North Dakota 1915(i) Billing Guide: Housing Support Services

Last Revised: February 28, 2022

This guide is not a substitute for official guidance from the North Dakota Department of Human Services.

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Introduction

This document serves as a guide to the billing process for 1915(i) services, specifically Housing Support Services, through the North Dakota Department of Human Services (ND DHS). This guide was created by Ei-Consultants and CSH, who are providing technical support to 1915(i) providers and prospective 1915(i) providers. ***This guide is not a substitute for official guidance from DHS.*** Please reference the ND DHS 1915(i) website for more information. *The 1915(i) billing process is subject to change. Please check the ND DHS 1915(i) website for the most up-to-date information. Ei-Consultants and CSH will work to keep this guide as current as possible.*

Currently, this guide only provides step-by-step guidance for submitting claims for Traditional Medicaid-enrolled members. Guidance for submitting claims for Medicaid Expansion-enrolled members will be added to this document at a later date as more information becomes available.

Billable Services, Billing Rates, and Service Limits

Billable Services

There are two categories of billable services for 1915(i) Housing Support. These are **pre-tenancy services** (services delivered prior to a client being housed, to help clients secure and transition into housing) and **tenancy services** (services delivered after a client is housed, to help clients sustain their tenancy). Enrolled Medicaid 1915(i) providers are required to provide the whole scope of service rather than only portions of the service. For example, a 1915(i) Housing Support provider must offer both pre-tenancy supports and tenancy supports rather than just one or the other.[1]

Pre-tenancy Services	Tenancy Services
Supporting with applying for benefits to afford housing.	Skills training on financial literacy.
Assisting with the housing search process and identifying and securing housing of their choice.	Providing training and education on the role, rights, and responsibilities of the tenant and the landlord.
Assisting with the housing application process including securing required documentation.	Coaching on how to develop and maintain relationships with landlords and property managers.
Helping with understanding and negotiating a lease.	Assistance with the housing recertification process.
Helping identify resources to cover expenses including the security deposit, moving costs, and other one-time expenses.	Assisting with achieving housing support outcomes as identified in the person-centered plan.
Services provided in pre-tenancy supports may not duplicate the services provided in community transition supports or in care coordination.	Skills training on how to maintain a safe and healthy living environment. Skills training should be provided onsite in the individual's home.
	Assisting with resolving disputes between landlord and/or other tenants to reduce the risk of eviction or other adverse action.
	Supporting with applying for benefits to afford their housing including securing new/renewing existing benefits.
	Coordinating and linking individuals to services and service providers in the community that would assist an individual with sustaining housing.
Source: DHS 1915i Housing Support Service Policy	

For more information and the latest guidance from DHS, please refer to the DHS 1915i Housing Support Service Policy document.

[1] Source: DHS 1915i Housing Support Service Policy.

Billing Rates

As of July 1, 2021, Housing Support is billed in 15-minute units, at $10.70/unit. This comes out to $42.80/hour.

Guidance from CMS states the following pertaining to measuring 15-minute units: "When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes." Medicaid regulations regarding minute intervals for billing units are as follows:

Units	Number of Minutes
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
The pattern remains the same for additional units.	

Service Limits[2]

Housing Support services are available to individuals six months prior to their 18th birthday.

There is a daily maximum of 8 hours, or 32 units, of Housing Support services.

For pre-tenancy supports, there is a limit of 78 hours per **3-month** authorization period, for a maximum of 156 hours per year. For tenancy supports, there is a limit of 78 hours per **6-month** authorization period for a maximum of 156 hours per year. Providers can request additional hours from DHS to prevent a member's imminent institutionalization, hospitalization, or out-of-home/out-of-community placement.

For more information and the latest guidance from DHS, please refer to the DHS 1915i Housing Support Service Policy document.

[2] Source: DHS 1915i Housing Support Service Policy.

Submitting Claims for Traditional Medicaid-enrolled Housing Support Recipients

For Housing Support recipients who are enrolled in Traditional Medicaid, 1915(i) providers submit claims via the North Dakota MMIS Web Portal. The ND MMIS Web Portal is the system where agencies and individual providers completed their group and individual provider enrollment applications. A step-by-step guide to submitting claims in the ND MMIS Web Portal is presented below. The screenshots included in this document are courtesy of DHS's 1915(i) MMIS Web Portal Training (revised 09/02/2021). Additional information can be found in the DHS 1915(i) Claims policy.

Please note that Housing Support recipients who are enrolled with Blue Cross Blue Shield are Medicaid Expansion-enrolled, and claims for services rendered to Medicaid Expansion-enrolled clients must be submitted via Blue Cross Blue Shield's process, not via the ND MMIS Web Portal.

Billing Overview

The steps for billing 1915(i) Housing Support services are as follows:

1. **Service Authorization**: Client must be approved to receive services. *(Not covered in this document)*
    - A Care Coordinator will first work with the client on their Person-Centered Plan of Care and will identify the other 1915(i) services that the client needs and identify providers for those services. They will need to submit a service authorization.
    - Your agency will also need to submit a service authorization to provide Housing Supports (or other 1915(i) services).
2. Check **client's eligibility** before providing a service.
    - Traditional Medicaid: Call AVRS line: (toll free) 877-328-7098; (local) 701-328-7098
3. Ensure the required **documentation** has been completed. *(Not covered in this document)*
4. Submit a **professional claim** in the MMIS Portal.
    - For your reference: The information that must be provided when submitting claims via the ND MMIS Web Portal is essentially identical to the information that would be entered onto a CMS 1500 professional claims form.
5. If the claim is denied, **appeal**.

Submitting Claims via the ND MMIS Web Portal[3]

At the time of completing each group and individual provider enrollment application, the ND MMIS Web Portal created an account for the agency and each individual. These accounts will be used when submitting claims.

To get started, access the ND MMIS Web Portal. From there, click the link to access the login page for providers.

[3] Source: DHS 1915(i) MMIS Web Portal Training (revised 09/02/2021).

Step 1: Sign In

Then, sign into the ND MMIS Web Portal using the login information created at the time of submitting your 1915(i) provider enrollment application.

Step 2: Create Professional Claim

Next, select “Claims” from the top menu bar, then “Create Claims” > “Create Professional Claim.” Essentially, when billing for 1915(i) Housing Support services, you will enter the same information from a CMS 1500 professional claims form directly into the ND MMIS Web Portal.

North Dakota MMIS Web Portal

Mar 23, 2020

Skip Navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EDI | Authorizations | My Account | FES

Claims menu: Create Claims, Manage Claims, Create Templates, Manage Templates, Claim Status Inquiry, Payment Inquiry, 1099 Inquiry, Pharmacy Claims

Create Claims submenu: Create Professional Claim, Create Institutional Claim, Create Dental Claim, Create Claim from Template, Create Claim from Processed Claim, Travel/Lodging Claim, HCBS/DD Claim

➢ **Submit a Claim**

- Claims
- Create Claims
- Create Professional Claim

Step 3: New Professional Claim

Next, select the appropriate option when asked whether this claim is a void/replacement. If this is a new claim, select “No.” Select “Yes” if this claim is being submitted to void/replace a previously submitted claim.

New Professional Claim
Print | Help
*Required Field
Basic Claim Info
Other Claim Info
Provider Member Basic Claim Service Line Items
Is this a void/replacement?
Yes No
Submitter Information
Submitter ID

- **New Professional Claim**
  - Is this a void/replacement?
    - ✓ Defaults to “No.”
    - ✓ Select “Yes” **only** if you are replacing or voiding a previously processed claim.

If the claim is a void/replacement of a previously submitted claim, indicate whether this new claim is a void or a replacement and enter the Transaction Control Number (TCN) assigned for the claim being voided or replaced. The TCN is the 17-digit claim number that is assigned to a claim after it is submitted via the ND MMIS Web Portal.

New Professional Claim
Print | Help
*Required Field
Basic Claim Info | Other Claim Info
Provider Member Basic Claim Service Line Items
Is this a void/replacement?
Yes No
Claim Resubmission Information
*Resubmission Type Code
Replacement
Void
*TCN to Void/Replace
Note: For Void/Replacement of a Paid Claim, prior claim data (if available) will populate once the user has either a) tabbed out of the TCN field,or b) selected another field on this page.

- **New Professional Claim**
  - **Is this a void/replacement?**
    - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
    - ✓ **Resubmission Type Code** – Select **Replacement** or **Void**
    - ✓ **TCN to Void/Replace** (TCN is Transaction Control Number)
      - Enter TCN (17 digit claim number) that needs to be replaced or voided

Next, enter the agency's taxonomy code (251S00000X for Housing Support) and the agency's tax ID number. A taxonomy code is a 10-digit alphanumeric code that indicates a practice classification and specialization. Leave the SSN field blank: do not enter an individual provider's SSN.

➢ Billing Provider

- Enter **Taxonomy Code** (provider group taxonomy code)
- Enter **Tax ID** or **SSN Number** (provider group Tax ID)

Under the "Additional Billing Provider Information" section, select "Non-Person" for "Entity Qualifier," as the billing entity is the agency, not the individual provider. Then, enter your agency's name and full address.

➢ Additional Billing Provider Information

- **Entity Qualifier** - Select **Non-Person**
- Enter **Org/Last Name, Address, City, State and Zip**

If the pay-to address for your agency is the same as the previously entered address, select “Yes” to the next question, “Is the Billing Provider Address also the Pay-To Address?” If the pay-to address is different from the previously entered address, select “No” and enter the pay-to address information.

Is the Billing Provider Address also the Pay-To Address?

Yes No

Pay-To Address

*Address 1 *City State Zip and Extension Country Subdivision Code

Address 2

➢ **Is the Billing Provider also the Pay-To Address?**
- Defaults to “Yes”
- If Pay-To Address is **different**, select “**No**”
  - ✓ Complete the **Pay-To Address** section with the **Address, City, State, and Zip**

The next question asks, “Is the Billing Provider also the Rendering Provider?” This question is asking whether the provider name entered above (i.e., the name of the agency) is also the name of the provider who rendered the 1915(i) Housing Support services (i.e., the name of the individual provider). Most agencies will select “No” for this question. Only select “Yes” if the provider is a sole entity not a part of a larger agency (i.e., the agency name entered earlier is the same as the individual provider’s name).

Then, enter the Medicaid Provider ID of the employee providing the 1915(i) service. The Medicaid Provider ID is assigned upon approval of the individual 1915(i) provider enrollment application. Enter the individual provider’s NPI number. Enter the individual provider’s taxonomy code (171M00000X for Housing Support).

Is the Billing Provider also the Rendering Provider?

Yes No

Rendering (Performing) Provider

Medicaid Provider ID | National Provider ID | Taxonomy Code | Location Number

➢ **Is the Billing Provider also the Rendering Provider?**

- If provider group name is the same as the sole employee, select “Yes”, otherwise select “No”
  - ✓ Enter Rendering Provider’s (individual provider performing service) **Medicaid Provider ID**
    - Must be the Rendering Provider Medicaid ID for the program being billed
  - ✓ Enter **National Provider ID** (individual provider’s 1915(i) NPI)
  - ✓ Enter **Taxonomy Code** (1915(i) taxonomy code)

The next question asks if this service is the result of a referral. Answer as appropriate.

Is this service the result of a referral?

Yes No

➢ **Is this service the result of a referral?**

- Defaults to “No”

Step 4: Member Information

In the next section, you will enter the member information of the person receiving 1915(i) services. “Member ID” refers to the member’s 9-digit ND Medicaid ID Number. Enter “ND” or zeros before the 9-digit number. You do not need to complete the SSN or “Property Casualty Number” fields.

Member Information

*Member ID | *Last Name | First Name | MI | Suffix | *Date of Birth | *Gender | SSN

Property Casualty Number

➢ Member Information

- Enter **Member ID** (member's 9-digit ND Medicaid ID Number)
  - ✓ Must enter "ND" or "zeros" before 9-digit number
- Enter Member's **Last Name**
- Enter Member's **First Name**
- Enter Member's **Date of Birth**
  - ✓ Use format: MM/DD/YYYY
- Enter Member's **Gender**
  - ✓ F = Female
  - ✓ M = Male

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Next, enter the member's address.

Member Address

*Address 1 | *City | State | Zip and Extension | Country | Subdivision Code

Address 2

➢ **Member Address**
- Enter Member's **Address, City, State and Zip**

When asked whether the member has other insurance, answer according to the member's situation. 1915(i) services are only covered by Traditional Medicaid and Medicaid Expansion. However, if the member has other insurance, you will still need documentation that the other insurance plan will not cover 1915(i) services because Medicaid is the payer of last resort. Persons who are served by the Veterans Administration commonly do not have healthcare coverage through the VA, though they may receive services from the VA. Whether or not they receive services from the VA is not germane to this issue.

Other Insurance Information

*Does the member have other insurance?

Yes No

Step 5: Claim Information

The next section asks for claim information. Select "No" for "Is this claim accident related?" Then, enter the service authorization number for that member. The service authorization number is 10 digits and begins with a "W." This is the number assigned when submitting a service authorization to DHS for a client to be approved to receive 1915(i) Housing Support services.

Claim Information

Go to Other Claim Info to include the following claim level information:
Specialized Line Information, Line Providers , Other Payer Service Line information, Test Result and Form Identification Information.

*Is this claim accident related?
Yes No

Service Authorization #

Referral #

- **Claim Information**
  - **Is this claim accident related?**
    - ✓ Select "**No**"
  - **Service Authorization #**
    - ✓ Must be entered on the claim
    - ✓ Service Authorization Number starts with a "W" and is 10-digits
    - ✓ Submit only one Service Authorization Number per claim

The “Claim Note” section is not required. An example of what type of note could be shared here is proving the one-year timely filing limit policy remittance advice (RA) date and TCN number. From [DHS’s 1915(i) Claims policy]() document, “Providers may enter any additional information you would like the dept to know here. For example, if you are trying to prove timely filing limits you could enter information in the claim note section.”

Claim Note

*Type Code

*Note

80 Characters Remaining

*Type Code

Additional Information
Certification Narrative
Diagnosis Description
Goals, Rehab Potential, or Dsch Plans
Third Party Organization Notes

- **Claim Note**
  - **Not Required**
    - ✓ Provider may add any pertinent information in this section for the department to review.

Next, enter the Patient Account # (the member’s 9-digit ND Medicaid ID Number) and the place of service. The full list of place of service codes from CMS is available [here]().

Claim Data

*Patient Account #

*Place of Service

*Assignment Code

- **Claim Data**
  - Enter **Patient Account #** (member’s 9-digit ND Medicaid ID Number)
  - Enter **Place of Service** (location where service was rendered)
    - Common Place of Service Codes
      - ✓ 02 – Telehealth
      - ✓ 03 – School
      - ✓ 04 – Homeless Shelter
      - ✓ 11 – Office
      - ✓ 12 – Home
      - ✓ 18 – Place of Employment Worksite

Next, select “Not Assigned” for “Assignment Code,” “Not Applicable” for “Benefits Assignment Certification,” and “Yes, Provider has a signed statement” for “Release of Information Code” (the member’s signature on the Plan of Care meets the requirements of a signed statement).

Claim Data

*Patient Account #

*Place of Service

*Assignment Code

*Benefits Assignment Certification

*Release of Information Code

- **Claim Data**
  - **Assignment Code** - Select “**Not Assigned**”
  - **Benefits Assignment Certification** - Select **“Not Applicable**”
  - **Release of Information Code** – Select “**Yes, Provider has signed statement**”

You must enter at least one ICD-10 diagnosis code. International Classification of Diseases (ICD)-10 diagnosis codes are codes for diagnoses that must be used by all parties covered by HIPAA, including providers who bill Medicaid. The ICD-10 code(s) for the client can be found on the member’s State Form Number (SFN) 741: 1915(i) Eligibility Application or Plan of Care.

Diagnosis Codes

Version # ICD-09 ICD-10

*1. 2. 3. 4.

5. 6. 7. 8.

9. 10. 11. 12.

- **Diagnosis Codes**
  - Defaults to "ICD-10"
  - Enter **ICD-10 Code(s)** that service you are billing for pertains to
    - ✓ ICD-10 Codes can be found on the member’s SFN 741 1915(i) Eligibility Application or Plan of Care.
    - ✓ If you have 3 ICD-10 codes entered in this section, then each “New Line Item” on Slide 21 has to be tied to the appropriate diagnosis code.

Step 6: Line Items

For each ICD-10 code, complete the "New Line Item" section. If you previously entered multiple ICD-10 codes, ensure that each "New Line Item" corresponds to the appropriate diagnosis code.

In the "New Line Item" section, note that each day must be billed separately. To add additional dates, click "Save" after completing each line item and then select "Add Service Line Item."

The procedure code for Housing Support is "H2021," and the modifier is "U4." Procedure codes and modifiers can be found on the ND Medicaid 1915i Services Fee Schedule document. Procedure codes and modifiers indicate the 1915(i) specific service that is being billed. Enter the dollar amount being billed in the "Line Item Charge Amount" field (per-unit rate x number of units). The "Diagnosis Pointers" fields are to tie the line items with the diagnosis codes entered earlier. Select "Units" for "Unit Code." Enter the number of units being billed.

New Line Item
Save | Save & Add Other Svc Info/TPL | Reset | Cancel
*Service Date Begin
Service Date End
Place of Service
*Procedure Code
Procedure Description
Modifiers 1. 2. 3. 4.
*Line Item Charge Amount $
Diagnosis Pointers *1. 2. 3. 4.
*Unit Code
*Units

- **New Line Item**
  - Enter **Service Date Begin** and **Service Date End**
    - ✓ Use format: MM/DD/YYYY
    - ✓ Must bill each day separately. (Ex. 09/01/2021 - 09/01/2021)
    - ✓ Dates must fall within the approved service authorization dates.
  - **Place of Service** (location where service was rendered)
  - **Procedure Code** (code that identifies the service being provided)
  - **Modifiers** (if the procedure code has a modifier, it must be entered on the claim)
  - **Line-Item Charge Amount** (dollar amount being billed)
  - **Diagnosis Pointers** – Select "**First Diagnosis, Second Diagnosis, etc**." to tie to appropriate ICD-10 code(s) entered on Slide 20
  - **Unit Code** – Select "**Units**"
  - **Units** (how many units are being billed)
- **To bill for multiple days**, select "**Save**" after completing the fields above, then select "**Add Service Line Item**". Repeat "**New Line Item**" entry as above.

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Next, enter the service authorization number. This was also entered earlier in a previous step.

Service Authorization

Service Authorization #

Referral #

- **Service Authorization**
  - **Service Authorization #**
    - ✓ Must be entered on the claim
    - ✓ Service Authorization Number starts with a "W" and is 10-digits
    - ✓ Submit only one Service Authorization Number per claim

Next, select "No" for "Is there additional line-specific information/TPL to be entered?" "TPL" stands for "third-party liability."

Additional Service Line Information

Is there additional line-specific information/TPL to be entered?

Yes No

Submit Claim | Save Claim | Reset | Cancel

- **Is there additional line-specific information/TPL to be entered?**
  - Select "**No**"

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

Step 7: Submitting the Claim

Lastly, select "Save Claim," and then "Submit Claim."

Is there additional line-specific information/TPL to be entered?

Yes No

Submit Claim | Save Claim | Reset | Cancel

- Select "**Save**"
- Select "**Save Claim**"
- Select "**Submit Claim**"

You will then be taken to a screen showing that the claim has been submitted. Please print and save this page for your records. Note that on this screen, a Transaction Control Number (TCN) has been assigned for the claim.

Claim Submitted Print Help

TCN:

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

TCN:
Date of Service: 03/20/2020 - 03/20/2020
Provider #:
Member ID:

Claim Status: C - To Be Dnd
Total Charge: $200.00
*To Be Paid Amount: $0.00
*Co-Payment: $0.00
*Total Recipient Liability: $0.00
Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	204	This service/equipment/drug is not covered under the patient?s current benefit plan
1	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
1	26	Expenses incurred prior to coverage.
1	27	Expenses incurred after coverage terminated.

1 - 4 of 4

Remark Codes

Line #	Remark Code	Description
No Data		

➢ **Print** and **Save** for your records

Checking Claim Status

To check the status of a claim, you can call the AVRS line:

- Toll free: 877-328-7098
- Local: 701-328-7098

The ND MMIS Web Portal may also show the status of claims.

Appealing Denied Claims for Traditional Medicaid Members

Because claims must be filled out very precisely and accurately, it is not uncommon for claims to be denied. When claims are denied, your agency should submit an appeal. Often, when claims are denied, it is because a detail was not filled out exactly as it should be; in these cases, the issue can be easily corrected via an appeal. DHS's Medicaid Provider Appeals Summary document outlines the appeals process. Situations that can be appealed are the denial of payment and a reduction in the level of service payment. The member must have been eligible for Traditional Medicaid at the time of service.

An appeal must be filed within 30 days of the date of DHS's notice of denial or reduction in level of service (remittance advice).

To file the appeal, use SFN 168: North Dakota Medicaid Provider Appeal to file a written notice of appeal with DHS that includes a statement of each disputed item and the reason or basis for the dispute. Note that the remittance advice from DHS may note errors in the claim that need to be corrected. Mail SFN 168 to:

ND Department of Human Services
Appeals Supervisor
State Capitol – Judicial Wing
600 E. Boulevard Ave.
Bismarck, ND 58505

DHS has 75 days following receipt of the appeal to issue a decision. The provider can appeal DHS's decision regarding the appeal in district court.