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1915(i) Service Authorization FAQ

Where do I enter a service authorization for members on Traditional Medicaid?

Members on Traditional Medicaid coverage will have their Service Authorization (SA) entered into MMIS. Instructions for using MMIS can be found here - MMIS SA process.

How long does it take for a service authorization to be approved once it has been entered in MMIS?

Allow up to 10 business days for a service authorization to be approved in MMIS for Traditional Medicaid members.

Where do I enter a service authorization for members on Expansion?

Members on Medicaid Expansion will have their service authorization entered into the Availity Essentials portal. Instructions for using the Availity portal can be found here – https://www.hhs.nd.gov/1915i/mco.

How do I verify if a member is on Traditional or Expansion Medicaid?

You may contact the AVRS line at 1-877-328-7098 or use the MMIS web portal to verify Traditional Medicaid coverage. To verify Medicaid Expansion coverage, use this link for step-by-step instructions - BCBSND MCO Link | Health and Human Services North Dakota.

How many units can be requested for a service?

All 1915(i) services, except for respite, can be requested for the maximum amount (8 hrs. per day) based on the number of days being requested. This is calculated by taking the number of days x 8 (max. hours per day) x 4 (units per hour).

What start date should be used when entering a service authorization?

The start date for a Service Authorization (SA) will be the date you enter it into the system (MMIS or Availity), unless it's a SA for care coordination and it's the member's initial Plan of Care. Then it can be backdated to the date of initial contact as long as the POC was completed within 30 calendar days of initial contact. Care coordination is the only service allowed to be back dated.

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What if a member switches from Traditional Medicaid to Medicaid Expansion or vice versa?

Refer to the Service Authorization policy that outlines these steps under the section "Individual's Traditional Medicaid Eligibility Changes to Medicaid Expansion" and "Individual's Medicaid Expansion Eligibility Changes to Traditional Medicaid".

What documents must be attached to a service authorization?

All Service Authorizations (SA) must have the plan of care and the individual acknowledgement attached. If the SA includes a request for all services, the Request for Service Provider form must be attached following the Conflict of Interest procedures.

How can I check the status of a service authorization?

Steps to view the status or edit a Service Authorization (SA) can be found in the SA Training PowerPoint found here - Service Authorization PowerPoint.