

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.

Applicability

Eligible Providers

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

Eligible Members

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

Covered Services and Limits

General Provider Policies

The [General Provider Policies](#) details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;

- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

Service Authorization Requirements

Effective November 1, 2024, service authorizations are no longer required on most services. Service policies indicate which services still require service authorizations, please refer to individual service policies for more information.

Non-Covered Services

General Non-Covered Services

The [Noncovered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid.

Documentation Requirements

General Requirements

Service documentation must occur in Therap beginning January 6, 2025. Providers must keep legible medical and financial 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](#).

Reimbursement Methodology and Claim Instructions

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.

Third-Party Liability

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability 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](#).

Reimbursement

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

Care coordination is the only 1915(i) service that has 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. If it is after 30 calendar days, care coordinators are not allowed to back date billing and can only bill from date of POC submission.

In regards to a member's 1915(i) redetermination, the 1915(i) redetermination application must be submitted 30 calendar days, but no more than 45 calendar days, before the end of the member's eligibility span, and if the 1915(i) care coordination agency submits the plan of care within 5 business days of the member's 1915(i) redetermination application being approved, the care coordination agency may back date billing to the start of the new 1915(i) eligibility period.

All 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.

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.

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 Definitions

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.

Provider Appeals Process

[SFN 168 Medicaid Provider Appeals](#)

[Medicaid Provider Appeals Summary](#)

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

General Provider Manual

Further information is available in the [General Provider Manual](#)

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 1915 (i) 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 [Place of Service Codes](#) visit:

References

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

Contact

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Policy Updates

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