

The provider must send a written request via certified mail. This request must include any additional information, any medical records not previously supplied, and the rationale for the request within 45 days of certified receipt date of the DRG notification letter.

The request will be reviewed by a coding professional. If following the review, the conclusion remains adverse, a medical doctor will review the case and make the final determination.

BCBSND will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration determines if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

If the attending physician and/or Medical Director wish to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request a second level reconsideration.

**Second Level of Reconsideration**

Providers must send a written request via certified mail with any additional information within 45 days of the certified receipt date of BCBSND first level reconsideration response.

An external physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within
45 days of certified receipt date of the request. This is the final level of reconsideration for issues related to DRG Coding Audit with BCBSND.

**Independent External Review**

A health care provider may request an Independent External Review (IER) as outlined in the Appeals and Grievances section of this manual. The IER may be requested only after exhausting the reconsideration processes.

**Rebilling Process**

**DRG Coding Review**

The provider must submit a claim adjustment with the appropriate recommended changes as indicated in the final determination within 45 days from receipt; new claims are not accepted. Providers should complete and submit the SIU/Provider Audit Adjustment Form along with a copy the notification letter. If a claim adjustment request is not received within 45 days from date of certified notification, the claim will be denied. Access the SIU Institutional/DRG Adjustment Form at [https://www.bcbsnd.com/providers/news-resources/forms-documents](https://www.bcbsnd.com/providers/news-resources/forms-documents) under the Claims Processing section.

**DEFINITIONS**

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

**1915(i) Services**

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

**Affiliation**

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

**Affordable Care Act (ACA)**

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

**Allowed Charge**

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

**Ancillary Services**

All hospital services for a patient other than room and board and professional services. Laboratory tests and X-rays are examples of ancillary services.
Authorized Referral
If a level or type of service is not available within the Medicaid Expansion network, an authorized referral is required to be submitted by a network provider for benefits at the in-network level.

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

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

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

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

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

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

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

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

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

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

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

**Member**
Any individual enrolled in the Medicaid Expansion program.

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

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

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

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

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

**Precertification**
The process of the member or the member’s representative notifying BCBSND to request approval for specified services. Eligibility for benefits for services requiring precertification is contingent upon compliance with the provisions of a member’s benefit plan. Precertification does not guarantee payment of benefits.
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.