NORTH Dakota | Health & Human Services
Be Legendary.

Conflict of Interest Procedure Guide

The care coordination agency must provide justification they are the only willing and qualified provider per the steps below.

1. Review the current 1915(i) Provider List on the 1915(i) website to identify if there are any other providers in the county in which the member resides rendering the service(s). **NOTE: The provider list on the website is updated frequently as new provider enrollments are approved. The most current list on the website must always be utilized.**
    a. If there are no other providers, identify your agency as the service provider on the plan of care and follow the standard service authorization process.
    b. If there are other providers and the member has chosen your agency for both care coordination and other 1915(i) services, continue with Steps 2-4.

2. Complete the Request for Service Provider form and send to each agency rendering the service in the county in which the member resides identified on the provider list. The requests must be in order of member choice. If an agency denies the request, the denial must be documented on the form. Signature, date, and denial reason are required.
    - What happens if an agency accepts the request?
        - The accepting agency is identified on the plan of care as the service provider, and the standard service authorization process is followed.
    - What is the timeframe to wait for a response to the request?
        - The Request for Service Provider form indicates an agency is to respond within two business days. It is encouraged providers respond in a timely fashion due to the timeframe for plan of care development. However, if an agency doesn't respond within five business days, the care coordination agency can accept that as a denial. The email documenting that no response was received must be attached to the service authorization request if the care coordination agency will be rendering both care coordination and the other 1915(i) service(s).

3. The Request for Service Provider form documenting all denials from the provider(s) in the county in which the member resides identified on the provider list must be submitted with the plan and care and attached to the service authorization request in MMIS.

4. The Department will review the request to ensure all providers identified on the current provider list have denied the service request before approving.