1915(i) Claims

PURPOSE

The purpose of this policy is to provide clear and consistent guidance for providers on the proper submission of claims for 1915(i) services under both Traditional Medicaid and Medicaid Expansion.

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 Medicaid Expansion, on a daily basis prior to providing services.

Providers can view a member's eligibility in MMIS. Instructions to do this are located on the 1915(i) Provider Guidance and Policies webpage. Providers can also call AVRS 1-877-328-7098 to verify Traditional Medicaid member 1915(i) eligibility.

Providers can visit the MCO's claims website, Availity, 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.

Traditional Medicaid will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional Medicaid or Medicaid 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 circumstances, 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.

THE CLAIMS PROCESS

For all 1915(i) services rendered on or after January 1, 2026, providers will use the billing module in Therap to submit their claims for both Traditional Medicaid and Medicaid Expansion. Resources for how to submit claims in Therap can be found in the Therap section of the 1915(i) Provider Guidance and Policies webpage and on Therap's North Dakota 1915(i) webpage.

DOCUMENTATION REQUIREMENTS

Providers must keep legible medical records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

RELEVANT INFORMATION FOR SUBMITTING CLAIMS

Provider claims must be within the limits of the approved Plan of Care.

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.

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

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 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 factsheet: fact-sheet-medicaid-recipient-liability.pdf

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.

REIMBURSABLE VS. NON-REIMBURSABLE

The activities contained in the service description are 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 submissions.
- 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 an approved Plan of Care.
- Non-valid claims.
- Not following the Telehealth policy for when services are rendered, and the member is not present.

RETROACTIVE BILLING

If the Plan of Care (POC) is an Initial POC, care coordination providers are allowed to back date billing to the initial date of contact, if that POC is submitted within 30 calendar days of the initial date of contact. Retroactive billing is only on the initial POC, or initial POC with a new agency in the case of a care coordination transfer. If it is after 30 calendar days, or is not an initial POC, care coordinators are not allowed to back date billing and can only bill from date of POC submission. Care coordination is the only 1915(i) service that has retroactive billing. All other 1915(i) services require that there be an approved POC listing that specific service and provider in order for there to be claims submitted for billing.

MEDICAL RECORDS REQUIREMENTS

See the 1915(i) Provider Requirements *policy* for documentation requirements.

PROVIDER APPEALS PROCESS

SFN 168 Medicaid Provider Appeals

Medicaid Provider Appeals Summary

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

DEFINITIONS

- **Managed Care Organization (MCO):** The department contracts with an entity to serve as the MCO and administer services for Expansion members.
- **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 (for the applicable 1915i services requiring a service authorization) and claims into MMIS.
- **ND Medicaid:** Also referred to as the Medical Service's Division or State Medicaid Agency (SMA) within the North Dakota Department Health and Human Services. ND Medicaid administers the 1915(i) for individuals eligible for Traditional Medicaid.
- **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.
- **Place of Service (POS) Codes:** The POS codes identify the location where 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. For a complete list of POS codes visit:https://www.cms.gov/Medicare/Coding/placeof-service-codes/Place_of_Service_Code_Set

REFERENCES

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

FREQUENTLY ASKED QUESTIONS

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CONTACT

Medical Services
600 East Boulevard Ave
Bismarck, ND 58505-0250
Phone: (701) 328-2310
Email: dhsmedicalservices@nd.gov

POLICY UPDATES

Section	Summary
Purpose	Updated the summary purpose of the policy
The Claims Process	Updated to reflect billing in Therap
Third Party Liability	Removal of Third Party Liability Section, as 1915(i) does not have Third Party Liability.
Documentation Requirements	Add the Documentation Requirements section