PROVIDER GUIDANCE

Substance Use Disorder Voucher Program

NORTH Dakota Be Legendary. | Behavioral Health HEALTH & HUMAN SERVICES

October 2025

Table of Contents

Summary of Changes

The SUD Voucher program guidance contain various changes that are detailed below. Providers are responsible to understand and comply with program requirements contained in this document.

Providers should carefully review the following chapters for updates:

1. Covered Services
    a. Clarification on utilizing Telebehavioral Health services, bottom of page 20
    b. Clarification on out-of-pocket documentation needed for individuals receiving treatment simultaneously at multiple locations, page 23

Program History

During the 64th Legislative Session the Department of Human Services (DHS) was appropriated funding to administer a voucher system to pay for substance use disorder (SUD) treatment services. The Department's Behavioral Health Division was assigned the responsibility to develop administrative rules and implement the voucher system

Strategic Plan

The SUD Voucher Program was developed using the following logic model to guide program development and decisions.

Problem	Intervening Variable	Strategy	Short Term Goals	Long Term Goals
Individuals are in need of Substance Use Disorder services	Individuals have barriers to accessing needed services to achieve recovery	**SUD Voucher Program**	Allow individual to choose provider Improve access to quality services	Lives are improved and individuals recover

Program Goals

Expanding upon the short-term goals identified in the logic model provides additional framework for program decisions and efforts.

Goal 1

Allow Individual to Choose Provider

- Increase number of providers and service options
- Communicate service options to individuals

Goal 2

Improve Access to Quality Services

- Reduce financial barriers for individuals accessing needed services
- Program providers offer evidence-based services tailored to each individual's need

Legislative Updates

Below is a summary of the historical legislative updates to the SUD Voucher Program since its inception:

69th Legislative Session (2025)

Medical costs are covered during institution for mental diseases (IMD) residential stay, effective July 1, 2026. Costs may not exceed the total amount appropriated.

No more than 50% of the appropriated amount may be allocated for residential services with more than sixteen beds.

During the last quarter of the biennium, the department may reallocate projected unused funds that were allocated to non-IMD to IMD residential facilities.

68TH Legislative Session (2023)

Licensed substance treatment programs with sixteen beds or more can apply for the Voucher program, effective July 1, 2023 (SB2012)

67th Legislative Session (2021)

DHS shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020. (HB 1012)

DHS shall allocate no more than forty-five percent of the appropriated amount for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds. (HB 1012)

An out-of-state licensed substance abuse treatment program located within a bordering state may participate in the voucher program to serve an underserved area of this state pursuant to the rules adopted by the department. Reimbursement is only for outpatient and community-based services upon a provider completing an assessment of need and receiving approval from the department. Effective July 1, 2022 (HB 1402)

66th Legislative Session (2019)

Providers who access the SUD Voucher were expanded to public agencies (i.e., public health and tribal agencies) who hold a substance abuse treatment program license-not including Human Service Centers (HB 1105)

65th Legislative Session (2017)

Methadone Maintenance was added as a covered service, effective July 1, 2017 (HB 1012)

64th Legislative Session (2015)

The ND Department of Human Services was appropriated funding to administer a voucher system to pay for substance use disorder treatment services. The Department's Behavioral Health Division was assigned the responsibility to develop administrative rules and implement the voucher system. (SB 2048)

Becoming a SUD Voucher Provider

How to Apply:

Addiction Treatment Programs must be a Licensed Substance Abuse Treatment program in North Dakota or licensed in their state of origin prior to applying for the SUD Voucher. All SUD Voucher providers are required to enroll and become credentialed to bill North Dakota Medicaid (NDMA) and North Dakota Medicaid Expansion. Providers are required to submit their NDMA Provider Application number to sudvoucher@nd.gov within 30 days of applying for the SUD Voucher program. Information on NDMA Provider Enrollment can be found here Provider Enrollment

Licensed Substance Abuse Treatment Programs must be registered with North Dakota Secretary of State to receive payment from the State. To become registered, complete the Substitute IRS Form located here and submit with Provider Application.

North Dakota Licensed Treatment Providers

1. Complete Provider Application

Out-of-State Licensed Treatment Providers

1. Complete and Submit Assessment of Need (AON)
2. Once the AON is approved, Complete Provider Application

The department shall approve or deny a program's application within twenty working days of receipt of a complete application. The department may declare an application withdrawn if an applicant fails to submit all required documentation within sixty days of the department's notification to the provider that the application is incomplete. https://www.legis.nd.gov/information/acdata/pdf/75-09.1-11.pdf

Cause for Suspension or Revocation of Voucher Services:

Non-compliance with conditions listed in the Provider Agreement may result in suspension or revocation of voucher services for a period identified by the department.

Provider Portal System (PPS)

The recommended browser to utilize the PPS is Google Chrome or Microsoft Edge.

The Provider Portal System (PPS) is utilized to submit and track all aspects of an individual's voucher activity, including individual applications, releases of information, prior authorizations, invoices, eligibility reviews and outcome measures.

- Each program will need an ND Login account to access the PPS
- Programs registered with the North Dakota Secretary of State (ND SOS) will already have a ND Login Programs can use the already existing ND SOS account or create a unique ND login.
- To create a unique ND login account, visit: https://apps.nd.gov/itd/ldap/registration.htm
- To access the PPS as a registered user, visit: https://portalapps.nd.gov/sud-voucher/provider-portal/

To review the Portal Payment System PowerPoint, which provides detailed instructions for navigating the PPS, click here or visit https://www.hhs.nd.gov/sudvoucher/provider-guidance to view all Resources for Providers.

Individual Eligibility

The SUD Voucher was implemented to reduce financial barriers to addiction treatment. General eligibility parameters include:

- Individual is a resident of ND
- Individual is 12 years of age or older, (effective 4/1/2024)
- Individual's annual household income is less than or equal to 200% Federal Poverty Guidelines (FPG)
- Individual does not have other means for payment of SUD treatment
- A licensed professional operating within their scope of practice has determined the individual is in need of SUD services.

In certain circumstances, the SUD Voucher Program may allow an exception to the income requirements when the individual can exhibit that their discretionary income is less than or equal to 75% FPG. The SUD Voucher program defines discretionary income as gross income minus eligible expenses, which may be subject to deduction caps.

Individual Application Process

To apply for the SUD Voucher Program, an individual may independently complete an application online, or a participating provider may assist them with submitting the application within the Provider Portal.

Upon receipt of a complete application, the SUD Voucher Program team will complete the following steps:

- For applications that are complete, the program will provide a notice of decision within 5 business days.
- For applications that are incomplete and cannot be processed without additional information, the program team will attempt to obtain this information from the individual submitting the application.
    - If the requested information is received within 10 business days of the request, the program team will provide a notice of decision within 5 business days of receiving the required information.
    - If the requested information is not received within 10 business days of the request, the application will be denied, and the participant may submit a new application with the required information.

Living Environment Definitions

Within the individual application form, individuals are asked to identify their current living situation. Below are the definitions of these living status options

- Homeless - individuals with no fixed address; include shelters.
- Dependent Living – individuals living in a supervised setting such as residential institution, halfway house or group home, and children (under age 18) living with parents, relatives, or guardians or in foster care.
- Independent Living – individuals living alone or with others without supervision. Includes adult children (age 18 or over) living with parents.

North Dakota Medicaid Requirements

Per North Dakota Administrative Code article 75-09.1-11, the SUD Voucher is to be payer of last resort. If an individual is approved for the SUD Voucher program and appears eligible for North Dakota Medicaid, an eligibility specialist will contact the individual to begin the Medicaid application process. To remain eligible for the SUD Voucher Program, the individual must complete all steps of the Medicaid application process. Individuals who do not complete the Medicaid application process will have their SUD Voucher program benefits discontinued.

Medicaid Application Process for SUD Voucher Program

- SUD Voucher Application is received by the SUD Voucher team
  - Application is reviewed within 1-5 working days by the SUD Voucher team
  - If additional information is needed to determine eligibility, the SUD Voucher team will reach out to individual and request the information be provided within 10 days

- Once the SUD Voucher application is approved, it is routed to the Medicaid Eligibility Review Specialist (MAERS)
  - If the individual is determined to potentially be eligibility for Medicaid, the MAERS will contact the individual and provider within 5 working days

- Individual Medicaid application must be received within 30 days of MAERS initial outreach
  - If Medicaid application is not received within 30 days, SUD Voucher team will begin the Medicaid compliance process

Eligibility Documentation Requirements

Documentation of proof of eligibility is required for the SUD Voucher, with the expectation that the most recent documentation be used to determine eligibility. Certain documents must be submitted with an individual's application, as outlined below. When a provider assists an individual in applying for the SUD Voucher, the provider is required to obtain and retain copies of all eligibility documentation for a period of no less than seven years.

A provider should be aware that the SUD Voucher Program will conduct both routine and targeted audits to verify income and expense figures submitted with an application.

Eligibility Criteria	*Acceptable Verification Documents*	*Required with Application?* **
Residency	One or more of the following: - Utility bill - Mortgage statement or lease agreement - Statement from shelter - Signed affidavit from individual attesting to residency in North Dakota (only permitted if no other options exist)	No. Provider must retain copy on file.
Age	One or more of the following: - State-issued ID - Passport - Birth certificate	No. Provider must retain copy on file.
Earned Income	One or more of the following: - Copies of paystubs from all employers for the last 30 days, if currently employed - Copy of employer termination letter(s) - Business income (or loss) - Gains (or losses) from the sale or trade of business property, including real estate - Farm income - Signed affidavit from individual attesting no income (only permitted if no other options exist)	Yes
Other Income	One or more of the following: - Workers Compensation - SSI and/or SSDI monthly payments - Child Support received - Alimony you received, if the alimony agreement took effect before 2019 - Tax refunds and credits for state and local income taxes - Unemployment benefits - Rental income, royalty payments, trust income, and income from a partnership or S corporation - Miscellaneous income such as awards, cancelled debts, or dividends from a whole life insurance policy, if they exceed the premiums paid for the policy	Yes

Additional Requirements for Income Exception Requests Only		
Eligibility Criteria	***Acceptable Verification Documents***	***Required with Application?*** **
Core Expenses	One or more of the following: - Water - Utilities - Phone - Internet - Student Loans - Rent or Mortgage - Renters or homeowners insurance - Child Support - Medical Insurance - Insurance Deductible*** - Insurance Copays** - Childcare - Auto loans - Auto Insurance	Yes
Other Expenses	One or more of the following: - Credit Cards - Property taxes (if not included in mortgage) - Legal Fees - Medical Bills	No SUD Voucher Administrator may request

***Individuals who submit an application without the assistance of a provider will be required to submit all verification documents. If documentation is not submitted a delay application processing will occur. It is therefore recommended that a provider work with potential applicants to expedite application processing. *** For deductible and copay expenses, policy documents outlining the insured's financial responsibility are required.*

Participant Updates and Eligibility Reviews

It is the expectation that individuals who utilize the SUD Voucher Program benefits only do so as long as they remain eligible for the program. The following sections provide information on expectations for reporting changes and conducting routine continuing eligibility verification.

Participant Updates

Providers are expected to update the Provider Portal System (PPS) when they are made aware of any changes to the individual's income, address, insurance, etc. by using the Participant Update feature in the PPS.

Eligibility Reviews

Routine, recurring eligibility reviews will also be conducted for all Active Approved applications at intervals of every 90 days to ensure individuals remain eligible for the SUD Voucher Program. Below are some additional details about this recurring requirement:

- The PPS will prompt providers under the Individual Dashboard; temporarily locking the Release of Information, Prior Authorization, and Invoice section until the Eligibility Review is completed.
- The Initial Eligibility Review prompt will occur 90 days following the application approval date.
- Subsequent Eligibility Review prompts will occur 90 days following the most recent Eligibility Review submit date.
- Providers will not receive emails for these prompts.

Updating Employment/Income Changes

When updating employment/income changes, a provider is required to upload supporting documentation and estimate the participant's projected income for the next 28 days. In the Participant Update form within PPS, options for calculating projected income are provided to assist a provider in completing this step.

In the event a participant's employment/income change causes the participant to no longer be income eligible, the SUD Voucher Program will request the individual submit all eligible expenses within 10 working days in order to see if the individual can continue eligibility under an exception request. See Eligibility Documentation Requirements for details on eligible expenses.

Program Review of Participant Changes/Eligibility Reviews

For all participant updates and eligibility reviews, the SUD Voucher program will review the changes to ensure the participant remains eligible.

For participants who remain eligible	• Participants remain eligible with no changes to program benefits • No notifications will be sent to the individual or provider
For participants who are determined to no longer be eligible	• Participant benefits will end 30 days following the date the update/eligibility review is completed • The individual and provider will receive an Advance Notice of Discontinuation of Benefits

Release of Information (ROI) Requirements

Below are the steps a provider must follow to obtain and submit the Release of Information.

1. Obtain Release of Information (ROI) from the participant to mutually exchange information between the provider and the Department of Health and Human Services (DHHS)
    - ROI must indicate the Department of Health and Human Services, 600 East Boulevard, Bismarck, ND 58505 as one of the parties in section 2
    - ROI must include detailed description of the information to be disclosed in section 3: Name and other personal identifying information of individual receiving substance use disorder treatment services, behavioral health treatment information necessary to support services, level of care, and medical necessity including, diagnosis, screening, assessment, treatment plan, progress notes, urine analysis, discharge summary and billing and payment information.
    - Providers are encouraged to use the pre-filled DHHS Authorization to Disclose Information (SFN 1059) form, which can be located on website: https://www.hhs.nd.gov/behavioral- health/sudvoucher/provider-guidance under Resources for Providers section

2. Upload the ROI to the Provider Portal System (PPS)
    - A release of information (ROI) must be uploaded in the PPS before any information can be communicated to a provider about a Voucher participant.
    - Upload completed ROI to the Provider Portal System here https://portalapps.nd.gov/sud- voucher/provider-portal/ under 'Releases' tab

3. Provider access to individual's information in Provider Portal System
    - Each ROI received will be reviewed by the SUD Voucher team.
    - The provider will receive an autogenerated email notifying them of the decision to approve or deny the ROI.
    - Upon approval of an ROI, the provider will be able to locate the applicant within the PPS under the 'Active Individual Applications' tab. This is also where additional ROIs, prior authorization requests, invoices, eligibility reviews and outcome measures can be submitted.

Covered Services

The table below provides a review of all covered services, including information about prior authorization and billing specific to each covered service type. A provider must also refer to the Prior Authorization Requirements and Billing for Services sections, which provide additional important general information common to all services. Rates will be reviewed at the beginning of each Fiscal Year, with the intention of aligning with Medicaid rates where applicable and appropriate. When rate changes do occur, they will be effective on Oct 1st of each year.

ASAM 1.0	**Service Description**	**Low intensity outpatient substance-use disorder treatment services** • Includes telebehavioral health services* (effective 10/1/2025) Refer to bottom of page 20 • < 9 hours per week for adults • < 6 hours per week for adolescents
	Unit Description	1 Unit = 15 minutes
	Prior Auth Request Maximums	Units: 120 units (30 hours) Days: 120 Days
	LAC Review Threshold	Cumulative requests exceeding 360 units (90 hours) or 360 days, whichever occurs first, may require LAC staffing to verify whether medical necessity review is required
	Billing Limits	Daily limit: 16 units (4 hours) per day Weekly limit: 32 units (8 hours) for adults; 24 units (6 hours) for adolescents
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $16.44 per unit DOS 10/1/25 – 9/30/26: $ 16.77 per unit
ASAM 2.1	**Service Description**	**High intensity outpatient substance-use disorder treatment services** • Includes telebehavioral health services*(effective 10/1/2025) Refer to bottom of page 20 • Intended for multidimensional instability • 9-19 hours per week for adults • 6-19 hours per week for adolescents
	Unit Description	1 Unit = 1 day
	Prior Auth Request Maximums **Initial or Change Request** **Continuation of Care**	Units / Days 50 units / 120 Days 12 units / 30 Days
	LAC Review Threshold	Cumulative requests exceeding 62 sessions or 150 days, whichever occurs first, may require LAC staffing to verify whether medical necessity review is required
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $204.15 per unit DOS 10/1/25 – 9/30/26: $208.23

ASAM 2.5	**Service Description**	**Partial Hospitalization substance use disorder treatment services** • Includes telebehavioral health services*(effective 10/1/2025) Refer to bottom of page 20 • Intended for multidimensional instability requiring 20 or more hours of weekly treatment
	Unit Description	1 Unit = 1 day
	Prior Auth Request Maximums	Units: 30 units Days: 45 Days
	LAC Review Threshold	Cumulative requests exceeding 60 days of care require may require LAC staffing to verify whether medical necessity review is required. Additional units/days exceeding maximums may be approved at LAC discretion.
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS 10/1/24 – 9/30/25 $396.97 per day (adult) $396.97 per day (adolescent) DOS 10/1/25 – 9/30/26 $404.91 per day (adult) $404.91 per day (adolescent)
ASAM 3.5	**Service Description**	**Clinically managed residential substance use disorder treatment services** • Intended for high intensity services for adults or medium intensity services for Adolescents • Program provides 24-hour care to the individual
	Unit Description	1 Unit = 1 day
	Prior Auth Request Maximums	Units: 30 units Days: 45 Days
	LAC Review Threshold	Cumulative requests exceeding 60 days of care may require LAC staffing to verify whether medical necessity review is required. Additional units/days exceeding maximums may be approved at LAC discretion.
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS 10/1/24 – 9/30/25 $612.46 per unit (adult) $612.46 per unit (adolescent) DOS 10/1/25 – 9/30/26 $624.71 per day (adult) $624.71 per day (adolescent)

Assessment	**Service Description**	**Psychosocial evaluation to determine diagnostic impressions and treatment recommendations** • Includes telebehavioral health services* Refer to bottom of page 20
	Unit Description	1 Unit = 1 day
	Prior Auth Request Maximums	Authorization is not required
	Billing Limits	• 1 initial assessment per provider per application • Additional assessment(s) may be allowed to re-evaluate a change in the individual's care needs (e.g. return to services)
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $185.65 per unit DOS 10/1/25 – 9/30/26: $188.27 per unit
Family Therapy	**Service Description**	**Counseling provided to improve communication and resolve conflicts within a family** • Includes telebehavioral health services* Refer to bottom of page 20
	Unit Description	1 Unit = 1 session
	Prior Auth Request Maximums	• Authorization is not required • Additional units may be requested as medically necessary/ beneficial to the individual
	Billing Limits	Daily limit: 1 unit per day App limit: 10 units per episode of care
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $110.23 (with patient) $110.23 (without patient) DOS 10/1/25 – 9/30/26: $116.06 per unit (with patient) $116.06 per unit (without patient)
Individual Therapy	**Service Description**	**One-on-one counseling provided to an individual to address their needs based on their treatment plan** • Includes telebehavioral health services* Refer to bottom of page 20
	Unit Description	1 Unit = 1 session
	Prior Auth Request Maximums	• Authorization is not required • Additional units may be requested as medically necessary/ beneficial to the individual
	Billing Limits	Daily limit: 1 unit per day App limit: 80 units per episode of care
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $84.48 per unit (30 minutes) $111.32 per unit (45 minutes) $164.25 (60 minutes) DOS 10/1/25 – 9/30/26: $89.16 per unit (30 minutes) $117.90 per unit (45 minutes) $174.27 (60 minutes)

Methadone Intake	**Service Description**	**Methadone services provided to an individual to *initiate* a Medication for Opioid Use Disorder (MOUD) at an Opioid Treatment Program (OTP)** • Reimbursement includes face-to-face assessment by a physician, psychiatrist, nurse practitioner or physician assistant • Reimbursement does not include licensed addition counselor Assessment or any related urinalysis; can be billed separately
	Unit Description	1 Unit = Week 1 of starting program (any 7-day period between Monday–Sunday)
	Prior Auth Request Maximums	Authorization is not required
	Billing Limits	1 unit per provider per application
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $124.54 DOS 10/1/25 – 9/30/26: $128.47
Methadone Maintenance	**Service Description**	**Methadone services provided to maintain an individual's participation in a (MOUD) program at an OTP** • Reimbursement includes clinical assessment(s) deemed necessary to establish an individual's continued eligibility in the MAT program as well as any related treatment planning • Reimbursement does not include the methadone administered for any 7-day period and is reimbursable only in conjunction with Methadone Administration • Reimbursement does not include urinalysis or individual therapy; can be billed separately
	Unit Description	1 Unit = 1 week
	Prior Auth Request Maximums	Units: 26 units Days: 180 days
	Billing Limits	1 Unit per week, starting on week 2 of methadone services
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $80.80 per unit DOS 10/1/25 – 9/30/26: $81.86 per unit

Methadone Administration	**Service Description**	**Distribution of daily methadone to an individual at an OTP to be taken onsite or at home**
	Unit Description	1 Unit = 1 Day
	Prior Auth Request Maximums	Units: 180 units Days: 180 days
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $3.50 per unit DOS 10/1/25 – 9/30/26: $3.57 per unit
Out-of-Pocket Expenses	**Service Description**	**Reimbursement intended to offset an individual's responsibility for services provided, as determined by the individual's primary health insurer**
	Unit Description	1 Unit = $1.00 dollar (total out-of-pocket maximum on individual's insurance plan including deductible)
	Prior Auth Request Maximums	• Authorization is required • A copy of the individual's insurance benefits summary must accompany the request, along with an estimated cost of treatment summary
	Billing Limits	Only amounts not reimbursed by an individual's primary insurer are reimbursable, based on a case-by-case basis. A copy of the individual's explanation of benefits or plan limitations is required.
	Reimbursement Rate	N/A
Peer Support	**Service Description**	**Recovery support offered by a Certified Peer Support Specialist**
	Unit Description	1 Unit = 15 minutes
	Prior Auth Request Maximums	Authorization is not required
	Billing Limits	• 500 units/ 125 hours of care per episode of care • Additional units may be requested as medically necessary/beneficial to the individual
	Reimbursement Rate	DOS on or after 12/5/22 $12.63 per unit

Room & Board	**Service Description**	**Residential lodging and food provided to an individual in applicable ASAM levels of care.** • Service day is identified as the day an individual occupies a bed up to midnight of the same day.
	Unit Description	1 Unit = 1 Day
	Prior Auth Request Maximums **Initial or Change Request** **Continuation of Care**	Units / Days 30 units / 45 Days 30 units / 45 Days
	LAC Review Threshold	Cumulative requests exceeding 60 days of care require may require LAC staffing to verify whether medical necessity review is required. Additional units/days exceeding maximums may be approved at LAC discretion.
	Billing Limits	Daily limit: 1 unit per day *Room and board is only reimbursable when provided alongside approved ASAM 2.1, 2.5, 3.5.*
	Reimbursement Rate	DOS 10/1/24 - 9/30/2025: $107.00 per unit (adult); $107.00 per unit (adolescent) DOS 10/1/25 - 9/30/2026: $110.00 per unit (adult); $110.00 per unit (adolescent)
Screening	**Service Description**	**Brief assessment to determine if an individual meets criterion for a full assessment**
	Unit Description	1 Unit = 1 Day
	Prior Auth Request Maximums	Authorization is not required
	Billing Limits	1 unit per provider per application
	Reimbursement Rate	DOS 10/1/24 – 9/30/25: $24.61 per unit DOS 10/1/25 – 9/30/26: $25.10 per unit

Transportation	**Service Description**	**Reimbursement provided to an individual who requires financial support for the transportation to and from approved addiction service appointments** • Reimbursements must be distributed to an individual in a manner identified in provider policy and approved by department.
	Unit Description	1 Unit = 1 mile
	Prior Auth Request Maximums	• Authorization is required • Approvals are granted for 180 days at a time, based on the calculated round trip mileage from an individual's home address to the point of service.
	Billing Limits	• Transportation is only reimbursable when submitted alongside other approved services. • Mileage units are limited to the calculated roundtrip distance from the individual's home address to the point of service. • Provider administrative costs cannot exceed individual reimbursement.
	Reimbursement Rate	<u>DOS 10/1/24 – 9/30/25</u> $0.48 per unit <u>DOS 10/1/25 – 9/30/26</u> $0.50 per unit
Urine Analysis	**Service Description**	**Urine screening test to determine the absence or presence of substances**
	Unit Description	1 Unit = 1 Day
	Prior Auth Request Maximums	Authorization is not required
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	<u>DOS 10/1/24 – 9/30/25</u> $17.14 per unit <u>DOS 10/1/25 – 9/30/26</u> $17.14 per unit

"Telebehavioral health" means using electronic communication and information technologies to deliver or support real-time psychiatric, psychological, mental health, marriage and family therapy, social work services, addiction counseling, and other behavioral health services at a distance. *

Programs utilizing telebehavioral health services must adhere to health insurance portability and accountability act (HIPAA) regulations to protect patient health information (PHI) through secure practices and technology. *

Telebehavioral health for the purposes of reimbursement through the SUD Voucher Program is applicable when an individual is not physically located at the treatment program and is receiving services by a counselor over two-way video conferencing. *

Prior Authorization Requirements

While the Covered Services table above provides information specific to a service type, the following pertains to all services that require prior authorization.

- Authorization requests should be based on medical necessity and the individual's treatment plan.
- Requests submitted outside of the Prior Auth Request Maximums identified in the Covered Services table will be partially approved, not to exceed the identified maximum per request.
- Prior Authorizations should be submitted prior to a service being rendered whenever possible. The SUD Voucher Administrator will not approve prior authorizations for dates of services more than 90 days past the date of service and 14 days prior to application submitted on date, whichever date occurs first.

Submitting a Prior Authorization Request

Prior Authorization (PA) requests are submitted by a provider utilizing the Provider Portal System (PPS). The steps below provide the details for submitting a prior authorization request:

1. Identify the Type of Service Request
   The first thing a provider will need to do is identify the type of request being submitted. The available types to choose from are detailed below:

Initial Request for Treatment	• This type of request is selected for the first prior authorization request for an individual • Initial request can only be selected once per application, per provider.
Change or Continuation of Care Request	• This type of request is submitted when either continuing an individual's level of service or changing the individual to another level of service
Transportation	• This type of request is submitted for any transportation service request • Google map or travel reimbursement plan is required with all requests. • A program must ensure that the total miles requested aligns with google map or travel reimbursement plan.

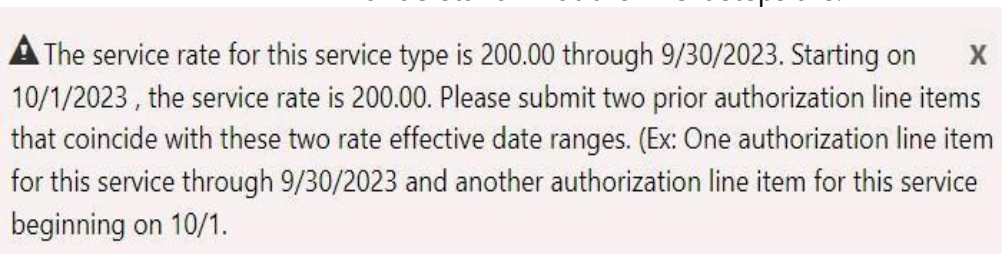
2. Identify Service Type and Prior Authorization Maximums
   Identify the treatment provider's recommendations for each service in the individual's treatment plan and refer to the Covered Services table to identify any applicable maximum allowances that may be present.

   Specific guidance for submitting prior authorization out-of-pocket (OOP) expense can be found on page 23 and specific billing can be found on page 24 of this document.

3. Identify Anticipated Service Dates
   For each service line item, enter Anticipated Start Date and Anticipated End Date
   a) End date cannot precede start date, start date cannot exceed end date.
   b) End dates cannot exceed Sept 30th of any year
   c) Prior authorization begin dates occurring on or after Oct 1st of any year can be submitted on or after August 1st of any year
   d) Effective 9/30/2023, two prior authorization line items are required for dates of services overlapping September and October dates of services. (Ex: One authorization line item for a service

through 9/30/2023 and another authorization line item for a service beginning on 10/1/2023)

- Attempts to submit a prior authorization outside of the above parameters will result in a message similar to the example below, which is intended to help Users understand what their next steps are.



Service Begin Month	Service Duration				
	<31 days	<60 days	<90 days	<120 days	<180 days
Jan					
Feb					
March					
April					
May					
June					
July					
Aug					
Sept					
Oct					
Nov					
Dec					

	Submit 1 Prior Authorization- service end date occurs prior to 10/1
	Submit 1 Prior Authorization if the service end date occurs prior to 10/1 Submit 2 Prior Authorizations if the service end date occurs on or after 10/1

- The table above was developed to assist prior authorization submitters with identifying how to submit requests based on the beginning month of service and the expected duration of services:

Examples:

- Example 1: On 9/1, An individual is recommended for services beginning 9/1 and ending 10/15
  - Submit a single prior authorization request as follows:
    - One prior authorization line for 9/1 – 9/30
    - One prior authorization line for 10/1 – 10/15
- Example 2: On 7/15 an individual is recommended for services beginning 7/15 through 10/15 (120 days)
  - On 7/15, submit a prior authorization for services for 7/15 – 9/30
  - On 8/1 or after, submit a prior authorization for services 10/1 and after

- Example 3: On 7/1, an individual is recommended for MAT services occurring 7/1 – 12/31 (180 days)
  - On 7/1, submit a prior authorization request for services 7/1 – 9/30
  - On 8/1 or after, submit a prior authorization for services 10/1 and after

4. Submit Prior Authorization Request
   Review the prior authorization requests for accuracy and press submit.
   Please note: Pending PAs can be edited by clicking on edit button. Type of Service request cannot be changed but services and dates can be edited prior to submitting.

5. Review for Program Response
   Upon receipt of a prior authorization request, SUD Voucher Administrators will review to verify service requests fall within the Prior Authorization Request Maximums listed in table above.
   - For services that fall within the parameters, PA will be approved.
   - For services that exceed the parameters, the SUD Voucher Administrator will reduce the units and/or dates of service range to align with parameters and select 'Partially Approved'. The PPS will auto-generate the approved amount based on the approved units.

   Although delays may occur, the SUD Voucher Program strives to review and process all initial requests within 1 business day, and all change or continuation of care requests within 3 business days.

Submitting a Prior Authorization for Out-of-pocket (OOP) Expense type

When creating a prior authorization for out-of-pocket (OOP) Expense type, User will be prompted to upload supporting documentation; summary of benefits statement indicating remaining OOP costs per individual plan. The summary of benefits is a snapshot of a health plan's costs, benefits, and covered health care services. The document must include personal identifying information (PII) for the individual applying or a parent's PII if the individual applying is an adolescent.

User will not be able to submit a prior authorization without uploading supporting documentation. The total amount requested for the authorization must match the total out-of-pocket amount remaining on the individual's benefit plan including remaining deductible amount. If the total amount requested does not match the total out-of-pocket amount remaining, type/write on the uploaded document the reason for this discrepancy.

An OOP prior authorization for an individual who is receiving treatment at the same program simultaneously at multiple locations requires an explanation of benefits (EOB) to be uploaded as supporting documentation.

Prior Authorization Status Reasons

Below is a description of the meaning for each of the statuses assigned to a prior authorization request, which is visible in the PPS. ***IMPORTANT NOTICE: Approved prior authorization does not guarantee payment. Final payments are dependent upon individual on-going eligibility and determining primary payer.***

Status	Description
Pending	The prior authorization request was successfully submitted to BHD and has not yet been processed.
Approved	The prior authorization request has been adjudicated and is approved as requested.
Partially Approved	The prior authorization request has been adjudicated and is partially approved with reason.
Approved Closed	The Prior Authorization is not active or current for treatment, but billing may still occur. (The prior authorization is for DOS in the past or all units have been exhausted).
Partially Approved Closed	
Denied	The prior authorization request has been adjudicated and is denied with denial reason

Licensed Addiction Counselor Reviews

From time to time, an individual may require care which exceeds the maximums allowed as identified in the Covered Services table. When this occurs, the SUD Voucher Administrator will request supporting documentation from provider for an LAC review to ensure medical necessity.

Billing for Services

While the Covered Services table above provides information specific to a service type, the following pertains to all services.

- Services must meet medical necessity. Medical Necessity is defined as an accepted health care service provided by health care entities that is appropriate to the evaluation and treatment of a disease, condition, illness, or injury, and is consistent with the applicable standard or care.

The Voucher is the payer of last resort. Services must first be billed to all third-party payer(s) providers are contracted with. If unable to contract with third-party-payer(s), email denial reason to the Voucher program.

- Only submit for reimbursement for services in which the individual was in attendance and only for the amount of time the individual was in attendance.
- Repay the SUD Voucher program for services reimbursed from other payers;
- Billings for duplicative group, individual, or family therapy services will not be paid. If two professionals are in a same group, only one professional is able to bill for the service.
- Copies of the other insurance denial must be submitted to sudvoucher@nd.gov
    - Adult and adolescent services that are denied by an insurance company or another third-party payer due to not meeting medical necessity will be reviewed on a case-by-case basis.
- North Dakota Medicaid covered, and non-covered services can be located here or visit https://www.hhs.nd.gov/healthcare/medicaid
    - SUD Voucher will cover court ordered assessments not covered by Medicaid.
- For detailed Medicaid Provider guidelines, including information specific to Behavioral Health and institutions for mental diseases (IMDs) click here or visit https://www.hhs.nd.gov/healthcare/medicaid
- North Dakota Blue Cross Blue Shield Medicaid Expansion covered, and non-covered services can be located here What's Covered | BCBSND Medicaid Expansion Program | BCBSND
- Providers should only submit one invoice per month per individual (as applicable) to ensure timely reimbursements can be made.
- Billing for services must be submitted within 180 days from when services are provided. If it is past 180 days from when services are provided, reimbursement may be forfeited.
- Provider reimbursements will be paid in the PPS once per calendar month on or after the fifth working day. For services that require a prior authorization, a provider will be permitted to submit an invoice line item only when a prior authorization exists and has approved funding available.
- Documentation requirements:
    - All services provided must be identified in the individual's treatment plan.
    - All progress notes must include the date of service and duration of service and identify the medical necessity of the intervention.

Submitting an Out-of-pocket (OOP) invoice in the PPS

Reimbursement for out-of-pocket (OOP) expense is intended to offset an individual's responsibility for services provided, determined by the individual's primary health insurer.

When creating an invoice for OOP Expense, User will be prompted to 'indicate the service type(s) provided, for which out-of-pocket expense reimbursement is being requested'.

Prior to submitting an OOP invoice, User will be prompted to upload insurance's itemized patient responsibility statement identifying services for which reimbursement is being requested.

User will not be able to submit invoice without uploading supporting insurance documentation. The total amount(s) entered on the invoice should coincide with the remaining amount(s) of itemized patient responsibility statement. If the amount(s) does not coincide, type/write on the uploaded document the reason for this discrepancy.

Submitting an Invoice in the PPS

For services that require authorization, a provider will only be permitted to submit an invoice for services that are authorized. It is therefore recommended that a provider review current prior authorization(s) prior to submitting an invoice to prevent invoicing errors or confusion. Each authorization will show the status, as defined above, the amount remaining/available for each service type, and the authorized date range.

Please note, the system limits invoice submission to a single prior authorization match. To bill for services that span two separate authorizations, a provider must submit separate invoice line items specific to each prior authorization.

To submit an invoice in the PPS, a provider will complete the following steps:

1. Select the service type
2. Enter the applicable Dates of Service
3. Enter the total units
4. Click Submit

Voucher Repayment/Refund

In order to increase immediate access to treatment services, the SUD Voucher will reimburse providers while an individual is waiting on approval of other payer resources. Providers are required to provide repayment/refund to the SUD voucher for any services reimbursed from other payers.

Refunds must be sent to the BHD address below and must include the following information:

- Name of individual
- Individual Application number (IAxxxx)
- Invoice number (INVxxxxx)
- Total amount of refund
- Date(s) of service
- Type of service
- Reason for refund

Remit address for all Voucher refunds:
Behavioral Health Division
Attn: SUD Voucher Program
600 East Boulevard Ave, Dept 325
Bismarck, ND 58505

Process and Outcome Measures

Programs utilizing the SUD Voucher are required to provide a brief assessment of each participant at the beginning of their treatment and again at the conclusion of their treatment, referred to as an Outcome Measure. The information collected in these measures is used to assist with future planning and funding efforts, to identify potential training and technical assistance needs, and to provide information to the ND Legislature and other stakeholders. Program Overview and Outcomes Measures can be viewed here or by visiting hhs.nd.gov/sudvoucher to see all Program Information.

Submitting Outcome Measures

Providers are required to submit outcome measures within the PPS, as outlined below:

Baseline Measures	• Must be completed before a provider can initiate invoicing for the application. • The PPS will activate the invoice functionality only after the baseline outcome has been submitted.
Annual Update Measures	• Must be completed for participants whose participation in the program exceeds one year, and each year thereafter. • The PPS will lock invoicing at each one-year mark and will unlock it only after the annual outcome measure has been submitted.
Discharge Measures	• Must be completed when a participant has been discharged from the program.

Discharge Reasons

Below are the Discharge Reasons identified in the SUD Voucher Program:

- Participant completion of treatment program
- Participant discontinues program against staff advice
- Participant incarceration
- Participant relocation to another state
- Participant referral to a new agency
- Change in payer status
- Provider termination of relationship with participant

Timely Submission of Discharge Outcomes

The table below was developed to assist a provider in identifying when to submit a Discharge Outcome.

For individuals who complete a treatment program	Submit the Discharge Outcome as soon as treatment concludes
For individuals who discontinue program participation against staff advice	Submit a discharge outcome when an individual has been inactive for a period of 90 days. An individual who reinitiates treatment within 90 days of inactivity may continue to utilize the current application and the provider does not need to submit a discharge outcome until the individual completes treatment or another discharge reason occurs.
For all other discharge scenarios	Submit the Discharge Outcome as soon as the 'other' condition occurs. (e.g. incarceration, relocation to another state, referral made, new insurance obtained, client relationship adversely terminated)

Application Closure

When an Application Status is changed from Approved to Approved Closed it means the participant is no longer actively treating under the program, but their application remains open for submission of invoices. At the time a provider submits a discharge outcome, the application will be moved to a status of Approved Closed.

The SUD Voucher program will monitor applications to identify applications that do not have a discharge outcome on file but are inactive. The SUD Voucher program defines inactivity as an application that meets the following conditions:

- No current prior authorization on file for a period of 90 days
- Invoiced dates of service are greater than 90 days in the past

In the event the SUD Voucher Program identifies an application that is inactive and does not have a discharge outcome, the SUD Voucher Administrator will close the application.

For an Approved Closed Application:

A provider will be allowed to continue submitting invoices for services occurring on or prior to the discharge date, for a period of 180 days following a discharge, provided that the discharge date does not exceed an administrative discharge date.

- A provider will not be allowed to submit a new prior authorization
- Eligibility review is not required for applications with a status of Approved Closed