1915(i) Policy

Claims 510-08-60

Claims training PowerPoints are available on the 1915(i) website. These resources provide step-by-step instructions for the claims process. Providers will need to reference these resources to accurately submit a claim.

In addition to this policy, providers must visit the *MCO's website* to obtain claims requirements specific to Expansion members.

Definitions applicable to this section:

1. **Managed Care Organization (MCO):** The department contracts with an entity to serve as the MCO and administer services for Expansion members.

2. **Medicaid Management Information System (MMIS):** A claims processing and information system that State Medicaid programs must have to be eligible for Federal Medicaid funding. The system controls Medicaid business functions, such as service authorizations, claims, and reporting. 1915(i) providers will enter all service authorizations and claims into MMIS.

3. **ND Medicaid:** Also referred to as the Medical Service's Division or State Medicaid Agency (SMA) within the North Dakota Department of Human Services. ND Medicaid administers the 1915(i) for individuals eligible for Traditional Medicaid.

4. **Service Limits and Codes Document:** This document identifies the limits for each service, as well as various codes the provider will need to submit claims.

5. **Place of Service (POS) Codes:** The POS codes identify the location a provider delivers a service to an individual. When submitting a service authorization request, the provider is required to identify the one POS code you expect to deliver the majority of the services at. Later, when submitting the claim, the provider will list the correct POS code for each of the services they provided and are submitting a claim for reimbursement. A Place of Service Codes document listing

commonly used codes is located on the 1915(i) website. For a complete list of POS codes visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Third Party Liability (TPL)

1915i providers do not need to bill other insurances for 1915(i) services prior to billing Medicaid.

Client Share

Client share, also referred to as recipient liability, is the monthly amount a member must pay toward the cost of services before the Medicaid program will pay for services received. It works like a monthly deductible. 1915(i) individuals with a client share are responsible for their client share. Client share applies to Traditional Medicaid individuals, but does not apply to individuals covered under the alternative benefit plan (ABP), also referred to as Medicaid Expansion, where 1915(i) benefits are administered through the managed care organization (MCO).

Each month, ND Medicaid applies a member's client share amount to claims submitted based on the order in which the claims are submitted and processed. The client share may be applied to one or more claim(s). Once the entire monthly client share amount is applied to a claim(s), ND Medicaid pays for other covered services received during the month. When client share is applied to a claim, ND Medicaid sends a notice to the member showing the provider's name, date of service, and the amount of client share owed to the provider. The member is responsible for paying the client share to the provider(s) listed on the notice. Providers are notified via the remittance advice of the amount of recipient liability owed from a member. Providers cannot collect client share at the time of service, and must wait until client share populates in their remittance advice to collect the client share.

Providers may refer individuals with questions regarding client share to this fact sheet: http://www.nd.gov/dhs/info/pubs/docs/medicaid/fact-sheet-medicaid-recipient-liability.pdf

The Claims Process

Providers will use one of two separate claims processes depending on whether they are serving a Traditional Medicaid member or an Expansion Medicaid member.

Providers will use the North Dakota Department of Human Services' process when submitting claims for Traditional Medicaid members. This policy outlines the process providers will follow for Traditional Medicaid members.

Providers will use the Managed Care Organization's (MCO) process when submitting claims for Expansion Medicaid members. Providers are to visit the 1915(i) website for the MCO's contact information and to obtain their process for submitting claims.

Verification of Member Eligibility Status

It is the provider's responsibility to verify a member's 1915(i) eligibility, as well as Traditional Medicaid or Expansion status, on a daily basis prior to providing services.

Providers are to call AVRS 1-877-328-7098 to verify Traditional Medicaid member 1915(i) eligibility.

Providers are to visit the MCO's website for instruction on how to verify Medicaid Expansion member 1915(i) eligibility.

Medicaid will not pay provider claims for services provided to individuals not eligible for Medicaid and 1915(i) on the date of service provision.

State Medicaid will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional or Expansion coverage type to the other in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate, and the member is still 1915(i) eligible. In such circumstance, either coverage type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

Relevant Information for Submitting Claims

Providers will submit claims for Traditional Medicaid members in MMIS on a Professional Claim form. See the most current 1915(i) *Fee Schedule* located on the 1915(i) website.

Each 1915(i) service has its own unique description, age requirement, rate type, code, possible modifier, rate, service limit, remote support limit, specialty code, group taxonomy, and individual taxonomy associated with it.

See the *Service Limits and Codes* located on the 1915(i) website for the codes necessary to submit a claim.

All claims must reference the service authorization number the claim is associated with.

Provider claims must be within the limits of the approved service authorization.

Only one service authorization number per claim is allowed.

Medicaid can only reimburse for one individual provider delivering the same service for the same time period. Medicaid cannot reimburse a second individual provider delivering the same service at the same time to the same individual. This would be considered duplication of services which is not allowed.

Electronic Visit Verification (EVV) requirements are applicable to the respite service. See the Respite Service Policy for special instructions on the use of the Therap system for providers submitting service authorizations and claims for the respite service.

Counting Minutes for 15 Minute Units

Providers can bill a single 15-minute unit for services greater than or equal to 8 minutes through and including 22 minutes. Providers should not bill for services performed for less than 8 minutes. If the duration of a service in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for times in excess of 2 hours.

Minutes from the same day, with the same Place of Service (POS) code, and for the same individual can be combined and billed when adding up to at least 8 minutes.

For example, if a care coordinator is making telephone calls to a half dozen providers, each taking two to three minutes, the time can be combined and billed as 1 unit. The content of the calls must relate to the scope of service. If the cumulative time for one day is greater than 8 and 15 minutes or less, 1 unit can be billed. Documentation must show how time was accumulated to arrive at the total time billed. A telephone call that does not result in a contact is not a billable activity.

MMIS Submission Frequently Asked Questions

What does entity qualifier non-person or person entity mean?

The 1915(i) requires individual providers be affiliated with the group so 1915i providers will use "non-person" which is the agency a.k.a. group provider.

What is a rendering provider?

The Individual provider person performing the service is the rendering provider.

What is the claim note section used for?

Providers may enter any additional information you would like the dept to know here. For example, if you are trying to prove timely filing limits you could enter information in the claim note section.

Under claim data, what does assignment code mean?

The Assignment Code will always be "Not Assigned".

What does benefits assignment certification mean?

The provider will choose "Not Applicable" as no insurance pertains to these services.

What should be checked under Release of Information?

Always check "Yes, Provider has a signed statement". The existence of a member's signature on the POC meets the requirements of a "signed statement".

What is the Type Code?

If you are adding a claim note, then select additional information. If you are not adding a claim note leave this section blank.

What is the Patient Account Number?

The patient account number is the member's ND Medicaid ID Number.

How is the Diagnosis Section completed?

The diagnosis code defaults to ICD-10 - Providers must use ICD 10 diagnosis codes on the claim form. Use at least one of the client's current 1915(i) qualifying diagnosis. If you have 5 diagnosis codes on your claim, then each line item has to be tied to the appropriate diagnosis code.

What is the Procedure Code?

This is the code that identifies the service you are providing. See the rate schedule on the 1915(i) website to obtain the code. The procedure code on the claim must match the procedure code you used on the service authorization.

How to complete the Description?

The description will auto-populate based on the procedure code entered.

What are the Modifiers?

If the procedure code/rate code has a modifier you must use it on your claim. Codes and Modifiers are available on the rate schedule on the 1915(i) website.

What is the Line-item charge amount?

This is the $ amount you are billing (the rate times the number of units for example). Each date of service needs to be on a separate "New Line

Item". You cannot cross days or months on the claim form. There is a spot that says "Add Service Line Item" to add additional billing lines for the next service entry.

What is the Place of Service (POS) Code?

The POS codes identify the location a provider delivers a service to a member. When submitting a service authorization request, the provider is required to identify the one POS code you expect to deliver the majority of the services at. Later, when submitting the claim, the provider will list the correct POS code for each of the services they provided and are submitting a claim for reimbursement. A Place of Service Codes document listing commonly used codes is located on the 1915(i) website. For a complete list of POS codes visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Reimbursable vs. Non-Reimbursable

The activities contained in the service description is what CMS allows reimbursement for. The following are examples of what is not reimbursable to the provider:

- Services provided not included in the service description including associated costs incurred for providing the service, for example, checking a member's eligibility.
- Services provided to a non-eligible member. Providers are responsible for confirming member eligibility prior to delivering each service.
- Claims submitted to the state via MMIS for Expansion members.
- Services provided by a non-qualified provider. Group providers are responsible for ensuring their group and affiliated individual providers meet all qualifications and have completed training.
- Services provided to a member not meeting the specific requirements of the service, such as age.
- Services provided without a valid service authorization.
- Non-valid claims.
- Client not present. The client must always be present with the provider for reimbursement to occur for all services other than care coordination.

Medical Records Requirements

See the *1915(i) Medical Records policy* for documentation requirements.

Provider Appeals Process

SFN 168 Medicaid Provider Appeals
https://apps.nd.gov/itd/recmgmt/rm/stFrm/eforms/Doc/sfn00168.pdf

Medicaid Provider Appeals Summary
Medicaid Provider Appeals Summary | Health and Human Services North Dakota

General Provider Manual

Further information is available in the General Provider Manual located at this link: Provider Manuals and Guidelines | Health and Human Services North Dakota

ND Medicaid Call Center

For questions on claims for Traditional members contact the ND Medicaid Call Center at:

Contact Information
Telephone: 877-328-7098
Email: mmisinfo@nd.gov