



1915(i) Service Authorizations in MMIS

NORTH
Dakota Be Legendary.

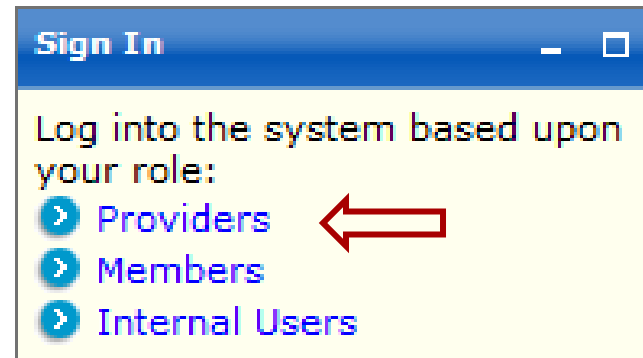
Health & Human Services

Revised ¹6/28/23

SERVICE AUTHORIZATIONS

- Service Authorizations for Traditional Medicaid covered members with the 1915(i) State Plan must always be submitted via the ND Medicaid MMIS Web Portal.
- Web-based service authorizations have a quicker response time with or without the need for documentation.
- On average – service authorizations are pended no more than 10 business days.

- Providers will log into the ND Health Enterprise MMIS Portal:
 - You must log in with your agency's MMIS login, not your individual provider log in
 - If you need assistance with the login, please contact the ND Health Enterprise MMIS Call Center – 1-877-328-7098



- Enter Agency Login Username and Password:

A screenshot of a web application window titled "ProviderLogin". The window has a blue title bar with standard window controls (minimize, maximize, close). The main content area contains the following text:

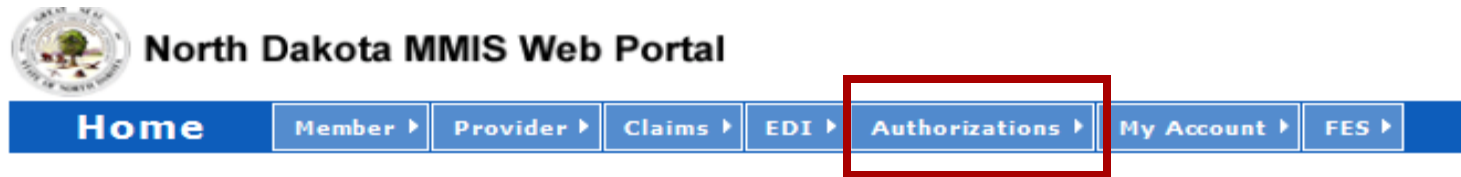
To access secure areas of the portal,
please log in by entering your User ID
and Password.

Below this text are two input fields, each preceded by an asterisk (*):

- * User ID:
- * Password:

Below the input fields is a blue hyperlink: [Forgot User Name or Password ?](#)At the bottom right of the form are two buttons: "Login" and "Reset".

- To create a service authorization, providers will click on Authorizations:



- Providers will then choose Submit Professional Authorization:

The screenshot displays the 'Authorizations Main Page' with a blue header. Below the header, a text line reads: 'From this page you can view, create, edit, submit and resubmit Service Authorizati'. The page is divided into two columns: 'Authorizations' and 'Submit Authorization'. The 'Submit Authorization' column contains a list of options: 'Submit Professional Authorization', 'Submit Dental Authorization', 'Submit DME Authorization', and 'Submit Institutional Authorization'. The 'Submit Professional Authorization' option is highlighted with a red rectangular box, and a red arrow points to it from the right.

Authorizations	Submit Authorization
<ul style="list-style-type: none">• View / Edit Authorization• View / Edit Referral	<ul style="list-style-type: none">• Submit Professional Authorization• Submit Dental Authorization• Submit DME Authorization• Submit Institutional Authorization

- Providers will see that their Submitter ID is noted at the top of the service authorization and that no Service Authorization ID has been issued. This will be issued when the authorization has been submitted to the Department. Providers will see the Service Level is SV1 (Professional Service) and that Transaction Purpose is a Request:

Member	Requesting Provider	Event Provider	Health Care Services Review	Diagnosis	Service Line Items	Reject Reasons	
Service Authorization ID	Submitter ID PROFUA	Service Level SV1 (Professional Service)	Transaction Type RU (Medical Services Reservation)	Transaction Purpose Request	Entered Date / Time 09/19/2017 02:00:22 PM	Certification Action	Review Decision Reason

- Providers will then enter Member Information. All fields marked with an asterisk are required fields.
- Member information required: Member ID, Last Name, First Name, and Date of Birth:

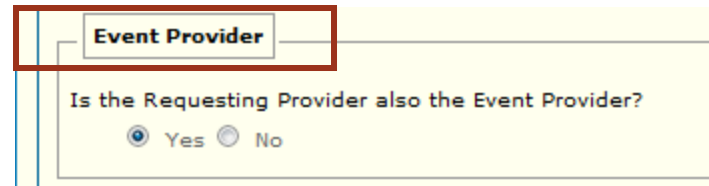
The screenshot shows a form titled "Member Information" with a red border around the title. The form contains several input fields:

- *Member ID: A text input field.
- *Last Name: A text input field.
- Prefix: A dropdown menu.
- *First Name: A text input field.
- MI: A text input field.
- Suffix: A dropdown menu.
- *Date of Birth: A date picker field.
- Gender: A dropdown menu.

- The Requesting Provider will be pre-populated with the enrolled ND Medicaid Agency ID information. This should reflect your agency Medicaid ID. No information needs to be entered in this section. (This is the Billing Provider Information in Box 33 on the Professional CMS-1500 Claim form.)

Requesting Provider				
Medicaid ID 1458343	Other Provider ID	Other Provider ID Type	*Entity Code Provider	*Entity Type Person
Provider Code ▼	Taxonomy Code	Provider Name		
+ Additional Requesting Provider Information				
+ Contact Information				
+ Additional Requesting Supplemental Provider ID				

- Event Provider defaults to Yes. The event provider is the rendering provider on the Professional CMS-1500 Claim form (Box 24J). It is recommended to leave this defaulted to YES.



The image shows a screenshot of a form field. At the top, there is a label 'Event Provider' enclosed in a red rectangular box. Below the label, the question 'Is the Requesting Provider also the Event Provider?' is displayed. Underneath the question, there are two radio button options: 'Yes' and 'No'. The 'Yes' radio button is selected, indicated by a filled circle.

Health Care Services Review Information:

- The Request Category and Certification Type are pre-populated. These two fields can be skipped on the authorization.
- The Service Type requires a valid value. It is recommended to select **Transitional Care** from the dropdown menu.
- The Level of Service requires a valid value. It is recommended to select **Elective** from the dropdown menu.

Health Care Services Review Information

*Request Category

Health Services Review ▼

*Certification Type

Initial ▼

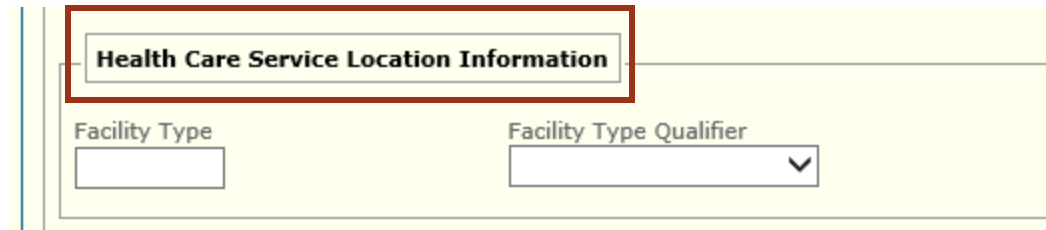
Service Type



Level of Service



- Health Care Service Location Information:
 - Facility Type (Place of Service)
 - Facility Type Qualifier (Place of Service Code)
 - A valid value is required for each of these fields. To view a full list of approved CMS Place of Service Codes visit: [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place of Service Code Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place%20of%20Service%20Code%20Set)
 - The most common place of service codes are:
 - 02-Telehealth
 - 03-School
 - 11-Office
 - 12-Home
 - 18-Place of Employment-Worksite
 - The Place of Service Code on the service authorization is an approximate value. The place of service code billed on the claim must accurately be reported.



The image shows a screenshot of a form titled "Health Care Service Location Information". The title is enclosed in a red-bordered box. Below the title, there are two input fields: "Facility Type" and "Facility Type Qualifier". The "Facility Type" field is a text box, and the "Facility Type Qualifier" field is a dropdown menu with a downward arrow.

- Providers must complete the Dates of Service. ND Medicaid must receive a Requested Begin Date and Requested End Date.

The image shows a screenshot of a form titled "Dates of Service". The form has a light yellow background. At the top, the title "Dates of Service" is enclosed in a red box. Below the title, there are two rows of fields. The first row contains "Requested Begin Date" and "Requested End Date", both of which are enclosed in red boxes. The second row contains "Approved Begin Date" and "Approved End Date". To the right of these fields, there is a label "Certification Issue Date".

Requested Begin Date:

- Requested begin date should be dated the date the provider submits the SA into MMIS. *(see Service Authorization policy for retroactive requirements)*
- Service Authorization approval or denial will be dated the date the authorization was submitted in MMIS by the provider. Providers will not be reimbursed for services provided prior to the service authorization approval date.

Requested End Date:

- The maximum time period a service authorization can be requested is to the end of the individual's 1915(i) eligibility period. The date of the individual's next annual 1915(i) eligibility determination, obtained from the Zone, is the same date as the end of the individual's 1915(i) eligibility period. *(see Housing Support policy for requirements for this service)*

When the service authorization dates span two calendar years (i.e. 6/26/23 - 4/30/24) two service lines are required for the service requested with the calculated units requested.

Service Line Item Information												
Service Line Summary												
LI	LI Status	Begin Date	End Date	Service Code Type	From Svc Code	To Svc Code	Modifier				List	
							M1	M2	M3	M4		
1	P-Pended			0-Proc Code	H2015							
2	P-Pended			0-Proc Code	H2015							

- For example: Line one dates of service 06/26/23 - 12/31/23. Line two dates of service 1/1/24 - 4/30/24. Total units from each line must add up to the requested amount on the POC for each service.

Service Code Description: Comp comm supp svc, 15 min

Revenue Code Description

Requested Begin Date: 06/26/2023

Requested End Date: 12/31/2023

Approved Begin Date: []

Requested Units: 6048.00

Unit Of Measure: UN-Unit

Approved Units: 0.00

Used Units: - 0.00

Service Code Description: Comp comm supp svc, 15 min

Revenue Code Description

Requested Begin Date: 01/01/2024

Requested End Date: 04/30/2024

Approved Begin Date: []

Requested Units: 3872.00

Unit Of Measure: UN-Unit

Approved Units: 0.00

Used Units: - 0.00

Requested Amount: []

Approved Amount: []

Used Amount: []

Remainin: []

- Providers have the ability to send any additional Notes for the State to consider when reviewing the service authorization. It is suggested that this be completed if special consideration is needed for any reason.



The image shows a screenshot of a web application interface. At the top, there is a tab labeled "Notes" with a small icon to its left. Below the tab is a large, empty text input area. At the bottom of the input area, there is a label "264 Characters Remaining".

- Providers must enter at least one 1915(i) qualifying Diagnosis. The Diagnosis Code must match the claim and must be a valid ICD-10 diagnosis code.

Diagnosis

Seq#	Diagnosis Code	Diagnosis Date	Diagnosis Type
1	F99	10/22/2020 <input type="checkbox"/>	Diagnosis (ICD-10) <input type="checkbox"/>
2			<input type="checkbox"/>
3			<input type="checkbox"/>
4			<input type="checkbox"/>
5			<input type="checkbox"/>
6			<input type="checkbox"/>
7			<input type="checkbox"/>
8			<input type="checkbox"/>
9			<input type="checkbox"/>
10			<input type="checkbox"/>
11			<input type="checkbox"/>
12			<input type="checkbox"/>

- Providers are required to submit at least one line item (service) for a service authorization to be considered.
- Multiple service lines or multiple services may be requested on the same service authorization.

- All service authorization line items must contain:
 - A **Service Code From** (HCPCS Code) and any applicable Modifiers
 - HCPCS: Healthcare Common Procedure Coding System
 - **Requested Begin Date and Requested End Date**
 - Must match the dates previously entered in Slide 13
 - Either **Requested Amount** (only for fiscal component of Training & Support Service or Community Transition Service) or **Requested Units** (for all other 1915(i) services)
 - If Units are requested, then a **Unit of Measure** is also required. Units should = Units.

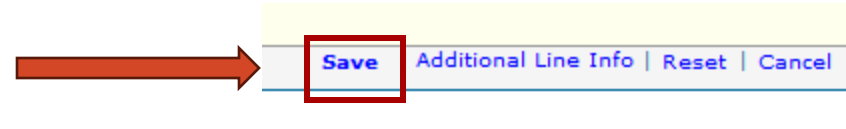
Please refer to the **Service Limits and Codes** chart to for service codes, modifiers, and requested unit limits

Service Limits and Codes

The screenshot shows a web-based form titled "Add Services Detail" with a yellow header bar and a grey navigation bar containing "Save", "Additional Line Info", "Reset", and "Cancel". The form is organized into several sections:

- Service Level:** SV1 (Professional Service)
- *Service Qualifier:** A dropdown menu showing "HC Fin Admin Common Proc Coding Sys".
- Certification Issue Date:** An empty text input field.
- Certification Action:** A section containing a red-bordered box around the ***Service Code From** text and an empty input field.
- Review Decision Reason:** A section containing a red-bordered box around the **Modifiers** text and four small input fields labeled 1, 2, 3, and 4.
- Service From Description:** An empty text input field.
- Service Code To:** An empty text input field.
- Service To Description:** An empty text input field.
- Requested Begin Date:** A red-bordered box around an empty date input field.
- Requested End Date:** A red-bordered box around an empty date input field.
- Requested Amount:** A red-bordered box around an empty numeric input field.
- Requested Unit(s):** A red-bordered box around an empty numeric input field.
- Unit of Measure:** A red-bordered box around a dropdown menu with a downward arrow.
- Approved Begin Date:** An empty date input field.
- Approved End Date:** An empty date input field.
- Approved Amount:** An empty numeric input field.
- Approved Unit(s):** An empty numeric input field.
- Service Description:** A large empty text area.
- Line Item Diagnosis:** A section with a plus icon and a blue link "Line Item Diagnosis" above an empty text input field.

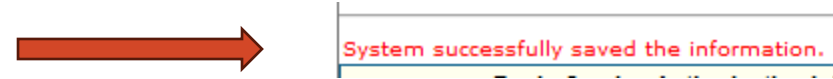
- After entering all line item information, the line item MUST BE SAVED:
 - If each line item is not saved, the data will be lost.



- To add an additional line, click the Add Service Line Item button and enter in additional services:
 - **this is where the second line will be added when entering a service authorization that spans two calendar years (06/01/2023 - 04/30/2024).



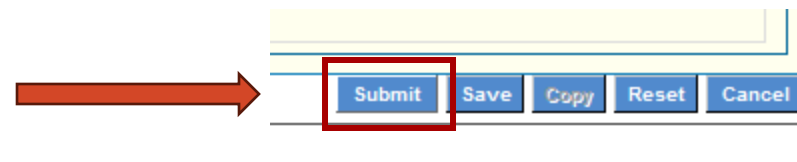
- To submit your service authorization to the Department:
 - First click **Save** at the bottom of the screen (this will give you a message at the top of the screen stating:



- If any errors occur, MMIS will generate an error message and those errors will need to be corrected before submitting the authorization to the Department.
- Under Reject Reasons, MMIS may also tell you if you have any errors on your authorization.



- Second click Submit at the bottom of the screen.



- After the service authorization has been submitted, a confirmation page will be shown on the screen. This confirmation page has very important information including:
 - Service Authorization ID Number
 - Member ID Number
 - Provider ID Number
 - Service Authorization Status
 - Submission Date and Time

It is very important to print your confirmation page and keep a copy for your records.

ADDING ATTACHMENTS

Documents that must be attached to the Service Authorization:

- Plan of Care
- Individual Acknowledgement
- Care Coordinator Attestation Signatures
- Meeting Attendee Signatures

- From the Confirmation Page, choose Upload Attachment:

Line item Detail

Svc Cd	Description	Requested Cost/Units	SA Line Item Status
99213	Office/outpatient visit est	0.00/1.0	Pended

1 - 1 of 1

[Print Submission Page](#) [Upload Attachment](#) [Submit Another SA](#) [SA Main Page](#)



- Attachments of any kind can be uploaded (.jpg, .docx .xlsx, .pdf) – documentation, care plan, treatment plan, etc.

The screenshot shows a web application window titled "E-Attachment" with a blue header bar containing "Print | Help" and a close button. Below the header is a tab labeled "Attachments". The main content area has a yellow background and contains the following elements:

- Buttons for "Submit" and "Exit/Cancel" in the top right.
- Fields for "SA ID:", "Member ID:", and "Member Name:", each followed by a redacted black box.
- An "Add Attachment" button on the right side.
- A table with a blue header and four columns: "Date Added", "Added By", "File Name", and "Description". The table body contains the text "No Data".
- A section titled "Add Attachment" with a blue header bar containing "Save | Reset | Cancel" buttons.
- Form fields for "*File" (with a "Browse..." button) and "*Description".
- A paragraph of instructions: "Please upload your file, enter a Description, and click the Save link; repeat this for as many attachments as needed. After all attachments have been uploaded and saved, it is time to upload them to the MMIS database. This is accomplished by clicking the 'Submit' button. You will receive a successful message after the upload has completed. Note: Please review all attachments BEFORE submitting as you will not be able to remove any attachment once submitted. However, if you attached a doc in error, please contact the Helpdesk."

1. Click **Add Attachment**.
2. Then click **Browse** to find the file to add on your computer.
3. Then give the file a name (no more than 40 characters without special symbols).
4. Click **Save**. (**VERY IMPORTANT!!**)
5. Continue to add additional attachments and
6. Click **Submit** to submit the attachment(s).

E-Attachment Print | Help - □

Attachments

SA ID:W [REDACTED] Member ID [REDACTED] Member Name: [REDACTED] [Submit](#) [Exit/Cancel](#)

[Add Attachment](#)

Date Added	Added By	File Name	Description
No Data			

Add Attachment [Save](#) [Reset](#) [Cancel](#)

*File [Browse...](#)

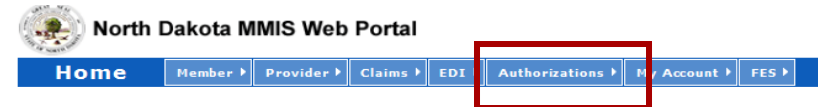
*Description

Please upload your file to the Description field and click the Save link; repeat this for as many attachments as needed. After all attachments have been uploaded and saved, it is time to upload them to the MMIS database. This is accomplished by clicking the 'Submit' button. You will receive a successful message after the upload has completed. Note: Please review all attachments BEFORE submitting as you will not be able to remove any attachment once submitted. However, if you attached a doc in error, please contact the Helpdesk.

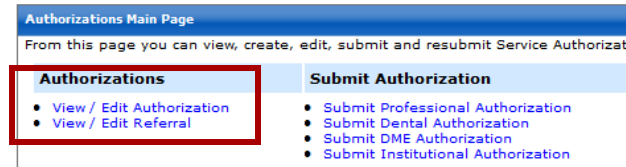
EDITING & VIEWING SERVICE AUTHORIZATIONS

Providers can view and edit saved, pending, and submitted service authorizations. **An authorization can only be edited in a saved, pending, or submitted status.**

- Choose Authorizations from the main page

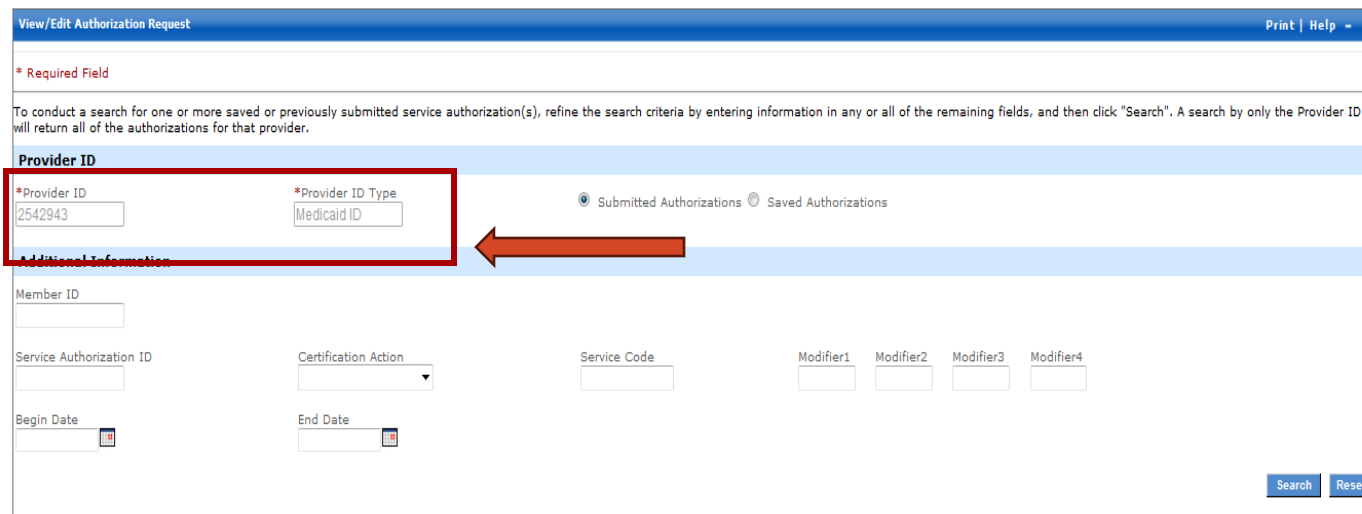


- View/Edit Authorization



- Choose Submitted Authorizations or Saved Authorizations

- Enter in the search criteria in the boxes below and edit the authorization as necessary.



View/Edit Authorization Request

* Required Field

To conduct a search for one or more saved or previously submitted service authorization(s), refine the search criteria by entering information in any or all of the remaining fields, and then click "Search". A search by only the Provider ID will return all of the authorizations for that provider.

Provider ID

*Provider ID: 2542943 *Provider ID Type: Medicaid ID

Submitted Authorizations Saved Authorizations

Additional Information

Member ID: []

Service Authorization ID: [] Certification Action: [] Service Code: [] Modifier1: [] Modifier2: [] Modifier3: [] Modifier4: []

Begin Date: [] End Date: []

Search Reset

WHAT CAN I EDIT/CHANGE ON AN AUTHORIZATION

- When an authorization is in “Saved, Pended, or Submitted” status, you may still make changes, add service lines, or add any additional attachments if needed.
- When an authorization has been denied by the state, do NOT attempt to make changes to the authorization. A new authorization must be submitted with any missing information or changes necessary.
- When an authorization is approved, modified, denied, or certified-partial, the header "requested begin/end" dates are greyed out and cannot be changed.
- If an authorization has only been "saved" and not submitted, you may access the saved request and finalize any additional services, add attachments, then save and submit the request.

SERVICE AUTHORIZATION STATUS

- Checking Status on the web portal – what do the HIPAA Values Mean??
 - A1: Certified in total means the service authorization has been approved.
 - A2: Certified partial means the service authorization has been partially approved (one line approved, one line pended or denied).
 - A3: Not Certified means the service authorization has been denied in total.
 - A4: Pended means the service authorization remains pended.
 - A6: Modified means the service authorization team has reviewed the service authorization and it is in process.

Service Authorization Contact:

Sara Regner

701-328-4825 (phone)

dhsserviceauth@nd.gov