1915(i) Benefits Planning

Applicability

This guideline applies to members who are eligible for public benefits such as Social Security Disability Insurance (SSDI), Supplemental Social Security Income (SSI), Medicare, Medicaid, etc., and who are considering or seeking employment.

Purpose

Benefits planning is to help members make informed choices regarding public benefits and available work incentives.

Eligibility Criteria

Benefits planning is available to members of all ages who are eligible to receive public benefits and who want to be employed.

Definitions

Home and Community Based Setting (HCBS) – means a member's own home or community location rather than an institution or other isolated setting.

Institutional setting – means nursing facilities (NF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), Qualified Residential Treatment Programs (QRTPs), Psychiatric Residential Treatment Facilities (PRTF), hospitals, and jails/prisons.

Telehealth – means the use of telecommunications and information technology to provide access to physical, mental, and behavioral health care across distance. Services must occur in real-time with the member present via telecommunications or information technology.

Covered Services and Limits

Members must be present for this service to occur.

- Development of an individualized assessment and benefits analysis. Plan must identify the individuals projected financial goal or actual financial status, explain any current public benefits, and outline of a plan describing how to use work incentives.
- Training and education on work incentives available through Social Security Administration (SSA) and on income reporting requirements for public benefits programs.
- Assistance with developing a Plan to Achieve Self Support (PASS) plan and other work incentives to achieve employment goals.
- Assistance with developing a budget.
- Assist with understanding health care coverage options (Medicaid, Medicaid Expansion, and other State Plan buy-in options).
- Making referrals and providing information about other resources in the community.
- Referrals to Protection and Advocacy for Beneficiaries of Social Security (PABSS) organization.
- Ongoing support and follow-up to assist the individual with managing changes in their benefits, the work incentives they use, negotiating with SSA, and other benefit program administrators.

Limits

Daily maximum of eight (8) hours (32 units).

Service authorization requests exceeding the maximum limit which are deemed necessary to prevent the member's imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed. All requests to exceed limits must initiate with the member's care coordinator.

Telehealth (Remote services)

Telehealth can be used. In-person support must be provided for a minimum of 25% of all benefit planning services provided in a calendar month.

See Telehealth policy for telehealth requirements.

Non-Covered Services

- Services not listed under Covered Services, 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.
- 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.
- Text or electronic messaging to and from the member, see Telehealth policy

Duplicative Services

Care coordinators are responsible for ensuring there is no duplication of services.

Service Requirements

Services must be rendered in a Home and Community-Based setting rather than an institutional setting. Providers not rendering this service in a member's private residence or a community-based non-residential setting should refer to the Home and Community to ensure services are rendered in a compliant setting.

Documentation

Benefits planning providers must provide a written monthly progress update to the member's care coordinator. This happens for two reasons:

- To ensure progress toward the member's goals, and
- To evaluate service necessity.

The member's progress is discussed at each 1915(i) plan of care meeting and documented in the plan.

Sample progress notes:
"Had an initial meeting with Johnny to review his current benefits and discuss his financial goals. Johnny stated he wants to apply for Supplemental Security Income (SSI). I went over the process for applying for SSI and scheduled a meeting with Johnny next week to start the paperwork."

See “Documentation Guidelines” section of Provider Requirements policy for Medicaid documentation requirements.

Service documentation must occur in Therap using the Supportive Service Case Note beginning January 6, 2025.

Provider Qualifications

Group

A group provider of this service must meet all the following:

1. Have a North Dakota Medicaid provider agreement and attest to the following:
    - individual practitioners meet the required qualifications
    - services will be provided within their scope of practice
    - individual practitioners will have the required competencies identified in the service scope
    - agency conducts training in accordance with state policies and procedures
    - agency adheres to all 1915(i) standards and requirements
    - agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints, and reporting procedures are written and available for ND Medicaid review upon request.

Individual

Certification in at least one of the below is required:

1. Certified Work Incentives Counselor (CWIC); or
2. Community Partner Work Incentives Counselor (CPWIC); or
3. SSI/SSDI Outreach Access and Recovery (SOAR).

The individual practitioner providing the service must:

1. Be at least 18 years of age.
2. Be employed by an enrolled ND Medicaid provider or enrolled billing group of this service.
3. Have knowledge and competency in person-centered plan implementation

Billing and Reimbursement

Benefits Planning is a 15-minute rate.

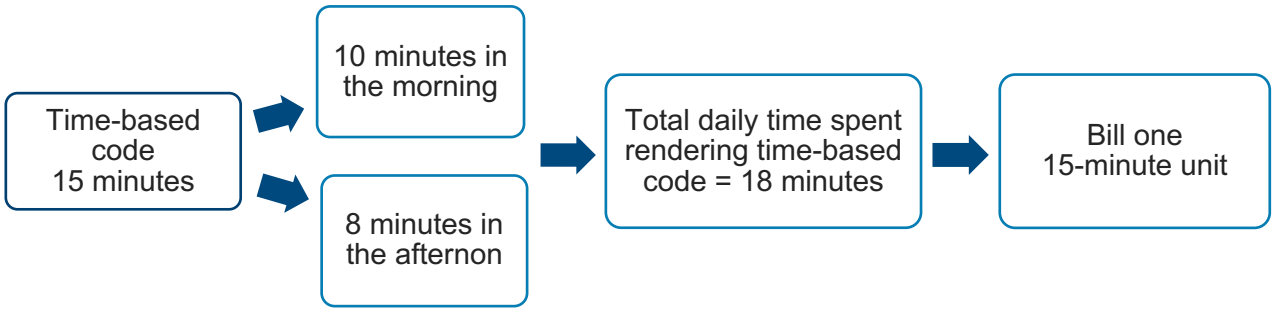
Code	Modifier	Description
H2021	U3	Benefits Planning (per 15 minutes)

15 Minute Units

Providers can bill a single 15-minute unit for services greater than or equal to 8 Minutes. Services performed for less than 8 minutes should not be billed. Minutes from the same day, with the same Place of Service (POS) code, and for the same member can be combined and billed when adding up to at least 8 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
- 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 exceeding 2 hours.



Rates are published under 1915(i) Services.