Provider Requirements

PURPOSE

This policy contains requirements providers must follow as an enrolled provider in ND Medicaid.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND POLICIES

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

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

Providers are required to check the Prescription Drug Monitoring Programs (PDMPs) before prescribing or dispensing controlled substances to a Medicaid member. ND Medicaid defines “before prescribing or dispensing” as one or more of the following:

- New or unestablished treatment;
- Every six months during established treatment;
- For early refills or patterns of taking more than prescribed dosage; and
- Upon suspicion or known drug overuse, diversion or abuse.

Provider policies do not have all of the ND Medicaid programs rules and regulations. Any rule citations in ND Medicaid policies are for reference and are not a summary of the entire rule.

SCOPE OF PRACTICE

Ordered or rendered services must be within the scope of practice of the provider ordering or rendering the service in accordance with applicable laws and rules.

ND Medicaid realizes there are other professional sources that define the relationship between the member and provider; including certain CPT® code definitions, current CDT® definitions, American Dental Association Guidelines and Dental Evidence, the American Academy of Pediatric Dentistry Oral Health Policies and Recommendations (the Reference Manual of Pediatric Dentistry),the ASAM Criteria: Treatment of Addictive, Substance-Related, and Co-Occurring Conditions (most current version), The Diagnostic and Statistical Manual of Mental Disorders (5th ed, DSM-5), current HCPCS codes, ethical standards of practice, accepted professional standards of practice, and current evidence-based practice guidelines. Providers are responsible for maintaining the qualifications for their licensure or certification and are not eligible to order or render services during any periods in which there is a lapse in their licensure or certification.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

ND Medicaid follows the National Correct Coding Initiative (NCCI) Edits. The Centers for Medicare and Medicaid Services (CMS) developed these edits based on coding conventions defined in the American Medical Association's Correct Procedure Terminology (CPT®) Manual, national and local polices and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS updates the National Correct Coding Initiative Coding Policy Manual annually.

RELEASE OF INFORMATION

Providers are required to release, upon reasonable request, information needed to support the services billed to ND Medicaid as a condition of your participation in the program. ND Medicaid is a covered entity under HIPAA and acts within its authority to request documentation. Supplying the requested documentation is not a HIPAA violation. Laws applicable to supplying documentation are:

- 45 C.F.R. § 164.506 - uses and disclosures to carry out treatment, payment, or health care operations.
- 45 C.F.R. § 164.512(d) - allows the disclosure of protected health information to a health oversight agency (which includes ND Medicaid as a government benefit program).
- 42 C.F.R. § 456.23 - ND Medicaid's authority to conduct a post-payment review.
- North Dakota Administrative Code § 75-02-05-04(2) – provider responsibilities, including supplying documentation upon request.
- 42 C.F.R. § 431.107(b)(2) – requiring providers to submit information regarding Medicaid payments for furnishing services.

MEMBER PARITY

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

MEDICAL NECESSITY

Services, care, prescribed drugs, and supplies ordered and rendered to ND Medicaid members must be medically necessary. Medically necessary/medical necessity means:

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

See N.D. Admin. Code § 75-02-02-03.2(10) and N.D. Admin Code § 75-02-02-08 for more information.

VERIFICATION OF MEMBER ELIGIBILITY

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

1) Log into ND Health Enterprise Medicaid Management Information System (MMIS). Click on the Member tab then select Check Eligibility.
2) Call the Provider Relations Call Center at (701) 328-7098 or (877) 328-7098.
3) Use the Automated Voice Response System (AVRS).

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

- Member Inquiry;
- Payment Inquiry;
- Claims Status; and
- Service Authorization Inquiry.

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

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

an NPI that is associated with more than one Medicaid ID number must use the PIN number assigned to the Medicaid ID number used to access AVRS.

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

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

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

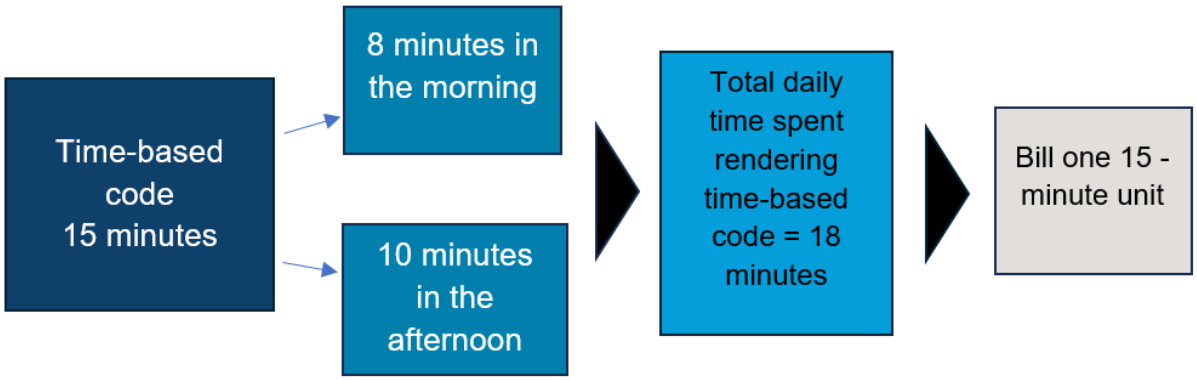
Option 4: **Service Authorization Inquiry**	Service Authorization (SA) information is available based upon the Member ID number entered, including: • SA Number • Date(s) of Service • Authorization Status

TIME BASED UNITS
Time is generally the face-to-face time spent with a member. See individual service policies for requirements.

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

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

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



DOCUMENTATION REQUIREMENTS

Documentation records must:
- Thoroughly document the extent of services rendered and billed. These records are used to decide medical necessity and correct billing;
- Be in their original or legally reproduced form. This may be electronic;
- Support the time spent rendering a service for all time-based codes. Start and stop time is required for all time-based codes.

- Be kept for a minimum of seven (7) years from the date of their creation or the date when they were last in effect, whichever is later. Note: State law may require a longer retention period for some provider types.
- Be signed by the ND Medicaid-enrolled provider rendering the service. Claims that do not have signed records are considered non-covered.
- Be legible, promptly completed, dated, and authenticated (signed) in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy. Signatures must follow Medicare requirements.
- Be kept confidential.

Documentation includes:

- Medical records including:
  - Member's name and date of birth;
  - Date of service;
  - Start and stop time spent with the member performing the service, to support payment for time-based billed services;
  - Name and title of provider rendering the service, if other than the billing practitioner;
  - Chief complaint or reason for each visit;
  - Pertinent medical history;
  - Pertinent findings on examination;
  - Medication, equipment and/or supplies prescribed or provided;
  - Description of treatment or service provided;
  - Recommendations for additional treatments, procedures, or consultations;
  - Diagnostic tests and results;
  - Dental photographs/teeth models;
  - Certification of medical necessity (if applicable);
  - Plan of treatment and/or care and outcome; and
  - Signature and date by the person ordering or rendering the service.
- Service authorization information;
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to members;
- Records and original invoices for items that are prescribed, ordered, or furnished;
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers, and other financial information; and
- Service-specific documentation requirements per policy.

AMENDING MEDICAL DOCUMENTATION

Any change or addition to a medical record must have the current date of that entry and be signed by the person making the change or addition. Late entries supply additional information that was not included in the original record. The person documenting must have total recall of the omitted information.

Additions provide information that was not available at the time the original record was made. The reason for adding or clarifying information must be added to the medical record.

Corrections when there is an error in the documentation:

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

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

FALSIFIED INFORMATION

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

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

CONFIDENTIALITY AND RECORDS ACCESS

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

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

- Medical records;
- Quality assurance documents;
- Financial records;

- Administrative records; and
- Other documents and records that must be maintained.

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

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

PAYMENT FOR SERVICES

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

- Provider is enrolled with ND Medicaid;
- Services are rendered by practitioners licensed and operating within the scope of their practice as defined by law or rule;
- Member is eligible for Medicaid;
- Service is medically necessary:
    - ND Medicaid may review medical necessity at any time before or after payment.
- Service is covered by ND Medicaid and is not considered experimental or investigational;
- Service authorization or coverage policy requirements are met where applicable;
- Claims are billed according to policy and correct coding guidelines;
- Billed charges are usual and customary:
    - "Usual and customary charge" refers to the amount the provider charges the public, in most cases, for a specific item or service. Providers may not charge ND Medicaid a higher fee than that charged to non-Medicaid covered individuals, even if the ND Medicaid fee schedule amount is greater than the provider's usual and customary charge. If special discounts are available to non-Medicaid covered individuals, claims submitted to ND Medicaid must represent the same discounted charges as those available to the general public.
- Payment to providers from Medicaid and all other payers do not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at $0;
- Claims meet timely filing requirements;
- If the member has third party liability (TPL), services were billed in accordance with the TPL requirements; and
- All claims are subject to post-payment review or audit.

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

BILLING A MEDICAID MEMBER
See "Providers Billing a Member" section in the Recipient Liability policy.

DEFINITIONS

Compliance with applicable laws, regulations and policies - adhering to the rules and requirements set by the government for the Medicaid program. This includes following all relevant state and federal laws, as well as any specific policies and procedures established by the Medicaid program itself, both at the state and federal level.

Laws and regulations - Refers to specific legal statutes and regulations that govern Medicaid, including those at the federal level (ex: Social Security Act) and the state level, which may implement or expand upon federal requirements.

Policies and procedures - ND Medicaid has its own internal policies and procedures that provider must follow. These guidelines on enrollment, eligibility, covered services, billing and compliance etc. can be found under Provider Guidelines, Manuals, and Policies.

Scope of practice - Range of services that a healthcare professional is legally authorized to provide within a specific state, as defined by that state's laws and regulations.

NOTE: This includes the types of services but also the level of supervision required, and whether the professional has the authority to prescribe medications or administer vaccines.

National Correct Coding Initiative (NCCI) - is a set of rules developed by CMS to promote correct coding and prevent improper payments in healthcare claims. For Medicaid, it requires state programs to incorporate these NCCI methodologies into their claims processing systems to ensure accurate billing. These methodologies include Procedure to Procedure (PTP) edits and Medically Unlikely Edits (MUEs)

Procedure to Procedure (PTP) edits - Edits that identify code pairs that should not be billed together for the same patient on the same day, unless a specific modifier is used to indicate a clinically appropriate circumstance.

Medically Unlikely Edits (MUEs) - Edits that define the maximum units of service that can be billed for a specific procedure code on a single date of service for a single patient.

Post Payment review and audit - Review of claims that have already been processed and/or paid.

- *Post-payment reviews* **-** Are routine actions by a payer. Medicare or Medicaid managed care products are required to do a review of claims for the Centers for Medicare & Medicaid Services (CMS) or your state Medicaid program to verify the payer is adjudicating the claims correctly.
- *Audits* - Are done randomly and meant to ensure integrity and efficiency of the ND Medicaid Program. During an audit, auditors will review medical records, billing statements, and other documentation to verify the accuracy of claims.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

CONTACT

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POLICY UPDATES

June 2025

Section	Summary
Compliance with Applicable Laws	Updates for prescriber or dispensing providers.

October 2025

Section	Summary
	Format updates and clarifications added throughout