PROVIDER GUIDANCE

Substance Use Disorder Voucher Program

NORTH Dakota | Behavioral Health

Be Legendary. HEALTH & HUMAN SERVICES

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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 substantive updates:

1. 67th Legislative Session
2. Becoming a SUD Voucher Provider
3. Eligibility Documentation Requirements
4. Eligibility Reviews
5. Release of Information Requirements
6. Covered Services
7. Voucher Repayment/Refund
8. Timely Submissions of Discharge Outcomes
9. Application Closure

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 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:

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). 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

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 Memorandum of Agreement (MOA) 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, prior authorizations, invoices, eligibility reviews and outcome measures.

- Each program will need a 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 citizen in ND
- Individual is 14 years of age or older
- Individual's income is less than or equal to 200% Federal Poverty Guidelines (FPG)
- Individual does not have other means for payment of SUD treatment

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.

North Dakota Medicaid Requirements

Per North Dakota Administrative Code article 75-09.1-11, the SUD Voucher is to be payor 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.

<u>Medicaid Application Process for SUD Voucher Program</u>

- 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 process to close the individual's SUD Voucher.

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 last 90 days, if currently working - Business income (or loss) - Gains (or losses) from the sale or trade of business property, including real estate - Rental income, royalty payments, trust income, and income from a partnership or S corporation - Farm income - Unemployment benefits - 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 - Child Support received - Alimony you received, if the alimony agreement took effect before 2019 - Tax refunds and credits for state and local income taxes - 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: - Rent or Mortgage - Renters or homeowners insurance - Property taxes (if not included in mortgage) - Child Support - Medical Insurance - Legal Fees - Medical Bills - Insurance Deductible*** - Insurance Copays**	Yes
Other Expenses	One or more of the following: - Water - Utilities - Phone - Internet - Student Loans - Credit Cards - Childcare - Auto loans - Auto Insurance	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.
    - Providers are encouraged to use the DHHS Authorization to Disclose Information (SFN 1059) form, which can be accessed here: https://www.behavioralhealth.nd.gov/sites/www/files/documents/2021.10%20SFN%201059.pdf

2. Upload the ROI to the Provider Portal System (PPS)
    - A release of information (ROI) is must be uploaded in the PPS before any information can be communicated to a provider about a 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.

ASAM 1.0	**Service Description**	**Low intensity outpatient substance-use disorder treatment services** • < 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, require LAC review	
	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 < 7/1/2022 $14.50 per unit	DOS on or after 7/1/2022 $14.83 per unit
ASAM 2.1	**Service Description**	**High intensity outpatient substance-use disorder treatment services** • 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	Units	Days
	Initial or Change Request	50 units	120 Days
	Continuation of Care	12 units	30 Days
	LAC Review Threshold	Cumulative requests exceeding 62 sessions or 150 days, whichever occurs first, require LAC review	
	Billing Limits	Daily limit: 1 unit per day	
	Reimbursement Rate	DOS < 7/1/2022 $217.53 per unit	DOS on or after 7/1/2022 $222.44 per unit

ASAM 2.5	**Service Description**	**Partial Hospitalization substance use disorder treatment services** • 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 LAC review
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS < 7/1/2022 $311.77 per unit (adult) $380.36 per unit (adolescent) DOS on or after 7/1/2022 $318.80 per unit (adult) $388.94 per unit (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 require LAC review
	Billing Limits	Daily limit: 1 unit per day
	Reimbursement Rate	DOS < 7/1/2022 $311.77 per unit (adult) $380.36 per unit (adolescent) DOS on or after 7/1/2022 $318.80 per unit (adult) $388.94 per unit (adolescent)

Assessment	**Service Description**	**Psychosocial evaluation to determine diagnostic impressions and treatment recommendations.**	
	Unit Description	I Unit = 1 day	
	Prior Auth Request Maximums	Authorization 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 < 7/1/2022 $130.28 per unit	DOS on or after 7/1/2022 $133.22 per unit
Family Therapy	**Service Description**	**Counseling provided to improve communication and resolve conflicts within a family**	
	Unit Description	1 Unit = 1 session	
	Prior Auth Request Maximums	• Authorization 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 < 7/1/2022 $101.93 (with patient) $105.88 (without patient)	DOS on or after 7/1/2022 $104.23 per unit (with patient) $108.27 per unit (without patient)
Individual Therapy	**Service Description**	**One-on-one counseling provided to an individual to address an individual's needs based on the individual's treatment plan**	
	Unit Description	1 Unit = 1 session	
	Prior Auth Request Maximums	• Authorization 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 < 7/1/2022 $63.53 per unit (30 minutes) $84.34 per unit (45 minutes) $126.33 per unit (60 minutes)	DOS on or after 7/1/2022 $64.96 per unit (30 minutes) $86.24 per unit (45 minutes) $129.18 per unit (60 minutes)

Methadone Maintenance- Daily	**Service Description**	**Services provided to an individual receiving Medication Assisted Treatment (MAT) services requiring 3 or more visits per week** • Reimbursement includes the methadone administered during that visit	
	Unit Description	1 Unit = 1 day	
	Prior Auth Request Maximums	<u>Units</u> 365 units	<u>Days</u> 365 days
	Billing Limits	Daily limit: 1 unit per day	
	Reimbursement Rate	<u>DOS < 7/1/2022</u> $8.92 per unit	<u>DOS on or after 7/1/2022</u> $9.12 per unit
Methadone Maintenance- Weekly	**Service Description**	**Services provided to an individual receiving MAT services requiring 2 or less visits per week** • Reimbursement includes the methadone administered during that visit	
	Unit Description	1 Unit = 1 day	
	Prior Auth Request Maximums	<u>Units</u> 104 units	<u>Days</u> 365 days
	Billing Limits	Weekly limit: 2 unit per week	
	Reimbursement Rate	<u>DOS < 7/1/2022</u> $19.46 per unit	<u>DOS on or after 7/1/2022</u> $19.90 per unit
Methadone Maintenance- Take Home	**Service Description**	**Methadone provided to an individual to be taken at home**	
	Unit Description	1 Unit = 1 Day	
	Prior Auth Request Maximums	<u>Units</u> 353 units	<u>Days</u> 365 days
	Billing Limits	Daily limit: 1 unit per day	
	Reimbursement Rate	<u>DOS < 7/1/2022</u> $1.00 per unit	<u>DOS on or after 7/1/2022</u> $1.02 per unit

Service	Item	Details
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. A copy of the individual's explanation of benefits or plan limitations may be required.
	Reimbursement Rate	N/A
Peer Support/ Recovery Coach	**Service Description**	**Recovery support offered by a Certified Peer Support Specialist**
	Unit Description	1 Unit = 15 minutes
	Prior Auth Request Maximums	Authorization 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 < 7/1/2022: $7.25 per unit DOS on or after 7/1/2022: $7.41 per unit
Room & Board	**Service Description**	**Residential lodging and food provided to an individual in applicable ASAM levels of care**
	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 LAC review
	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 < 7/1/2022: $74.97 per unit (adolescent); $61.45 per unit (adult) DOS on or after 7/1/2022: $76.66 per unit (adolescent); $62.84 per unit (adult)

Service	Field	Details
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 not required
	Billing Limits	1 unit per provider per application
	Reimbursement Rate	DOS < 7/1/2022 $34.81 per unit DOS on or after 7/1/2022 $35.59 per unit
Transportation	**Service Description**	**Reimbursement provided for an individual who requires financial support for the transportation to and from approved service appointments**
	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.
	Reimbursement Rate	DOS < 7/1/2022 $0.45 per unit DOS on or after 7/1/2022 $0.45 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	DOS < 7/1/2022 $14.86 per unit DOS on or after 7/1/2022 $15.20 per unit

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 from the date of service.

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 submittng 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.

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) Effective 7/1/2022, two prior authorization line items are required for dates of services overlapping June and July dates of services (end of state fiscal year). (Ex: One authorization line item for a service through 6/30/2022 and another authorization line item for a service beginning on 7/1/2022)

4. <u>Submit Prior Authorization Request</u>
   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. <u>Review for Program Response</u>
   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.

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.

<table>
<tr><th>Status</th><th>Description</th></tr>
<tr><td>Pending</td><td>The prior authorization request was successfully submitted to BHD and has not yet been processed.</td></tr>
<tr><td>Approved</td><td>The prior authorization request has been adjudicated and is approved as requested.</td></tr>
<tr><td>Partially Approved</td><td>The prior authorization request has been adjudicated and is partially approved with reason.</td></tr>
<tr><td>Approved Closed</td><td rowspan="2">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).</td></tr>
<tr><td>Partially Approved Closed</td></tr>
<tr><td>Denied</td><td>The prior authorization request has been adjudicated and is denied with denial reason</td></tr>
</table>

<u>IMPORTANT NOTICE: Approved prior authorization does not guarantee payment. Final payments are dependent upon individual on-going eligibility</u>

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 payor of last resort. Services must first be billed to all third-party payer(s).
- Copies of the other insurance denial must be submitted to sudvoucher@nd.gov
    - Services that are denied by an insurance company or another third-party payer due to not meeting medical necessity will not be covered by the Voucher.
- North Dakota Medicaid covered, and non-covered services can be located here North Dakota Medicaid
    - SUD Voucher will cover court ordered assessments not covered by 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 by 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.

Submitting an Invoice in 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 to 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 invoices specific to each prior authorization.

To submit an in 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)
- Total amount of refund
- Date(s) of service
- Type of service
- Reason for refund

Remit address for all Voucher refunds:
Behavioral Health Division
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 Administrators 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 Advanced Notice discontinuation 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