1915(i) Claim Submission

Providers will need to reference these resources to accurately submit a claim.

Definitions applicable to this section

Managed Care Organization (MCO) – The department contracts with an entity to serve as the MCO and administer services for Expansion members.

Service Limits and Codes Document – This document identifies the limits for each service, as well as various codes the provider will need to submit claims.

Place of Service (POS) Codes – The POS codes identify the location where a provider delivers a service to an individual. When submitting a service authorization request, the provider is required to identify the one POS code you expect to deliver the majority of the services to. Later, when submitting the claim, the provider will list the correct POS code for each of the services they provided and submit a claim for reimbursement. A Place of Service Codes document listing commonly used codes is located on the 1915(i) website.

Third Party Liability (TPL)

1915(i) providers refer to the third-party liability section of the provider manual.

The Claims Process

Providers will use the Blue Cross Blue Shield of North Dakota (BCBSND) process when submitting claims for Expansion Medicaid members. Providers are to visit the 1915(i) website to obtain their process for submitting claims.

Verification of Member Eligibility Status

Providers are to visit the BCBSND website for instructions on how to verify Medicaid Expansion member 1915(i) eligibility.

Medicaid Expansion will not pay provider claims for services provided to individuals not eligible for Medicaid Expansion and 1915(i) on the date of service provision.

Medicaid Expansion will honor those circumstances in which a retro-period of Medicaid Expansion eligibility has changed from a Traditional or Expansion coverage type to the other in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate, and the member is still 1915(i) eligible. In such circumstances, either coverage type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

Relevant Information for Submitting Claims

Each 1915(i) service has its own unique description, age requirement, rate type, code, modifier, rate, service limit, remote support limit, specialty code, group taxonomy, and individual taxonomy associated with it.

See the *Service Limits and Codes* located on the 1915(i) HHS State website for the codes necessary to submit a claim.

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Medicaid Expansion can only reimburse for one individual provider delivering the same service for the same time period. Medicaid Expansion cannot reimburse a second individual provider delivering the same service at the same time to the same individual. This would be considered duplication of services, which is not allowed.

Counting Minutes for 15 Minute 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.

Reimbursable vs. Non-Reimbursable

The activities contained in the service description is what CMS allows reimbursement for. The following are examples of what is not reimbursable to the provider:

- Services provided are not included in the service description 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.
- Claims submitted to the state via MMIS for Expansion members.
- 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.
- Services provided to a member not meeting the specific requirements of the service, such as age.
- Non-valid claims.
- Client not present. The client must always be present with the provider for reimbursement to occur for all services other than care coordination.

Medical Records Requirements

See Medicaid Expansion Provider Manual for documentation requirements.

Provider Appeals Process

Medicaid Expansion Provider Appeals
Provider Appeal Form (Online Version) | BCBSND

Medicaid Expansion Provider Appeals Summary
How to Request Appeals for Medicaid Expansion | BCBSND

General Provider Manual

Further information is available in the General Provider Manual located at this link: Medicaid Expansion Provider Manual

Medicaid Expansion Provider Service Center

For questions on claims contact our Provider Contact Center at 1-833-777-5779.