



1915(i) Service Authorizations in MMIS

NORTH
Dakota Be Legendary.

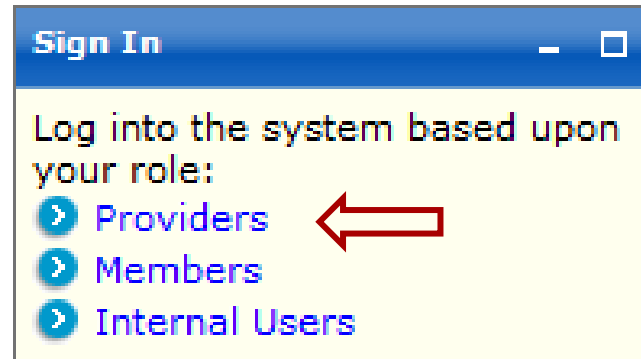
Health & Human Services

SERVICE AUTHORIZATIONS

- Service Authorizations for the 1915(i) State Plan must always be submitted via the ND Medicaid MMIS Web Portal.
- Web-based service authorizations have a quicker response time with or without the need for documentation.
- On average – service authorizations are pended no more than 10 business days.

- Providers will log into the ND Health Enterprise MMIS Portal:

Choose Providers



- Enter Provider Login Username and Password:

A screenshot of a web browser window titled "ProviderLogin". The window contains the following text and elements:

To access secure areas of the portal,
please log in by entering your User ID
and Password.

* User ID:

* Password:

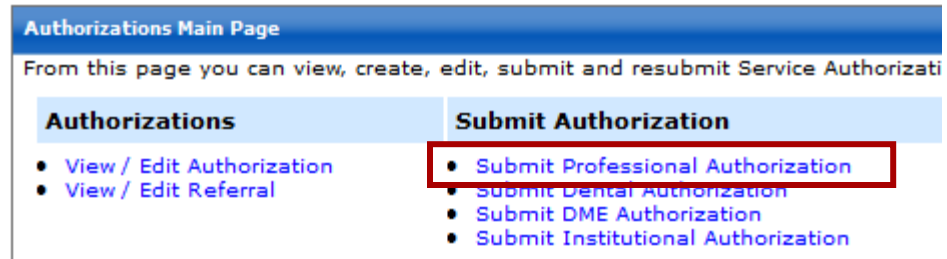
[Forgot User Name or Password ?](#)



- To create a service authorization, providers will click on Authorizations:



- Providers will then choose Submit Professional Authorization:



The screenshot shows a web interface for 'Authorizations Main Page'. It features a blue header bar with the page title. Below the header, there is a descriptive sentence. The main content area is divided into two columns: 'Authorizations' and 'Submit Authorization'. The 'Submit Authorization' column contains a list of options, with 'Submit Professional Authorization' highlighted by a red rectangular box.

Authorizations Main Page

From this page you can view, create, edit, submit and resubmit Service Authorizati

| Authorizations | Submit Authorization |
|--|---|
| <ul style="list-style-type: none">• View / Edit Authorization• View / Edit Referral | <ul style="list-style-type: none">• Submit Professional Authorization• Submit Dental Authorization• Submit DME Authorization• Submit Institutional Authorization |

- Providers will see that their Submitter ID is noted at the top of the service authorization and that no Service Authorization ID has been issued. This will be issued when the authorization has been submitted to the Department. Providers will see the Service Level is SV1 (Professional Service) and that Transaction Purpose is a Request:

Submit Professional Authorization Request Print | Help - □

* Required Field

Basic Service Authorization Info Patient Event Detail

Member Requesting Provider Event Provider Health Care Services Review Diagnosis Service Line Items Reject Reasons

| | | | |
|--------------------------|---|---|------------------------|
| Service Authorization ID | Service Level SV1 (Professional Service) | Entered Date / Time 09/19/2017 02:00:22 PM | Certification Action |
| Submitter ID PROFUA | Transaction Type RU (Medical Services Reservation) | Transaction Purpose Request | Review Decision Reason |

- Providers will then enter Member Information. All fields marked with an asterisk are required fields. Member information required: Member ID, Last Name, First Name, and Date of Birth:

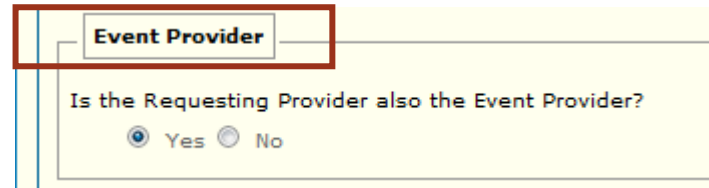
Member Information

| | | | |
|----------------------|----------------------|----------------------|----------------------|
| *Member ID | *Last Name | | |
| <input type="text"/> | <input type="text"/> | | |
| Prefix | *First Name | MI | Suffix |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| *Date of Birth | Gender | | |
| <input type="text"/> | <input type="text"/> | | |

- The Requesting Provider will be pre-populated with the enrolled ND Medicaid Provider ID information. No information needs to be entered in this section. (This is the Billing Provider Information in Box 33 on the Professional CMS-1500 Claim form.)

| Requesting Provider | | | | |
|--|----------------------|------------------------|--------------------------|------------------------|
| Medicaid ID 1458343 | Other Provider ID | Other Provider ID Type | *Entity Code Provider | *Entity Type Person |
| Provider Code | Taxonomy Code | Provider Name | | |
| <input type="text"/> | <input type="text"/> | | | |
| + Additional Requesting Provider Information | | | | |
| <input type="text"/> | | | | |
| + Contact Information | | | | |
| <input type="text"/> | | | | |
| + Additional Requesting Supplemental Provider ID | | | | |
| <input type="text"/> | | | | |

- Event Provider defaults to Yes. The event provider is the rendering provider on the Professional CMS-1500 Claim form (Box 24J). It is recommended to leave this defaulted to YES.



The image shows a screenshot of a form field. At the top, there is a label 'Event Provider' enclosed in a red rectangular box. Below the label, the question 'Is the Requesting Provider also the Event Provider?' is displayed. Underneath the question, there are two radio button options: 'Yes' (which is selected, indicated by a filled circle) and 'No' (which is unselected, indicated by an empty circle).

Health Care Services Review Information:

- The Request Category and Certification Type are pre-populated. These two fields can be skipped on the authorization.
- The Service Type requires a valid value. It is recommended to select **Transitional Care** from the dropdown menu.
- The Level of Service requires a valid value. It is recommended to select **Elective** from the dropdown menu.

Health Care Services Review Information

*Request Category

Health Services Review ▼

*Certification Type

Initial ▼

Service Type

▼

Level of Service

▼

- Health Care Service Location Information:

- Facility Type (Place of Service)

- Facility Type Qualifier (Place of Service Code)

- A valid value is required for each of these fields. To view a full list of approved CMS Place of Service Codes visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

- The most common place of service codes are:

- 02-Telehealth

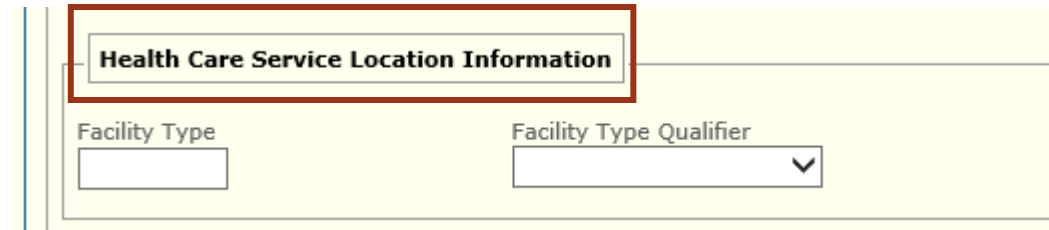
- 03-School

- 11-Office

- 12-Home

- 18-Place of Employment-Worksite

- The Place of Service Code on the service authorization is an approximate value. The place of service code billed on the claim must accurately be reported.



The image shows a screenshot of a form titled "Health Care Service Location Information". The title is enclosed in a red rectangular box. Below the title, there are two input fields: "Facility Type" which is a text box, and "Facility Type Qualifier" which is a dropdown menu with a downward arrow icon.

- Providers must complete the Dates of Service. ND Medicaid must receive a Requested Begin Date and Requested End Date.

The image shows a screenshot of a form titled "Dates of Service". The form has a yellow background and a white border. It contains three main sections: "Requested Begin Date", "Requested End Date", and "Certification Issue Date". Each section has a corresponding "Approved" field below it. The "Requested Begin Date" and "Requested End Date" fields are highlighted with red boxes. The "Requested Begin Date" field has a calendar icon next to it. The "Requested End Date" field also has a calendar icon next to it. The "Certification Issue Date" field is empty. The "Approved Begin Date" and "Approved End Date" fields are also empty.

- Requested Begin Date: Providers will enter the anticipated start date of services. Service Authorization approval or denial will be dated the date the authorization was submitted in MMIS by the provider. Providers will not be reimbursed for services provided prior to the service authorization approval date.
- Requested End Date: The maximum time period a service authorization can be requested is to the end of the individual's 1915(i) eligibility period. The date of the individual's next annual 1915(i) eligibility determination, obtained from the Zone, is the same date as the end of the individual's 1915(i) eligibility period.
- When the service authorization dates span two calendar years (i.e. 12/1/2021-11/30/2022) two service lines are required for the service requested with the calculated units requested.
- For example: Line one dates of service 12/1/2021-12/31/2021. Line two dates of service 1/1/2022-11/30/2022.

- Providers have the ability to send any additional Notes for the State to consider when reviewing the service authorization. It is suggested that this be completed if special consideration is needed for any reason.



The image shows a screenshot of a web form with a yellow background. At the top left, there is a tab labeled "Notes" with a small icon to its left. Below the tab is a large, empty text area for entering notes. At the bottom left of the text area, it says "264 Characters Remaining".

- Providers must enter at least one 1915(i) qualifying Diagnosis. The Diagnosis Code must match the claim and must be a valid ICD-10 diagnosis code.

Diagnosis

| Seq# | Diagnosis Code | Diagnosis Date | Diagnosis Type |
|------|----------------|-------------------------------------|---|
| 1 | F99 | 10/22/2020 <input type="checkbox"/> | Diagnosis (ICD-10) <input type="checkbox"/> |
| 2 | | | <input type="checkbox"/> |
| 3 | | | <input type="checkbox"/> |
| 4 | | | <input type="checkbox"/> |
| 5 | | | <input type="checkbox"/> |
| 6 | | | <input type="checkbox"/> |
| 7 | | | <input type="checkbox"/> |
| 8 | | | <input type="checkbox"/> |
| 9 | | | <input type="checkbox"/> |
| 10 | | | <input type="checkbox"/> |
| 11 | | | <input type="checkbox"/> |
| 12 | | | <input type="checkbox"/> |

- Providers are required to submit at least one line item for a service authorization to be considered.
- When the service authorization dates span two calendar years (i.e. 12/1/2021-11/30/2022) two service lines are required for the service requested with the calculated units requested.
- All service authorization line items must contain:
 - A Service Code From (HCPCS Code) and any applicable Modifiers
 - HCPCS: Healthcare Common Procedure Coding System
 - Requested Begin Date and Requested End Date
 - Must match the dates previously entered in Slide 13
 - Either Requested Amount **or** Requested Units
 - If Units are requested, then a Unit of Measure is also required. Units should = Units.

SERVICE AUTHORIZATION

NO Data

Add Services Detail

[Save](#) | [Additional Line Info](#) | [Reset](#) | [Cancel](#)

Service Level
SV1 (Professional Service)

Certification Issue Date

Certification Action

Review Decision Reason

*Service Qualifier

HC Fin Admin Common Proc Coding Sys ▼

*Service Code From

Modifiers

1 2 3 4

Service From Description

Service Code To

Service To Description

Requested Begin Date

Requested End Date

Requested Amount

Requested Unit(s)

Unit of Measure

 ▼

Approved Begin Date

Approved End Date

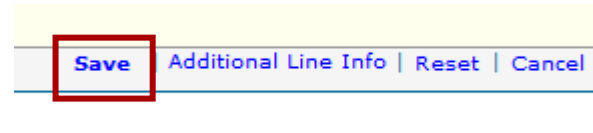
Approved Amount

Approved Unit(s)

Service Description

⊕ [Line Item Diagnosis](#)

- After entering all line item information, the line item MUST BE SAVED:
 - If each line item is not saved, the data will be lost.



- To add an additional line, click the Add Service Line Item button and enter in additional services:
 - **this is where the second line will be added when entering a service authorization that spans two calendar years (12/1/2021-11/30/2022).



- To submit your service authorization to the Department:
 - First click Save at the bottom of the screen (this will give you a message at the top of the screen stating:



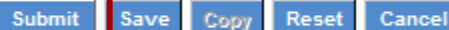
System successfully saved the information.

- If any errors occur, MMIS will generate an error message and those errors will need to be corrected before submitting the authorization to the Department.
- Under Reject Reasons, MMIS may also tell you if you have any errors on your authorization.



+ [Reject Reasons](#)

- Second click Submit at the bottom of the screen.



Submit Save Copy Reset Cancel

- After the service authorization has been submitted, a confirmation page will be shown on the screen. This confirmation page has very important information including:
 - Service Authorization ID Number
 - Member ID Number
 - Provider ID Number
 - Service Authorization Status
 - Submission Date and Time

**It is very important to print your confirmation page and keep a copy for your records.

Adding Attachments

- The Plan of Care must be attached to the service authorization.

- From the Confirmation Page, choose Upload Attachment:

Line item Detail

| Svc Cd | Description | Requested Cost/Units | SA Line Item Status |
|--------|-----------------------------|----------------------|---------------------|
| 99213 | Office/outpatient visit est | 0.00/1.0 | Pended |

1 - 1 of 1

[Print Submission Page](#) [Upload Attachment](#) [Submit Another SA](#) [SA Main Page](#)

- Attachments of any kind can be uploaded (.jpg, .docx .xlsx, .pdf) – documentation, care plan, treatment plan, etc.

The screenshot shows a web application window titled "E-Attachment" with a blue header bar containing "Print | Help" and a close button. Below the header is a tab labeled "Attachments". The main content area has a yellow background and contains the following elements:

- Buttons: "Submit" and "Exit/Cancel" in the top right; "Add Attachment" in the middle right.
- Fields: "SA ID:", "Member ID:", and "Member Name:" followed by redacted black boxes.
- Table: A table with a blue header and four columns: "Date Added", "Added By", "File Name", and "Description". The table body contains the text "No Data".
- Section: "Add Attachment" with a sub-header and "Save | Reset | Cancel" buttons on the right.
- Form: A form with two required fields: "*File" with a "Browse..." button, and "*Description" with a text input box.
- Text: A paragraph of instructions at the bottom: "Please upload your file, enter a Description, and click the Save link; repeat this for as many attachments as needed. After all attachments have been uploaded and saved, it is time to upload them to the MMIS database. This is accomplished by clicking the 'Submit' button. You will receive a successful message after the upload has completed. Note: Please review all attachments BEFORE submitting as you will not be able to remove any attachment once submitted. However, if you attached a doc in error, please contact the Helpdesk."

1. Click Add Attachment.
2. Then click Browse to find the file to add on your computer.
3. Then give the file a name (no more than 40 characters without special symbols).
4. Click Save. (**VERY IMPORTANT!!**)
5. Then continue to add additional attachments and click Submit to submit the attachment(s)(**VERY IMPORTANT**). Cancel will take you back to the confirmation page.

E-Attachment Print | Help - □

Attachments

SA ID:W [REDACTED] Member ID [REDACTED] Member Name: [REDACTED] [Submit](#) [Exit/Cancel](#)

[Add Attachment](#)

| Date Added | Added By | File Name | Description |
|------------|----------|-----------|-------------|
| No Data | | | |

Add Attachment [Save](#) [Reset](#) | [Cancel](#)

*File [Browse...](#)

*Description

Please upload your File, enter a Description, and click the Save link; repeat this for as many attachments as needed. After all attachments have been uploaded and saved, it is time to upload them to the MMIS database. This is accomplished by clicking the 'Submit' button. You will receive a successful message after the upload has completed. Note: Please review all attachments BEFORE submitting as you will not be able to remove any attachment once submitted. However, if you attached a doc in error, please contact the Helpdesk.

- Providers can also edit and view both saved and pending service authorizations.
 - Choose Authorizations
 - View/Edit Authorizations
 - Choose Submitted Authorizations or Saved Authorizations
 - Enter in the search criteria in the box below and edit the pending authorization as necessary.
 - An authorization can only be edited if it still in a pending status.

View/Edit Authorization Request Print | Help - □

*** Required Field**

To conduct a search for one or more saved or previously submitted service authorization(s), refine the search criteria by entering information in any or all of the remaining fields, and then click "Search". A search by only the Provider ID will return all of the authorizations for that provider.

Provider ID

*Provider ID: *Provider ID Type:

Submitted Authorizations Saved Authorizations

Additional Information

Member ID:

Service Authorization ID: Certification Action: Service Code: Modifier1: Modifier2: Modifier3: Modifier4:

Begin Date: End Date:

- Checking Status on the web portal – what do the HIPAA Values Mean??
 - A1: Certified in total means the service authorization has been approved.
 - A2: Certified partial means the service authorization has been partially approved (one line approved, one line pended or denied).
 - A3: Not Certified means the service authorization has been denied in total.
 - A4: Pended means the service authorization remains pended.
 - A6: Modified means the service authorization team has reviewed the service authorization and it is in process.

Service Authorization Contact:

Sara Regner

701-328-4825 (phone)

dhsserviceauth@nd.gov