1915(i) Billing and Claims Policy

NORTH Dakota Be Legendary.
Health & Human Services

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Presentation Overview

This training will:

- Identify the steps for billing Medicaid.
- Provide resources and support for the billing process.
- Answer questions about the billing process.

Traditional vs. Expansion

- As 1915(i) providers, you will serve both Traditional Medicaid and Medicaid Expansion members. This is included in the Provider Agreement you signed when enrolling as a 1915(i) provider.
- The 1915(i) is available to both Traditional Medicaid and Medicaid Expansion members.
- This training is applicable only to Traditional Medicaid members.
  - This training is not applicable to Medicaid Expansion, and you will use a different process when billing for services provided to an Expansion member.

Medicaid Expansion Members

- The Managed Care Organization (MCO) will provide training applicable to Expansion Members.
- Further information on 1915(i) for Expansion members, and contact information for the MCO is available on the 1915(i) website.

What is MMIS?

- MMIS is short for Medicaid Management Information System. It is the billing system used by ND Medicaid for submitting claims for Traditional Medicaid members.

- All 1915(i) provider claims for reimbursement for Traditional Medicaid members are submitted through MMIS.
  - Providers can not submit a claim for reimbursement for a service provided unless there is an approved service authorization in MMIS. Please view the Part I & Part II Service Authorization Training PowerPoints located on the 1915(i) website if you haven't already done so.

- Providers enter claims into MMIS and the department issues payment.

Third Party Liability (TPL)

1915(i) services will not have any other insurance payment.

A TPL bypass is set up in MMIS so 1915(i) 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. 1915i individuals with a client share are responsible for payment of 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 1915i 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.

Service Limits, Rates, Codes, etc.

Below is a chart found on the 1915(i) website which includes the 1915(i) service descriptions, eligible age, rate type (unit or $); rate codes and applicable modifiers; and the service limit for each of the 1915(i) services.

Service Limits and Codes

Service Description

Each service has a specific definition. A provider will only be paid for those services delivered which fall within the scope/definition of the service.

If a Care Coordination provider decides to provide math tutoring to the member, they will not be reimbursed for that as it doesn't fall within the scope of the service.

Age

Each 1915(i) service has age “limits” which identifies the ages of the individuals who can access the service.

Rate Type

Most of the rate types for 1915(i) services are “15 minute units”.

Other rate types include “dollar amount” for Community Transition and Training and Support services.

Code & Modifier

Each 1915(i) service has a rate code assigned to it.

A rate modifier is assigned to a rate code for some of the 1915(i) services. For example, the housing support service has a U4 modifier.

Service Limits

The 1915(i) services have established limits.

Service authorizations and claims may not exceed the established limit.

Provider Type

All 1915(i) providers use Provider Type 049.

NPI Number

All 1915(i) Group Providers and Individual Providers will obtain a National Provider ID (NPI).

Specialty Code

Each service has its own Specialty Code.

Group Taxonomy

Each service has its own group taxonomy assigned. Think of the Group Taxonomy code as the "Agency" Taxonomy code.

Individual Taxonomy

Each type of individual provider has its own taxonomy assigned. The "Individual" Taxonomy Code represents the "employee/enrolled individual provider" who is delivering the service.

Each Individual Provider must be affiliated with a Group Provider.

Key Points

- The Care Coordinator, in collaboration with the individual, determine the services, amounts, frequency, and duration that each provider will request in their service authorization.
- The service amount, frequency, and duration requested by the provider in the service authorization request must match the POC.
- Provider claims must be within the limits of the previously approved service authorization.

Place of Service Codes (POS)

- Medicaid requires 1915(i) providers to use Place of Service (POS) Codes.
- The POS Codes identify the location a provider delivers a service to a member.
- The link to the list of POS Codes is located on the 1915(i) website.

Place of Service Codes

- When submitting a service authorization request, 1915(i) providers are required to identify the one POS code you expect to deliver the majority of the services at.

- Later, when submitting the claim, the provider is required to list the correct POS codes for each of the services they provided and are billing the department for reimbursement.

Remote Support/Telehealth POS Codes

- Services delivered via remote support or telehealth must use one of the place of service codes during claim submission:
  - 02 – Telehealth provided other than in patient's home
  - 10 – Telehealth provided in patient's home

- Modifier 93 must be appended to any claim line where the service was delivered audio only without a face-to-face component.

Complete List of POS Codes

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Counting Minutes for 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.

Electronic Visit Verification (EVV)

The 21st Century Cures Act mandates that states implement Electronic Visit Verification (EVV) for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a providers by January 1, 2021.

1915(i) Respite Subject to EVV Requirements

The 1915(i) respite service is subject to Federal EVV Regulations. The individual provider is required to check in and out to confirm their presence in the home.

Respite providers will submit service authorizations first in MMIS for the State's approval. After approval from the State, the respite provider will enter a service authorization into Therap.

Therap will provide training to all 1915(i) respite providers in the use of EVV and the Therap system.

Diagnosis Codes Required

- The member's ICD-10 Diagnosis Code must be added to the claim.
- The member's diagnosis can be found on the Plan of Care.

Confirmation of Member Eligibility

It is the provider's responsibility to confirm 1915(i) eligibility prior to providing each service.

If 1915(i) eligibility ends, no services can be provided, and the service authorization is no longer valid. If you provide a service to someone who isn't eligible, you won't be reimbursed.

Providers are to call the AVRS 1-877-328-7098 line to check Traditional Medicaid member eligibility.

Traditional or Expansion Eligibility Verification

It is also the providers responsibility to know if the member is a Traditional or Expansion member prior to providing each service.

- If you submit a claim for an Expansion member into MMIS, it will be rejected.
- MMIS must have the service authorization for the Traditional member or MMIS will reject the claim.
- Instructions for verification of Medicaid Expansion member eligibility is available on the MCO Website.

1915(i) Claims Submission Process

1. An enrolled 1915(i) provider prepares to submit a reimbursement claim to the department for services provided.

2. The provider confirms the required documentation has been completed, and there is a valid service authorization in MMIS for the service(s) they are about to bill.

3. The provider creates and submits a professional claim in MMIS. See Billing and Claims: Part 2 - MMIS Training found on the 1915(i) website for instructions.

4. The department reimburses the provider for valid claims.

Documentation Requirements

ND Medicaid providers are required to keep records that thoroughly document the extent of services rendered to members and billed to ND Medicaid.

Records are used by ND Medicaid to determine the service was necessary and to verify that services were billed correctly.

Documentation (Cont.)

- Medical records must be in their original or legally reproduced form, which may be electronic.
  - The department is not requiring you to use a certain system for your documentation. Each provider is responsible for their own system and ensuring it meets these requirements.
- Documentation must support the time spent rendering a service for all time-based codes.
- 1915(i) records must be retained for a minimum of six years from the date of its creation or the date when it was last in effect, whichever is later. State law may require a longer retention period for some provider types.

Medical Record Valid Signature Requirements

For a signature to be valid, the following criteria is needed:

- Services that are provided must be authenticated by the author.
- Signatures shall be handwritten or an electronic signature. For additional guidance, CMS signature requirements can be found here:
  - https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements. *Note: This link does not work if using Internet Explorer.*
- Signatures are legible.
- Signature is dated and timed.

Case File Documentation Must Be Maintained

- In a secure setting.
- On each individual in separate case files.

Confidentiality and Access to Member Records

All Medicaid member, applicant information, and related medical records are confidential.

Providers are responsible for maintaining confidentiality of protected health information subject to applicable laws.

Confidentiality

- Providers are required to permit ND Medicaid personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the member because the purpose for the disclosure is to carry out treatment, payment or healthcare operations permitted under the HIPAA Privacy rule under 45 CFR §164.506.

- Notice that ND Medicaid and health plans contracting with ND Medicaid (i.e. MCO for Expansion members) must be allowed access to all information concerning services that may be covered by Medicaid. This access does not require an authorization from the member.

- Health plans contracting with ND Medicaid must be permitted access to all information relating to Medicaid services reimbursed by the health plan.

ND Medicaid Call Center

- Customer service representatives are responsible for answering questions from Medicaid providers and members relating to claim payments and submissions, program benefits, prior authorizations, and other Medicaid-related questions.

Contact Information

Telephone: 877-328-7098 or 701-328-7098

Email: mmisinfo@nd.gov

Provider Appeals

- 1915(i) providers use the same appeals form and process as other Medicaid providers.
- The SFN 168 Medicaid Provider Appeals form is located at the link provided. In order to appeal a denial or reduction of payment, this completed form must be submitted within 30 days of the date of the Department's remittance advice or notice.
- The Medicaid Provider Appeals Summary is located on the Medical Services website at the link provided.
  - 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

Resources

1915(i) website:

Medicaid 1915(i) State Plan Amendment | Health and Human Services North Dakota

The 1915(i) is an amendment to the ND Medicaid State plan; thus, all ND Medicaid State Plan Provider-related billing and claims policies and regulations also pertain to the 1915(i).