Community Health Worker Services

PURPOSE

Community Health Workers (CHWs) are frontline public health workers who serve as liaisons, links, or intermediaries between ND Medicaid members and health care and social service systems. CHWs can help engage members with necessary care and increase member health knowledge/literacy and self-sufficiency resulting in healthier members.

These services are to engage Medicaid members with chronic conditions, who are at risk of developing chronic conditions, and who have documented barriers related to access with regular health care. This includes teaching members how to effectively self-manage their chronic condition or delay development of a chronic condition.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

This policy applies to Community Health Workers certified in the state of North Dakota. ND Medicaid CHW services are a diagnosis-related medical intervention, not a social service.

CHWs must be employed by a Medicaid-enrolled billing provider and the billing provider must have and maintain documentation of CHW's North Dakota certification. CHW services must be rendered under the general supervision of a physician, pharmacist, dentist, or other licensed practitioner (OLPs).

Supervision can occur through a signed supervision agreement with a physician, pharmacist, dentist, or an OLP and the agreement must be in writing and maintained by the CHW billing provider.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System by dialing 1.877.328.7098.

CHW preventive services are medically necessary for ND Medicaid members who meet at least one of the criteria below:

- Has at least one chronic condition[1] (including behavioral health);
- Is at risk for developing at least one chronic condition[2] based on one or more of the following:
    - Medical indicators indicating an increasing risk of developing a chronic condition. These indicators may include elevated blood pressure or glucose levels; or
    - The presence of known risk factors including tobacco and/or nicotine use, excessive alcohol use, and/or drug misuse.
- Is at risk for developing at least one chronic condition or is unable to self-manage existing chronic conditions based on one or more of the following occurring within the last 12 months:
    - One or more visits to an emergency room for the chronic condition;
    - One or more hospital inpatient stays for the chronic condition, including stays at a psychiatric facility;
    - One or more stays at a residential treatment facility; or
    - Two or more missed medical appointments.
- Has a documented barrier[3] that affects the member's health as indicated through a health-related social needs or social determinants of health screening.
    - A documented barrier includes a lack of health literacy to self-navigate the health system/coordinate resources.

[1] Chronic conditions may include asthma, major depressive disorder, diabetes, chronic obstructive pulmonary disease, heart disease, high cholesterol, thyroid disease, post-traumatic stress disorder, substance use disorder, and hypertension.
[2] At risk for a chronic condition may include the following criteria: obesity, prediabetes, tobacco or nicotine use.
[3] Documented barriers may include transportation needs, cultural or language barriers, and/or lack of a telephone, financial constraints, social isolation, access to healthy food, housing, or transportation.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies detail 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.

Members must be referred for services by a physician, dentist, pharmacist or an OLP, and referrals must include:

- CHW services needed to address barriers;
- Duration of CHW services recommended; and
- Condition(s) and/or barrier(s) the CHW must address.

Members requiring more than 12 units of service by a CHW require a service plan drafted by or reviewed and approved by the supervising practitioner.

COVERED CHW SERVICES INCLUDE:

Health System Navigation and Resource Coordination

CHWs may offer support in many ways including helping to engage, or re-engage a member in the healthcare system with a focus on preventive care versus emergency care, ensuring proper follow-up in primary and preventive care, adherence to care plans, attending appointments with the member for support and helping to find other relevant resources such as support groups, food pantries, utilities assistance programs, and any other resources related to social determinants of health barriers the member may have that negatively impacts their health. A CHW may attend an appointment if CHW attendance at that type of appointment is specified in the member's service plan and there is written consent from the member.

Health Promotion and Coaching

Health promotion and coaching includes providing information that promotes positive contributions to their health. This includes information on tobacco cessation, chronic disease self-management, the reduction of misuse of substances, improvement in nutrition and physical fitness, and other health-related social needs.

Health Education and Training

Health education and training is offered by reenforcing education provided by the member's healthcare team that has been proven to be effective in avoiding or managing illness such as immunizations, control of blood pressure and diabetes, safety and accident prevention.

- Member education services provided by CHWs are to be provided under the guidance of a licensed practitioner; and
- Content of patient education must be consistent with established or recognized health or dental standards and be:
    - Diagnosis-related member education; and
    - Reinforcement of health-related education.

These services can be provided as individual or group services.

SETTINGS

Services, including initial visits, may be conducted in a health care clinic setting or community-based setting and may include a member's home. Services are community-based, meaning the bulk of the services should occur in a community versus a clinic setting unless that setting meets the needs of the member.

CHW services are not allowed in hospitals, Intermediate Care Facilities, nursing homes or basic care facilities, or carceral settings.

CHW services may be delivered individually or in a group setting.

CHW services may be provided via telehealth.

LIMITS

No more than 4 units of any combination of 98960, 98961, or 98962 are billable on a single date of service. The member is limited to 104 units of service in a year.

SERVICE AUTHORIZATION REQUIREMENTS

Requests to exceed service limits require a service authorization (SFN 481).

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.

CHW services may not duplicate other ND Medicaid services. If a CHW is qualified to provide another service covered by ND Medicaid, the CHW must enroll as a provider and bill under the guidelines for that service. Example: A CHW provides Non-Emergency Medical Transportation (NEMT) services, the CHW must complete a separate enrollment as a NEMT provider and bill as a NEMT provider.

Non-covered CHW services include:

- Advanced Care Planning;
- Chore Services;
- Companion Services;
- Medication Management Services duplicative of other ND-Medicaid-covered services;
- Services outside the scope of a CHW's practice;
- Services that require licensure or certification beyond that of a CHW
- Case management/care coordination, including dental CDT® codes D9991, D9992, and D99924;
- Transporting the member;
- Services within the scope of a direct support professional (DSP) or qualified services professional (QSP), including homemaker chore services, companion services, personal care services, etc.;
- Respite care;
- Care provided outside of the member's service plan or service referral;
- Documentation time;
- Child care;
- Helping a member enroll in traditional Medicaid or Medicaid Expansion;
- Discharge planning;
- Delivery of food, medication, medical equipment, or medical supply;
- Services duplicative of those in the 1915(i) Behavioral Health Services and Supports program – i.e. peer support, housing support, supported education or employment;
- Counseling and/or risk factor reduction intervention, see section in Preventive Services and Chronic Disease Management policy; and

- Screening, Brief Intervention, Referral to Treatment (SBIRT) services, see section in Preventive Services and Chronic Disease Management policy.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

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.

SERVICE PLAN

- A service plan drafted by or reviewed and approved by the supervising practitioner is required when the member requires continued CHW services after 12 units of service. CHWs may participate in care teams developing service plans.
    - Service plans must be reviewed by the supervising practitioner every six (6) months to determine if progress is being made and whether CHW services continue to be medically necessary. Service plan reviews and any resulting changes must be documented.
- Plans, when required, must be finalized prior to additional CHW services being rendered.
- The service plan must state:
    - How the member's need of CHW services relates directly to one or more eligibility criteria;
    - The barrier or reason for the referral;
        - For example, if a member has missed two or more appointments related to their diabetes; and
    - The duration of time CHW services are needed to accomplish the service plan goals.

For services not ordered by a member's primary care provider, the CHW must forward the order, service plan, and related documentation to the member's primary care provider for their awareness.

CHWs must maintain documentation of all services delivered, regardless of the number of units delivered and billed.

HEALTH-RELATED SOCIAL NEEDS SCREENING INSTRUMENTS

Documentation of a barrier that affects the individual's health must include the results of an accepted health-related social needs or social determinants of health screening instrument.

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 sources 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 (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

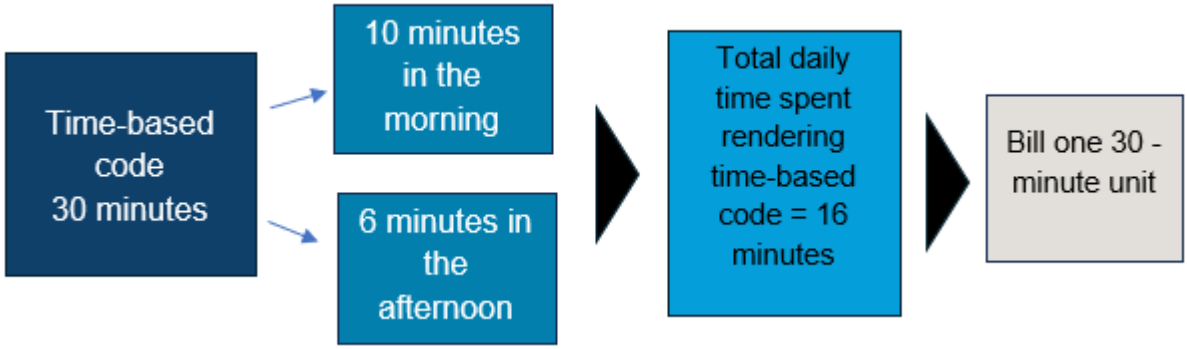
A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Billing for CHW services occurs through thirty (30) minute billing codes. The codes are listed below along with instructions on how to bill time-based units.

- 98960 self-management education and training, face-to-face, 1 member
- 98961 self-management education and training, face-to-face, 2–4 member
- 98962 self-management education and training, face-to-face, 5–8 members

Time-Based Units

When billing for one 30-minute code that is billed in units throughout a day, report the total amount of units on one claim line. In order to bill one 30-minute code the time spent rendering services must be at least 16 minutes. Providers should document start and stop times associated with all services billed with time-based codes.



FQHCs, RHCs, IHS and THPs

CHWs working for an encounter-based provider will not generate an encounter payment. Any claims for CHW services provided will be paid at the current fee for service (FFS) rate for CHWs.

CLAIM FORM

Community Health Worker services must be billed using the CMS 1500 claim form or 837p. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

DEFINITIONS

Chronic condition – means a condition that lasts twelve months or longer and requires ongoing medical attention and/or limits a member's activities of daily living.

General supervision – means a service is furnished under a physician or OLP's overall direction and control, but the physician or OLP's presence is not required during the performance of the service.

Health-related social needs – means the resulting effects of social determinants of health that negatively impact a member's circumstances and are in the purview of health care providers to identify and help address. HRSNs can be linked to poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.

Preventive Services – means services to prevent disease, disability, or other health condition or the progression of a disease, disability, or health condition.

Social Determinants of Health – Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030). Social determinants of health can influence the diagnosis and treatment of health conditions.

Telehealth – an umbrella term which includes digital health and synchronous two-way real-time interactive audio/visual services. It does not include store and forward services.

REFERENCES

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

FREQUENTLY ASKED QUESTIONS

Q: What does “medical indicators indicating increasing risk of developing a chronic condition” mean?
A: This means the member has some measurable health indicator showing they are at risk of developing a chronic condition as defined in this policy.

Q: How do we measure a member’s 12 units of CHW services?
A: The 12 units are any combination of CPT codes 98960, 98961, or 98962. Members must have a service plan for referred needs that will require 12 or more units of any combination of CPT codes 98960, 98961, or 98962. For this policy the 12 units where a member would not need a service plan would be tied to the member’s CHW service referral. If the member needs more than 12 units to meet the referred needs, then a service plan is necessary.

CONTACT

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

POLICY UPDATES

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Section	Summary
	Policy created