

# GENERAL INFORMATION FOR BEHAVIORAL HEALTH SERVICES

## NORTH DAKOTA MEDICAID



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## SUMMARY OF CHANGES

The October 2023 ND Medicaid Behavioral Health provider manual updates contain various changes that are detailed below. While providers should review chapters that are specific to their services, all enrolled Medicaid providers are responsible to understand and comply with program requirements contained in generic chapters such as provider enrollment, provider information, and in the General Information for Providers manual (such as Medicaid eligibility of a member, and noncovered Medicaid services).

Providers should carefully review the following chapters for substantive updates:

1. Provider Information
2. Other Licensed Practitioner \*new chapter
3. Behavioral Health Rehabilitative Services
4. Substance Use Disorder Treatment Services

New/revised language can be identified between «» symbols throughout the manual.

## PROVIDER ENROLLMENT

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### AM I ELIGIBLE TO ENROLL AS A PROVIDER?

To be eligible for enrollment, a provider must:

- Supply a covered service(s) to at least one ND Medicaid eligible member.
- Meet the conditions in this chapter and conditions of the ND Medicaid provider agreement (SFN 615).
- Be a provider with a valid license, certification, accreditation, or registration according to the state laws and regulations of the state in which services are rendered.
  - Health care providers with limited licenses, meaning providers licensed as assistants and those who must practice under supervision<sup>1</sup> pursuant to North Dakota laws and regulations applicable to their profession may not enroll as North Dakota Medicaid providers and cannot bill ND Medicaid for services rendered with their own National Provider Identifier (NPI).
    - **Exception:** Behavioral health care providers<sup>2</sup> eligible to render Rehabilitative Mental Health Services must enroll with ND Medicaid and bill for those services with their own NPI. (see Behavioral Health Rehabilitative Services chapter in this manual for more information).
  - Health care trainees (unlicensed) who are registered with their respective professional regulatory board, pursuant to North Dakota laws and regulations applicable to their profession, and who have a scope of practice in law or regulation may not enroll as North Dakota Medicaid providers and cannot bill ND Medicaid for services rendered.
- Be free of any exclusions from a federally funded program including the List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM) or a state Medicaid agency.

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<sup>1</sup> Supervision means the physician or other supervising provider must direct and oversee the service according to professional requirements in state law, rules, or guidelines of a regulating/licensing board or organization. It does not mean that the physician or other supervising provider must be present in the room when the service is rendered unless applicable laws or regulations for the profession require in-room presence.

<sup>2</sup> Behavior Modification Specialists, Licensed Associate Professional Counselors, Licensed Master and Baccalaureate Social Workers, Mental Health Technicians, Registered Nurses.

## DO I NEED TO ENROLL?

Eligible providers may not bill for services under a supervising or peer provider's NPI. All eligible providers must enroll and bill with their own NPI. A list of provider types eligible to enroll with ND Medicaid is located under Taxonomy Codes at <https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-provider-enrollment-information>.

## PHYSICIANS IN RESIDENCY

You must enroll with Medicaid to bill for services rendered to members if you have:

- A license to practice medicine in North Dakota by the ND Board of Medical Examiners, or
- A temporary special license for foreign medical school graduates as outlined in the Medical Practices Act of ND ([N.D.C.C. § 43-17-18\(4\)](#)).

You cannot bill using a supervising physician's NPI.

## OUT OF STATE PROVIDERS

Out of state providers may enroll with ND Medicaid. "Out of state provider" means a provider who is located more than fifty (50) miles from a North Dakota border. Out of state services require service authorization (except in the local trade area within 50 miles of the North Dakota border or services provided in response to an emergency).

Out of state emergency services require a retroactive authorization to receive payment. Out of state providers may apply for a retroactive enrollment date for the date of covered services provided to a member (see below section "What is an Enrollment Effective Date?").

## WHAT DO I NEED TO ENROLL?

Providers need to send:

- A [completed online application](#), and
- [Completed packet of supporting documentation](#) (see Required Documents under Enrollment). Supported documentation can be submitted by:
  - Fax to 701-433-5956 Attn: Provider Enrollment; or
  - Secure email. Request access to a secure link by sending an email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com). You will be sent a link to a secure site to submit your supporting documentation.

- An Out of State Enrollment Clarification form (SFN 509) if you are an out of state provider. The form is available at [www.nd.gov/eforms](http://www.nd.gov/eforms).

Your application processing does not begin until both your online application is completed and submitted and your completed packet of supporting documentation is received.

### **WHAT IS AN ENROLLMENT EFFECTIVE DATE?**

You will be able select an enrollment effective date on your application. An enrollment effective date is the date your enrollment will be made effective. It is limited to no more than ninety (90) days prior to the date your complete application packet is received. If you do not select an enrollment effective date, your enrollment will become effective on the date that your application is approved.

Providers who request a retroactive effective enrollment date may supply covered services prior to receipt of all required enrollment documents if the provider meets all eligibility requirements at the time the service is provided and only if appropriate documentation of the services supplied is maintained.

ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety (90) days for situations involving emergent care provided to a member. If the application involves an emergency service, a copy of the claim and medical notes must be sent with the application packet. If you do not submit this information a date beyond ninety (90) days of receipt of a completed application will not be approved.

Retroactive enrollment is not applicable to the 1915(i) program.

### **WHAT HAPPENS WHEN MY APPLICATION IS APPROVED?**

You will need a 7-digit Medicaid ID number. You will receive this in one of two ways. If you completed the security information section during your enrollment process, you will receive a letter via the United States Postal Service with enrollment information that includes your 7-digit Medicaid ID number and login information to access the web portal. If you did not complete the security section during the enrollment process, you can register for web access using the Provider Registration section on the home page of the MMIS Web Portal once your application is approved. To register for web access, click the "Register" link, enter your 7-digit Medicaid ID and Social Security Number (for individual providers) or Employer Identification Number (for billing groups).

**DO I NEED TO REVALIDATE MY ENROLLMENT?**

Yes, you will need to revalidate your enrollment at least once every five (5) years. Your revalidation date is in your online provider portal. ND Medicaid will also send notifications to the email address(es) associated with your enrollment record. A revalidation roster is updated and published on the ND Medicaid website that lists Provider Revalidation Dates that are due within 90 days of the published date.

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-revalidations-dates.xlsx>. Past due revalidations are also posted online at <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-revalidations-past-due.xlsx>.

**WHAT IF THERE IS A CHANGE IN MY ENROLLMENT?**

It's your responsibility to update your enrollment information. Changes that cannot be updated through the provider web portal may be sent via email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com). Changes that include sensitive information such as social security numbers, dates of birth, etc., may be sent via secure fax at 701-433-5956 Attn: Provider Enrollment or via secure email. Please email [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) and request a secure link to send updated information. You will be sent a secure link to send your required information.

To avoid payment delays, notify Provider Enrollment of address of Automated Clearing House (ACH) changes in advance.

**WHAT IF THERE IS A CHANGE IN OWNERSHIP?**

You have thirty-five (35) days to send changes of ownership for owners who have 5% or more ownership interest. Refer to [42 C.F.R. § 455.104](#) for more information. For tax reporting purposes, Provider Enrollment must be notified at least 30 days in advance of any changes that cause a change in a tax identification number.

Providers that are enrolled with both Medicare and Medicaid must ensure that the owners and managing employees match. Discrepancies delay application approvals and may result in payment suspensions for enrolled providers.

**PROVIDER UPDATES**

Provider updates such as affiliations, terminations, EFT, taxonomy, address, name, etc., must be sent to Provider Enrollment for Processing. Please see the [Provider Enrollment](#) section of the ND HHS website for more information on how to request these updates.

## **TERMINATING MEDICAID ENROLLMENT**

Send your notice of termination via email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or fax to 701-433-5956 Attn: Provider Enrollment. Include name, national provider identifier (NPI) if applicable, ND Medicaid number, and the termination date. Notice of termination without cause must be sent in writing and requires 30 days' advance notice. ND Medicaid may also end enrollment under the following circumstances:

- Breach of the provider agreement;
- Demonstrated inability to perform under the terms of the provider agreement;
- Failure to follow applicable North Dakota and United States laws; or
- Failure to follow regulations and policies of the North Dakota Department of Health and Human Services or the ND Medicaid program.

See [N.D. Administrative Code § 75-02-05](#) for more information.

## **PROVIDER REQUIREMENTS**

Your signature on the Medicaid provider agreement for North Dakota Medicaid means you agree to follow the conditions of participation in the provider agreement. The Medicaid Program Provider Agreement (SFN 615) is available at [www.nd.gov/eforms](http://www.nd.gov/eforms). More requirements may apply based on the provider type or specialty. Conditions include:

- You may not abandon a member in a way that would violate professional ethics.
- You may not refuse to serve a member because of race, color, national origin, age, or disability.
- You must advise members in advance if you are accepting them only on a private pay basis. This shall be in writing and signed by the member.
- When a provider arranges ancillary services for a member through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the member and they may not bill the member directly.

## **PROVIDER OBLIGATIONS**

You must ensure services are ordered or rendered within the scope of your practice according to state law and for release information needed to support services billed to ND Medicaid, as appropriate.

## **SCOPE OF PRACTICE AND LICENSURE**

ND Medicaid realizes there are other professional sources that define the relationship between the member and provider; including certain CPT© code



definitions, current CDT© definitions, American Dental Association Guidelines and Dental Evidence, the American Academy of Pediatric Dentistry Oral Health Policies and Recommendations (the Reference Manual of Pediatric Dentistry), the ASAM Criteria: Treatment of Addictive, Substance-Related, and Co-Occurring Conditions (most current version), The Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed, DSM-5), current HCPCS codes, ethical standards of practice, accepted professional standards of practice, and current evidence-based practice guidelines. Providers are responsible for maintaining the qualification for their licensure and are not eligible to order or render services during any periods in which there is a lapse in their license.

## RELEASE OF INFORMATION

You agree to release, upon reasonable request, information needed to support the services billed to ND Medicaid as a condition of your participation in the program. Medicaid is a covered entity under HIPAA and is acting within its authority to request documentation. Supplying the requested documentation is not a HIPAA violation. Laws applicable to supplying documentation are:

[45 C.F.R. § 164.506](#) - uses and disclosures to carry out treatment, payment, or health care operations.

[45 C.F.R. § 164.512\(d\)](#) - allows the disclosure of protected health information to a health oversight agency (which includes ND Medicaid as a government benefit program).

[42 C.F.R. § 456.23](#) - ND Medicaid's authority to conduct a post-payment review.

[North Dakota Administrative Code § 75-02-05-04\(2\)](#) – provider responsibilities, including supplying documentation upon request.

[42 C.F.R. § 431.107\(b\)\(2\)](#) – requiring providers to submit information regarding Medicaid payments for furnishing services.

## ELECTRONIC CLAIMS SUBMISSIONS

Medicaid claims sent electronically experience fewer errors and quicker payment. Electronic service claims must be in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. More information on the format and data requirements is available at <https://www.hhs.nd.gov/human-services/medicaid/provider/mmis-nd-health-enterprise-medicaid-management->

[information-system.](#)

Providers sending claims for non-medical services are exempt from sending HIPAA compliant claims. These services include home and community-based services, waiver services, and non-emergent transportation/meals/lodging services.

## PROVIDER INFORMATION

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### COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND POLICIES

Providers enrolled with ND Medicaid must follow all applicable rules of ND Medicaid and all applicable state and federal laws, regulations, and policies including:

- United States Code (U.S.C.) governing the Medicaid program;
- Code of Federal Regulations (CFR);
- North Dakota Century Code;
- North Dakota Administrative Code;
- Federal Department of Health and Human Services policies governing the Medicaid program;
- Written policies of the North Dakota Department of Health and Human Services; and
- All state laws and rules governing provider licensure and certification, as well as the standards and ethics of their business or profession.

Providers must be familiar with all current rules and regulations governing the ND Medicaid program. Provider manuals are to help providers in billing ND Medicaid; they do not have all ND Medicaid programs rules and regulations. Any rule citations in the manual are for reference and are not a summary of the entire rule.

### MEMBER PARITY

You must treat members and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by applicable regulations).

### DOCUMENTATION GUIDELINES FOR MEDICAID SERVICES

Your documentation records must:

- Thoroughly document the extent of services rendered and billed. These records are used to decide medical necessity and correct billing.
- Be in their original or legally reproduced form. This may be electronic.
- Support the time spent rendering a service for all time-based codes.
- Be kept for a minimum of seven (7) years from the date of their creation or the date when they were last in effect, whichever is later. Note: state law may require a longer retention period for some provider types.

- Be signed by the ND Medicaid-enrolled provider rendering the service. Claims selected for an audit that don't have signed records, shall be denied.
- Be legible, promptly completed, dated and time, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy. Signatures must follow [Medicare requirements](#).
- Be kept confidential.

## WHAT DOES DOCUMENTATION INCLUDE?

Documentation includes:

- Medical records including:
  - Patient's name and date of birth;
  - Date and time of service;
  - Name and title of provider rendering the service, if other than the billing practitioner;
  - Chief complaint or reason for each visit;
  - Pertinent medical history;
  - Pertinent findings on examination;
  - Medication, equipment and/or supplies prescribed or provided;
  - Description and length of treatment;
  - Recommendations for additional treatments, procedures or consultations;
  - Diagnostic tests and results;
  - Dental photographs/teeth models;
  - Certification of medical necessity (if applicable)
  - Plan of treatment and/or care and outcome; and
  - Signature and date by the person ordering or rendering the service.
- Service authorization information;
- Claims, billings and records of Medicaid payments and amounts received from other payers for services provided to members;
- Records and original invoices for items that are prescribed, ordered or furnished; and
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers and other financial information.

## «AMENDING MEDICAL DOCUMENTATION

Here is how to handle a late entry, addition, or correction to a medical record.

Any change or addition to a medical record needs to have the current date of that entry and be signed by the person making the change or addition.

Late entries supply additional information that was not included in the original record.

- The person documenting must have total recall of the omitted information.

Additions provide information that was not available at the time the original record was made.

- The reason for adding or clarifying information must be added to the medical record.

Corrections are necessary when there is an error in the documentation.

- Do not omit or write over any errors in the medical record. Draw a single line through the erroneous information, ensuring the original entry is legible.
- Sign or initial and date the deletion and state the reason for the correction.
- Document the correct information on the next line or space and refer back to the original entry.»

## WHAT IS MEDICAL NECESSITY?

Medically necessary/medical necessity means

- Medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment;
- Consistent with the recipient's diagnosis or symptoms;
- Appropriate according to generally accepted standards of medical practice;
- Not provided only as a convenience to the recipient or provider;
- Not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and
- Provided at the most appropriate level of service that is safe and effective.

See N.D. Admin. Code § 75-02-02-03.2(10).

## **HOW DO I HANDLE CONFIDENTIALITY AND RECORDS ACCESS?**

All member and applicant information and related medical records are confidential and must be protected subject to applicable laws. Access to records by ND Medicaid personnel, or authorized agents are permitted access to all information concerning any services that may be covered by Medicaid. This access does not require authorization by the member because disclosure to carry out treatment, payment, or healthcare operations are allowed under HIPAA. See [C.F.R. § 164.506](#). This includes health plans contracting with ND Medicaid for information relating to Medicaid services reimbursed by the health plan.

Providers must make available for examination and photocopying, upon request from authorized agents of the state or federal government, all:

- Medical records,
- Quality assurance documents,
- Financial records,
- Administrative records, and
- Other documents and records that must be maintained.

If providers are using electronic medical records, they must have a medical record system that ensures the record may be accessed and retrieved promptly. Failure to make records available may result in the provider's suspension and/or termination from Medicaid.

Release of records to other individuals may only happen if there is a signed release from the member authorizing access to the records or if the disclosure is for a permitted purpose under applicable confidentiality laws.

## **REQUIREMENTS FOR ORDERING, REFERRING AND PRESCRIBING PROVIDERS**

ND Medicaid requires ordering, referring, or prescribing providers to enroll as a participating provider. ND Medicaid cannot pay for ND Medicaid-covered services requiring a referral, order, or prescription from a physician or other licensed practitioner of the healing arts unless the referring, ordering, or prescribing provider is enrolled.

## **AM I ELIGIBLE TO BILL THROUGH A SUPERVISING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI)?**

Providers eligible to enroll with ND Medicaid may not bill through a supervising provider's NPI (See Section "Am I Able to Enroll as a Provider?" for more information.)

Services rendered by trainees and health care providers with limited licenses, meaning providers licensed as assistants and those who must practice under supervision<sup>3</sup> pursuant to North Dakota laws and regulations applicable to their profession, may be billed through the supervising provider's NPI number so long as the supervisee is not required to enroll and bill under their own NPI (Behavioral health care providers<sup>4</sup> eligible to render behavioral health rehabilitative services may not bill for services under a supervising practitioner's NPI). Please see the [Behavioral Health Services Provider Manual](#) for more information).

Services provided by a health care provider with a limited license or a trainee practicing under supervision must:

- be documented in medical records.

Supervising health care providers must be responsible for:

- satisfying all applicable state law and regulatory supervision requirements; and
- patient care provided by a supervisee.

## **VERIFICATION OF MEMBER ELIGIBILITY**

Providers must verify a member's Medicaid eligibility status before supplying services to the member. This can be done in one of three ways:

- 1) Log into ND Health Enterprise MMIS <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>. Click on the Member tab then select Check Eligibility.
- 2) Use the Automated Voice Response System (AVRS), see AVRS chapter in the [General Information for Providers](#) manual.
- 3) Call the Provider Relations Call Center at (701) 328-7098 or (877) 328-7098.

## **PAYMENT FOR SERVICES**

Medicaid payment for covered services will be made to providers when the following conditions are met:

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<sup>3</sup> Supervision means the physician or other supervising provider must direct and oversee the service according to professional requirements in state law, rules, or guidelines of a regulating/licensing board or organization. It does not mean that the physician or other supervising provider must be present in the room when the service is rendered unless applicable laws or regulations for the profession require in-room presence.

<sup>4</sup> Behavior Modification Specialists, Licensed Associate Professional Counselors, Licensed Master and Baccalaureate Social Workers, Mental Health Technicians, Registered Nurses.

- Provider is enrolled with ND Medicaid.
- Services are rendered by practitioners licensed and operating within the scope of their practice as defined by law.
- Member is eligible for Medicaid.
  - Verify a member's eligibility status and PCCM enrollment prior to supplying services to the member. If the member is enrolled in PCCM, you must assure referrals from the member's designated PCP are in place for any services received by the member to receive consideration of payment by ND.
- Service is medically necessary.
  - ND Medicaid may review medical necessity at any time before or after payment.
- Service is covered by ND Medicaid and is not considered experimental or investigational.
- Service authorization requirements are met where applicable.
- Medicaid and/or third-party payers are billed according to rules and instructions as described in this manual, the most current Provider Bulletin, and the ND Medicaid website.
- Billed charges are usual and customary.
  - Usual and customary charge" refers to the amount the provider charges the public, in most cases, for a specific item or service. Providers may not charge ND Medicaid a higher fee than that charged to non-Medicaid covered individuals, even if the ND Medicaid allowable fee is greater than the provider's usual and customary charge. If special discounts are available to non-Medicaid covered individuals, claims submitted to ND Medicaid must represent the same discounted charges as those available to the general public.
- Services are not provided free to other individuals.
- Payment to providers from Medicaid and all other payers do not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties is greater than the Medicaid fee, Medicaid will pay at \$0.
- Claims meet timely filing requirements.

## **SERVICE AUTHORIZATIONS**

Service authorizations (SA) are required for certain procedures, services, and items before being initiated, supplied, or performed. Providers or suppliers must review the Medicaid Covered Services and other provider sections of the General Information for Providers Manual and specific service manuals for further guidance related to SA requirements.



- Failure to obtain an SA will result in the denial of the service or supply.
- All claims are subject to post-payment review or audit. Any service or supply that paid without an approved SA is subject to recoupment. Approved service authorizations are service, supply, and provider-specific and are non-transferrable. An approved SA can only be modified by a written request from a provider at the department's discretion. Web-based authorizations cannot be altered by the department and require resubmission.
- The Department will review the documentation related to service authorization or date-extension requests. Providers must ensure the following:
  - Forms are complete and accurate.
  - Pertinent documentation relevant to the request being made is submitted.
    - Providers may highlight pertinent documentation that specifically supports the medical necessity of the SA request to expedite the review process.
  - Requests that do not meet these criteria will be returned or denied.
- Providers are to ensure that submitted documentation supports the following criteria:
  - Requested date spans are reflected on correct form and are included in all documentation submitted. Requests that do not meet these criteria could be rejected as incomplete.
  - The order/referral dates must be directly related to the dates requested.
  - Providers are to submit the minimum necessary documentation pertinent to the SA request.

## **RETROACTIVE SERVICE AUTHORIZATIONS**

Retroactive service authorizations may be submitted for consideration up to 90 days from the date of service with good cause i.e., urgent/emergent medical conditions, retrospective eligibility. They should not be used on a routine basis.

Retroactive authorization requests are reviewed and decided internally on a case-by-case basis.

The Department will only consider timely, retroactive, or extension SA requests if all required forms and supporting information are submitted. Submissions that are incomplete or missing information will be returned or

denied. Any re-submissions will need to be updated for dates, documentation, and orders so that they are current and complete based on the type of SA being submitted. The Department will not keep documentation from earlier submissions. Decisions will be based on the newest date of submission, not an earlier submission date.

### **WHAT IF THE MEMBER HAS OTHER INSURANCE?**

Do not send claims to Medicaid until the charges are processed by the primary payer for members also covered by Medicare, other insurance, or when another third-party is responsible for the cost of the member's health care. See the Third Party Liability chapter in the [General Information for Providers manual](#) for more information.

### **NATIONAL CORRECT CODING INITIATIVE (NCCI)**

ND Medicaid follows the National Correct Coding Initiative (NCCI) Edits. The Centers for Medicare and Medicaid Services (CMS) developed these edits based on coding conventions defined in the American Medical Association's Correct Procedure Terminology Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS annually updates the National Correct Coding Initiative Coding Policy Manual. For additional information reference [www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html](http://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html).

### **MEDICAID PAYMENT IS PAYMENT IN FULL**

Providers must accept Medicaid payment as payment in full for any covered service, except recipient liability that should be collected from the member.

### **WHEN CAN A MEDICAID MEMBER BE BILLED?**

In most circumstances, providers may not bill members for services covered by Medicaid. Providers may bill members directly under the following circumstances:

- For recipient liability (RL) amount documented on the remittance advice. Providers (except for Point-of-Sale Pharmacy) may not collect RL at the time of service.
- For services not covered by ND Medicaid, if the member was given advance notice prior to rendering services.
- If a provider chooses not to enroll as a Medicaid provider, the member is responsible for all charges if the member was given advance notice prior to rendering services.

Providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid; Medicaid payment is payment in full.
- When the provider bills Medicaid for a covered service and Medicaid denies the claim because of billing errors; or
- When the provider fails to secure the necessary service authorization to secure the necessary service authorization.

## **OTHER LICENSED PRACTITIONERS (OLPS)**

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«ND Medicaid covers licensed practitioners referred to in policy as Other Licensed Practitioners (OLPs) pursuant to 42 CFR § 440.60. Enrolled OLPs recognized by ND Medicaid and authorized under attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d may bill ND Medicaid for covered services allowed within their scope of practice.

Practitioners currently recognized as OLPs by ND Medicaid are:

- Nurse Practitioners (NPs)
- Physicians Assistants (PAs)
- Clinical Nurse Specialists (CNSs)
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Licensed Psychologists

These practitioners are Other Practitioners in the ND Medicaid State Plan. Other Practitioner Services reimbursement, unless otherwise specified, is the lower of billed charges or seventy-five percent (75%) of the ND Medicaid fee schedule amount. »

## **PARTIAL HOSPITALIZATION PSYCHIATRIC (PHP) SERVICES**

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ND Medicaid covers partial hospitalization psychiatric services provided to a member with an impairment resulting from a psychiatric, emotional, or behavioral disorder.

Services are provided by a multidisciplinary team of health care professionals, designed to stabilize the health of the member with the intent to avert inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization psychiatric services must be hospital-based and under the supervision of a licensed physician.

Level A is an intense level of services by at least three licensed health care professionals for at least four hours and no more than eleven hours per day for at least three days per week.

Level B is an intermediate level of services by at least three licensed health care professionals for three hours per day for at least two days per week.

ND Medicaid does not cover intensive outpatient programs for mental health as a bundled service.

### **BILLING GUIDELINES**

	<b>Billing Code</b>	<b>Revenue Code</b>
Level A	H0035	905
Level B	H0040	912

## **1915(i) MEDICAID STATE PLAN AMENDMENT HOME AND COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES**

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The 1915(i) program allows Medicaid to pay for home and community-based services to support members with behavioral health conditions including mental illness, substance use disorders, and/or brain injury to live in the community rather than an institution.

### **1915(i) ELIGIBILITY**

To receive 1915(i) services, members must:

- Be currently enrolled in ND Medicaid or Medicaid Expansion
- Have income of 150% or below of the federal poverty level
- Have a qualifying behavioral health diagnosis (a list of qualifying diagnoses can be found attached to the 1915(i) Eligibility Form – [SFN 741](#))
- Have a qualifying [WHODAS 2.0](#) (World Health Organization Disability Assessment Schedule) score

1915(i) providers that assist members in applying for 1915(i) services must inform the member of other available 1915(i) providers that are available to them in their area.

The 1915(i) program may not serve individuals residing in institutions. The member's 1915(i) care coordinator will verify that the setting(s) where the member receives services is a home and community-based setting.

The care coordinator will assist eligible members with developing their 1915(i) plan of care and submit referrals to additional service providers as needed. Conflict of interest standards apply.

### **1915(i) PROVIDERS**

Interested providers must

- Enroll with ND Medicaid as a 1915(i) provider, this includes providers already enrolled with ND Medicaid. Most providers, including providers such as Federally Qualified Health Centers (FQHCs) that are generally reimbursed on an encounter basis, can provide 1915(i) services, as long as they enroll as 1915(i) providers and follow 1915(i) requirements.

- Sign a provider agreement indicating they will serve both Traditional and Expansion 1915(i) members. Meet prescribed qualifications specific to each service.
  - Individual providers must affiliate with an enrolled 1915(i) group provider.
  - Group providers are responsible for maintaining qualifications required for their group enrollment and overseeing qualifications for individuals affiliated with their group.

### **THIRD PARTY LIABILITY AND CLIENT SHARE**

1915(i) providers are not required to bill other insurances for 1915(i) services prior to billing Medicaid. It is the provider's responsibility to verify a member's Medicaid eligibility status and 1915(i) enrollment prior to providing services to the member.

Client Share is applicable to the 1915(i). Visit the 1915(i) website for all 1915(i) related resources and additional information:

<https://www.behavioralhealth.nd.gov/1915i>.

### **1915(i) Policies**

Policies specific to 1915(i) services may be found at the 1915(i) Resources page <https://www.hhs.nd.gov/1915i/resources>.

### **1915(i) SERVICES**

Prior authorization of services is required.

Remote service delivery is allowable as specified within each service. Remote support/telehealth limits, codes, and modifiers are available at <https://www.hhs.nd.gov/sites/www/files/documents/1915i/1915i%20Codes.Rates.Limits.pdf>.

Service Type	Description	Age	Billing Code	Modifier (if applicable)
Care Coordination	Coordinates participant care, develops plan of care and assists eligible members with gaining access to needed 1915(i) and other services.	0+	H2015 <sup>T</sup>	
Training and Supports for Unpaid Caregivers	Service directed to individuals providing unpaid support to a recipient of 1915(i) services. Services are provided for the purpose of preserving, educating, and supporting the family and/ or support system of the individual.	0+	H0039* <sup>T</sup>	UK
Community Transition Services	Non-recurring basic household set-up expenses for members transitioning from certain institutions to a private residence where the person is directly responsible for his or her own living expenses.	0+	T5999	
Benefits Planning	Assists eligible members considering employment with making informed decisions regarding public benefits and work incentives. Counselors are knowledgeable on public benefits, including Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid etc.	0+	H2021*	U3
Non-Medical Transportation	Assists eligible members with transportation needs to gain access to services, activities, and resources, as specified by their plan of care.	0+	T2003	
Respite	Provided to eligible members unable to care for themselves. Furnished on a short-term basis because of the absence or need for relief of persons who normally provide care for the member.	0 to 21	T5999	



Service Type	Description	Age	Billing Code	Modifier (if applicable)
Prevocational Training	Assists eligible members with developing general, non-job-task-specific strengths and skills that contribute to paid employment.	6 months prior to 18 <sup>th</sup> birthday	H2023 <sup>T</sup>	
Supported Education	Assists eligible members who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment.	5+	H2025* <sup>T</sup>	U3
Supported Employment	Assists eligible members with obtaining and keeping competitive employment at or above the minimum wage.	14+	H2025* <sup>T</sup>	U4
Housing Support Services	Assists eligible members with accessing and maintaining stable housing in the community.	6 months prior to 18 <sup>th</sup> birthday	H2021* <sup>T</sup>	U4
Family Peer Support	Delivered to families caring for an eligible member, under the age of 18, by trained and certified Peer Support Specialists with lived experience as a parent or primary caregiver who have navigated child-serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral health care needs.	0 to 18	H0038* <sup>T</sup>	UK
Peer Support	Trained and certified individuals with lived experience as recipients of behavioral health services promote hope, self-determination, and skills to eligible members to achieve long-term recovery from a behavioral health disorder.	18+	H0038 <sup>T</sup>	

\*This service can be billed for individual or group setting. If group setting is provided, modifier UA must be appended to the line and reimbursement will be 25% of the allowed amount.

<sup>T</sup>This service may be delivered remotely.

## **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)**

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ND Medicaid covers services provided by Psychiatric Residential Treatment Facilities (PRTFs) that are licensed and enrolled with ND Medicaid.

### **CERTIFICATE OF NEED**

ND Medicaid will only cover PRTF services if the member meets certificate of need (CON) criteria. The admitting facility must complete an admission review with ND Medicaid's contractor to assure the child's cares and conditions meet North Dakota's CON criteria. Additional information and CON forms are available by clicking on *Under 21 Psychiatric Providers* on the Medicaid provider manuals webpage <https://www.hhs.nd.gov/healthcare/medicaid/provider/manuals-and-guidelines>.

### **RATES FOR IN-STATE PRTFs**

The rate established for in-state PRTFs is all-inclusive for routine services. Routine services include supplies, therapies, personal supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid. Enter only the room and board charges. Do not enter ancillary charges.

### **RATES FOR OUT-OF-STATE PRTFs**

The rate for out-of-state PRTFs is based on the rate for comparable services established by the Medicaid agency in the state where the facility is located.

### **BILLING GUIDELINES**

Claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

- Revenue Code **0110** In-House Medicaid Days
- Revenue Code **0183** Leave Days

Leave days are noncovered days. Payment is not available for any day that a member does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

A facility must submit a claim for every month a member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted

immediately after the month is over. Do not bill more than one calendar month per claim.

## **QUALIFIED RESIDENTIAL TREATMENT PROGRAMS (QRTPS)**

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### **PROVIDER ENROLLMENT**

Licensed Qualified Residential Treatment Programs (QRTPs) must enroll with ND Medicaid to bill for covered services. QRTPs have the option of additionally enrolling with ND Medicaid as a clinic to affiliate providers considered “other licensed practitioners (OLPs)” by ND Medicaid – currently LCSWs, LPCCs, LPCs, LMFTs, LACs, and psychologists. OLPs may bill for any service covered by ND Medicaid that is within their scope of practice.

### **COVERED SERVICES**

ND Medicaid covers individual, group, and family counseling, and targeted case management services provided by licensed QRTPs to children enrolled in ND Medicaid while the child resides at the facility.

Refer to the Behavioral Health Rehabilitative Services chapter of this manual for information on counseling and the Targeted Case Management for Child Welfare policy at <https://www.hhs.nd.gov/healthcare/medicaid/provider/manuals-and-guidelines#collapse-accordion-4969-8>.

### **THIRD PARTY LIABILITY**

Services rendered at QRTPs are subject to Medicaid Third Party liability requirements. This means providers must bill all services to liable third parties. Medicaid is the payer of last resort. See the Third Party Liability chapter in the General Information for Providers Manual for additional information (<https://www.hhs.nd.gov/sites/www/files/documents/general-information-medicaid-provider-manual%20.pdf>).

## **BEHAVIORAL HEALTH REHABILITATIVE SERVICES**

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Behavioral Health Rehabilitative Services is a range of services including assessments, intervention, counseling, and skill introduction/improvement. Services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice according to state law for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level. Behavioral health rehabilitative services are designed to be provided on a short-term basis and in most cases, should not be considered a pattern of long-term care.

### **COVERED SERVICES**

Behavioral health rehabilitative services include behavioral intervention services that consist of developing and implementing a regimen that will reduce, modify, or eliminate undesirable behaviors and/or introducing new methods to induce alternative positive behaviors and management including improving life skills. ND Medicaid members who receive behavioral health rehabilitative services should display measurable progress in these areas through the development, implementation, and evaluation of a plan of care (more information on the plan of care is below). Specific services are outlined in the table below.

Therapy and/or treatment that involves the participation of a family member/collateral and/or other non-Medicaid eligible individual(s) is for the direct benefit of the member, in accordance with the member's needs and treatment goals identified in the member's treatment plan and for assisting the member's recovery. The general expectation is that the member would be present for the service with the non-member; however, there may be some treatment session(s) where the practitioner's judgment is not to include the member.

Service Name	Definition of Services	Billing Code
<p>Screening, Triage, and Referral Leading to Assessment</p>	<p>This service includes the brief assessment of an individual’s need for services to determine whether there are sufficient indications of behavioral health issues to warrant further evaluation. This service also includes the initial gathering of information to identify the urgency of need. This information must be collected through a face-to-face interview with the individual and may also include a telephonic interview with the family/guardian as necessary. This service includes the process of obtaining cursory historical, social, functional, psychiatric, developmental, or other information from the individual and/or family seeking services to determine whether a behavioral health issue is likely to exist and the urgency of the need. Services are available 24 hours per day, seven days per week. This service also includes the provision of appropriate triage and referrals to needed services based on the individual’s presentation and preferences as identified in the screening process.</p>	<p>H0002</p>
<p>Behavioral Assessment</p>	<p>Interview with the individual, family, staff, or other caregivers, and observation of the individual in the environment to assess identified behavioral excesses or deficits. This service involves operationally defining a behavior, identifying environmental, antecedent and consequent events, and making a hypothesis regarding the likely function or purpose of the behavior as well as formulation of therapeutic recommendations/intervention regimen.</p> <p>The assessment may be conducted over a period of a few days, depending on the individual’s needs and what is being assessed. The assessment should only be billed after it has been completed. This service is limited to two per calendar year. If additional services are medically necessary, the provider may request and receive service authorization from ND Medicaid.</p>	<p>H0031</p>
<p>Crisis Intervention</p>	<p>Emergency behavioral health therapeutic intervention intended to assist in a crisis situation. Crisis situations may be defined as an individual’s perception or experience of an event or situation that exceeds the individual’s current resources or coping mechanisms. Crisis intervention seeks to stabilize the individual’s mental state and prevent immediate harm to the individual or others in contact with that individual. Crisis intervention includes facilitating emotion regulation, safety planning, providing support, providing guidance for preventing future crisis, promoting mobilization of emotion regulation skills, implementing order, and providing protection.</p> <p>Providers rendering crisis intervention services must be available 24 hours per day, 7 days per week, if the individual needs further follow up services.</p>	<p>H2011<sup>T</sup></p>

Service Name	Definition of Services	Billing Code
Nursing Assessment and Evaluation	<p>This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out an order from a licensed practitioner within their scope of practice. This service must consider all the following items:</p> <ol style="list-style-type: none"> <li>1. Assessment to observe, monitor, and care for the physical, nutritional and psychological issues, problems or crises manifested in the course of an individual's treatment;</li> <li>2. Assessing and monitoring the individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual for a medication;</li> <li>3. Assessing and monitoring the individual's medical and other health issues that are either directly related to the mental health disorder, or to the treatment of the disorder; and</li> <li>4. When appropriate, consulting with the individual's family and significant other(s) about medical, nutritional, and other health issues related to the individual's mental health disorder.</li> </ol>	T1001
Behavioral Health Counseling and Therapy	<p>Behavioral health counseling and therapy provides individual or group counseling by a clinician for children in foster care receiving services through a qualified residential treatment program or in a therapeutic foster care home. Clinicians must be employed by or contracted through the qualified residential treatment program or the therapeutic foster care agency.</p> <p>This service is limited to one hour per child per day of individual counseling and one hour per child per day of group counseling and must be within each practitioner's scope of practice in accordance with licensure and certification. If additional services are medically necessary, the provider may request service authorization from ND Medicaid.</p> <p>Federal financial participation is not available for care or services to Medicaid members residing in an IMD.</p>	H0004* <sup>T</sup>
Individual or Group Counseling	<p>Counseling is a process through which an individual or group works with a trained therapist in a safe, caring, and confidential environment to explore their feelings, beliefs, or behaviors, work through challenging or influential memories, identify aspects of their lives that they would like to change, better understand themselves and others, set personal goals, and work toward desired change.</p> <p>Counseling is considered an individual service and if provided in a group setting, must be billed with the appropriate modifiers.</p>	H0004* <sup>T</sup>

Service Name	Definition of Services	Billing Code
<p>Intensive in-home for Children</p>	<p>This service provides the Medicaid-eligible child(ren) and their family with intensive in-home crisis intervention and family education, to prevent one or more children from being placed in out-of-home care. The service must be for the direct benefit of the Medicaid-eligible child. Services are furnished in the child’s home. Providers are on call 24 hours a day, seven days a week. Services are time-limited and providers carry a limited caseload.</p> <p>Family education is the practice of equipping family members to develop knowledge and skills that will enhance their ability to help restore the Medicaid- eligible child to the best possible functional level.</p> <p>A child is at risk if the referring agency documents the child is at risk of out-of-home placement and one or more of the following criteria is present:</p> <ul style="list-style-type: none"> <li>• Court determination for need of placement;</li> <li>• Temporary custody transferred from parents with reunification as the plan;</li> <li>• History of significant law violation, physical or sexual abuse and/or neglect, incorrigibility, delinquency, substance abuse, severe mental health issues, etc.;</li> <li>• A referral from the child and family team process;</li> <li>• Prior placement of any child from within the family unit;</li> <li>• Prior placement history of child identified in the referral;</li> <li>• Prevent adoption disruption;</li> <li>• Child protection assessment resulting in a “Services Required”; and/or</li> <li>• Earlier intervention before court order involvement to prevent placement outside the home.</li> </ul> <p>Situations not covered above will be reviewed by ND Medicaid per a recommendation and proposed care plan from Intensive In-Home Service provider and the referring agency.</p> <p>This service must take place in the home where the child resides. Parents/guardians must be physically present while the service is being delivered.</p> <p>The length of service is brief, solution-focused and outcome-based. The average length of service is usually two to six months. Services provided beyond six months will require thorough documentation in the child’s plan of care and are subject to audit.</p>	<p>S9482</p>



Service Name	Definition of Services	Billing Code
<p>Skills Restoration</p>	<p>Skills restoration is a time-limited service that assists an individual with restoring needed and desired skills such as daily living/independent living skills to improve the functional impairments affected by the individual’s behavioral health diagnoses and symptoms to meet rehabilitation goals. Skills restoration is a systematic series of instructional activities, which include a mixture of education, confirmation, and demonstration of learned skills and capacity for observed learning over time to ensure lasting results that translate to the living environment.</p> <p>Skills restoration interventions used should be based on evidence-based practice.</p> <p>Skills restoration is considered an individual service and if provided in a group setting, must be billed with the appropriate modifiers.</p> <p>Services are limited to four hours per day and must be within each practitioner’s scope of practice in accordance with licensure and certification. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.</p>	<p>H2014* «≠»</p>
<p>Skills Integration</p>	<p>A service designed to support an individual in the community in their efforts to apply and integrate those life skills that have been learned in their therapy programs. The individual typically requires support for cueing/modeling of appropriate behavioral and life skills to maximize their skills and prevent need for higher levels of care.</p> <p>The service reduces disability and restores an individual to previous functional levels by assisting the individual in ongoing utilization and application of learned skills in normalized living situations. This strengthens the skill development that has occurred and promotes skill integration in various life roles.</p> <p>Services are limited to four hours per day and must be within each practitioner’s scope of practice in accordance with licensure and certification. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.</p> <p>Skills integration is considered an individual service and if provided in a group setting, must be billed with the appropriate modifiers.</p>	<p>H2017* «≠»</p>
<p>«≠ Services provided on behalf of the member to someone other than the member must be billed with a UK modifier.»</p>		

Service Name	Definition of Services	Billing Code
Behavioral Intervention	<p>Behavioral intervention is a service to identify responsive actions by an individual to stimuli and to develop and facilitate the implementation of an intervention regimen that will reduce, modify, or eliminate undesirable responses. This intervention is a comprehensive rehabilitative service that trains new positive behaviors to replace unwanted behavior through positive reinforcement of the desired behavior (i.e. reducing anxiety through deep breathing, reducing self-harm behavior by reinforcing replacement behavior).</p> <p>This service includes the assessment of the individual and the development a Behavioral Intervention Plan. The plan is to be reviewed and modified as needed to ensure the individual receives appropriate interventions.</p> <p>Services are limited to four hours per day and must be within each practitioner’s scope of practice in accordance with licensure and certification. If additional services are medically necessary, the provider may request service authorization from the North Dakota Medicaid Program.</p>	H2019
Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care (formerly known as Forensic Interview)	<p>An assessment performed by an accredited children’s advocacy center to determine if a child has experienced abuse and/or neglect. The assessment must be recorded and is designed to elicit a child’s unique information when there are concerns of possible abuse. The assessment should lead to a recommended plan of care.</p>	99499 (must append modifier 32)

\*This service may be provided in an individual or group setting. If group setting is provided, modifier UA must be appended to the line and the reimbursement will be 25% of the allowed amount.

† Indicates the service can be delivered via telehealth. See the Telehealth chapter of the [ND Medicaid General Information for Providers Manual](#) for more information.

**BEHAVIORAL HEALTH REHABILITATIVE SERVICES & PROVIDERS**

Code	Service Name	OLPs – include LCSWs, LPCCs, LPCs, LMFTs, LACs, and psychologists	LBSW	LMSW	Licensed Exempt Psychologist	LAPC	RN	BMS	MHT
H0002	Screening, Triage, and Referral Leading to Assessment	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X	X	X	X	X	
H0031	Behavioral Assessment	OLPs may bill for covered Rehabilitative Services within their scope of practice.		X	X				
H2011 <sup>T</sup>	Crisis Intervention	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X		X	
T1001	Nursing Assessment and Evaluation	OLPs may bill for covered Rehabilitative Services within their scope of practice.					X		
H0004 <sup>*T</sup>	Behavioral Health Counseling and Therapy	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X			
H0004 <sup>*T</sup>	Individual or Group Counseling	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X			
S9482	Intensive in-home for children	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X			

Code	Service Name	OLPs – include LCSWs, LPCCs, LPCs, LMFTs, LACs, and psychologists	LBSW	LMSW	Licensed Exempt Psychologist	LAPC	RN	BMS	MHT
H2014 *‡	Skills Restoration	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X	X	X	
H2017*‡	Skills Integration	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X		X	X
H2019	Behavioral Intervention	OLPs may bill for covered Rehabilitative Services within their scope of practice.			X			X	
99499 (must append modifier 32)	Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care (formerly known as Forensic Interview)	OLPs may bill for covered Rehabilitative Services within their scope of practice.	X	X		X			
<p>* Service may be provided in individual or group setting. If group setting is provided, modifier UA must be appended to the line and the reimbursement will be 25% of the allowed amount.</p> <p>† Service may be delivered via telehealth. See the Telehealth chapter in the <u>ND Medicaid General Information for Providers Manual</u> for more info.</p> <p>«‡ Services provided on behalf of the member to someone other than the member must be billed with a UK modifier.»</p>		<p><b>ABBREVIATIONS:</b>                      BMS – Behavior Modification Specialist                      LAC – Licensed Addiction Counselor                      LAPC – Licensed Association Professional Counselor                      LBSW – Licensed Baccalaureate Social Worker                      LCSW – Licensed Clinical Social Worker                      LMFT – Licensed Marriage and Family Therapist                      LMSW – Licensed Master Social Worker                      LPC – Licensed Professional Counselor                      LPCC – Licensed Professional Clinical Counselor                      RN – Registered Nurse                      MHT – Mental Health Technician                      OLP – Other Licensed Practitioner</p>							

Services rendered must be within the enrolled practitioner's scope of practice. Providers enrolled to render behavioral health rehabilitative services are not allowed to bill service codes outside of those noted above. Providers interested in seeking ND Medicaid's approval for additional codes must submit a Technology/Procedure Assessment (SFN 905). The form is available at [www.nd.gov/eforms](http://www.nd.gov/eforms).

Medicaid-eligible children under EPSDT can receive these and all other medically necessary services.

There is no duplication of billed services.

Behavioral health rehabilitative services do not include:

- Room and board;
- Services provided to residents of institutions for mental disease (IMDs);
- Services that are covered elsewhere in the State Medicaid Plan;
- Educational, vocational and job training services;
- Recreational and social activities;
- Habilitation services; or
- Services provided to inmates of public institutions.

## **TELEHEALTH**

Only services indicated with a <sup>T</sup> in the above table may be delivered via telehealth. See the telehealth chapter of the ND Medicaid General Information for Providers Manual for additional information.

## **SERVICE AUTHORIZATION**

Requests to exceed service limits may be submitted using SFN 481 ([www.nd.gov/eforms/sfn00481.pdf](http://www.nd.gov/eforms/sfn00481.pdf)). Requests will be determined based on medical necessity, as defined at ND Administrative Code 75-02-02-03.2.10.

## **MEMBER ELIGIBILITY FOR SERVICES**

The following requirements must be met before behavioral health rehabilitative services can be provided through the Medicaid program:

- The member must be eligible for the Medicaid program.
- Other than *Screening, Triage, and Referral Leading to Assessment, Behavioral Assessment, Crisis Intervention and Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care*, the service must be recommended by a practitioner of the healing arts within the scope of their practice under state law.

- The member must need mental health or behavioral intervention services that are provided by qualified practitioners.
- The member must have at least one of the following circumstances:
  - Be at risk of entering or reentering a mental health facility or hospital and demonstrate a score of 25 or above based on the WHODAS 2.0; and/or
  - Need substance use disorder treatment services; and/or
  - Have a mental health disorder and be from a household that is in crisis and at risk of major dysfunction that could lead to disruption of the current family makeup; and/or
  - Have a mental health disorder and be in family that has experienced dysfunction that has resulted in disruption of the family.

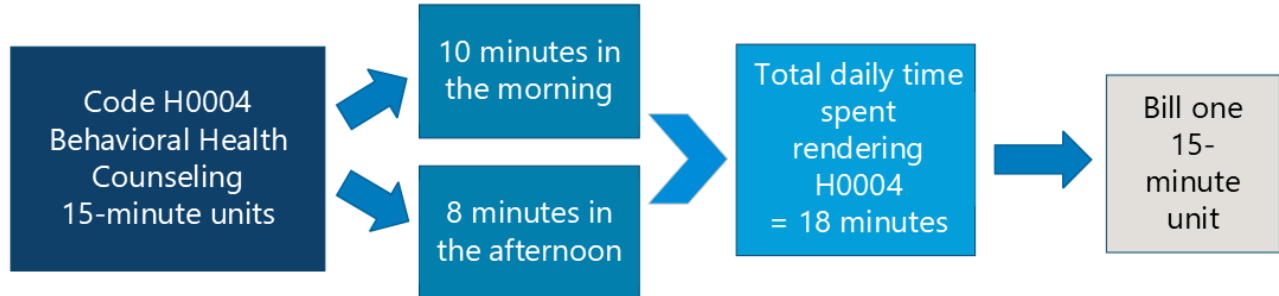
## **PLAN OF CARE**

Each member should have a primary point of contact at the entity. Identify the primary point of contact in the member's plan of care. The Plan of Care is to be initiated on the first date of service, reviewed at appropriate time intervals, and updated as the patient condition and needs require. Minimum plan of care contents are:

- Name
- Age and date of birth
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission, and discharge date)
- Narrative history or background of member
- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners providing care/services to the member
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

**«BILLING GUIDELINES**

Practitioners: When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.



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**PROVIDER QUALIFICATIONS**

Individual practitioners must meet the qualifications in the Provider Qualifications table and must be employed by an entity that has a provider agreement with ND Medicaid. The practitioner is responsible for ensuring services can be provided within their scope of practice and is responsible for maintaining the individual qualifications outlined in the table below.

Other Licensed Practitioners (OLPs) are not required to be enrolled as behavioral health rehabilitative services providers. Currently, providers considered to be OLPs include LCSWs, LPCCs, LPCs, LMFTs, LACs, and psychologists.

Practitioners who are enrolled to provide behavioral health rehabilitative services may only provide the services indicated for their practitioner type on the behavioral health rehabilitative services table. These practitioners may not bill for services under a supervising practitioner’s NPI.

Practitioners possessing a similar license/certification in a border state and operating within their scope of practice in that state may enroll to provide behavioral health rehabilitative services upon attesting to ND Medicaid of their comparable license/certification.

Practitioners who are governed by a state licensing board must follow the board’s requirements for supervision.

Provider Types	Licensure/ Certification Authority	Education/ Degree Required
Licensed Exempt Psychologist	Eligibility for licensure exemptions as determined by the ND Board of Psychologist Examiners	
Behavior Modification Specialist (BMS)		Master’s degree in psychology, social work, counseling, education, child development and family science, human services, or communication disorders. Or a bachelors’ degree in one of the above fields and two years of work experience in the respective discipline. The work experience must be in a professional setting and supervised by a licensed practitioner in a related field.
Licensed Baccalaureate Social Worker (LBSW)	Licensure as a LBSW by the ND Board of Social Work Examiners.	
Licensed Master Social Worker (LMSW)	Licensure as a LMSW by the ND Board of Social Work Examiners.	
Registered Nurse (RN)	Licensure as a RN by the ND Board of Nursing.	
Licensed Associate Professional Counselor (LAPC)	Licensure as a LAPC by the ND Board of Counselor Examiners.	
Mental Health Technician (MHT)	Certification as a Mental Health Technician and supervised by a licensed practitioner within their scope of practice.	



## SUBSTANCE USE DISORDER TREATMENT SERVICES

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Substance Use Disorder (SUD) Treatment are services provided to an individual with an impairment resulting from a SUD which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for treatment of SUD may be hospital-based or non-hospital-based.

### MEMBER ELIGIBILITY FOR SERVICES

ND Medicaid members receiving SUD treatment services must:

1. Meet diagnostic criteria for a substance use disorder as described in the DSM; and
2. Meet specifications in each of the American Society of Addiction Medicine (ASAM) dimensions required for the recommended level of care.

### COVERED SERVICES

«ASAM Level 3 <sup>rd</sup> Edition	Service	Billing Code	Revenue Code (if applicable)	«Hours per week»
1	<p><b>Outpatient Services (individual)<sup>T</sup></b> «- Adult</p> <p>Organized nonresidential service or an office practice that provides professionally directed aftercare, individual, and other addiction services to clients according to a predetermined regular schedule of fewer than 9 contact hours per week.»</p>	Use individual psychotherapy codes (professional fee schedule).	N/A	«Offer no more than 8 hours of programming per week.»
1	<p><b>«Outpatient Services (individual)<sup>T</sup> - Youth»</b></p>	Use individual psychotherapy codes (professional fee schedule).	N/A	«Offer no more than 5 hours of programming per week.»
1	<p><b>Group Outpatient Services<sup>T</sup></b></p>	<p>H2035</p> <p>«Modifier UA must be appended to the line. Reimbursement is 25% of allowed amount.»</p>	N/A	«See above hours for youth and adult.»

2.1	<p><b>Intensive Outpatient Services<sup>T</sup></b> «- Adult</p> <p>Treatment provided to clients requiring a primary, organized treatment program able to establish abstinence and recovery within the context of the client’s usual environment and daily activities. Programming is in a structured environment and is typically offered in the evening hours.»</p>	H0015	0906	«Offer no less than 8 hours and no more than 19 hours of structured programming.»
2.1	« <b>Intensive Outpatient Services</b> – Youth»			«Offer no less than 6 hours per week.»
2.5	<p><b>Partial Hospitalization Services</b> «- Youth and Adult</p> <p>SUD program that uses multidisciplinary staff and offers highly structured intensive treatment to those clients whose condition is sufficiently stable so as not to require twenty-four hour per day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.»</p>	S9475	0913	«Offer no less than 20 hours of structured programming no less than 4 days per week.»
3.1	<p><b>Clinically Managed Low-Intensity Residential Care</b> «- Youth and Adult</p> <p>ASAM 3.1 will only be reimbursed for members concurrently receiving ASAM 2.1 or 2.5.</p> <p>Twenty-four hour a day staffed, ongoing therapeutic environment for clients requiring some structured support in which treatment is directed toward</p> <ul style="list-style-type: none"> <li>• Applying recovery skills,</li> <li>• Preventing relapse,</li> <li>• Improving emotional functioning,</li> <li>• Promoting personal responsibility, and</li> <li>• Reintegrating the individual into the worlds of work, education, and family life, adaptive skills that may not have been achieved or have been diminished during the client’s active addiction.</li> </ul> <p>The residential component may be combined with low-intensity outpatient, intensive outpatient, or day treatment.»</p>	H2034	1003	«Offer at least 5 hours of professionally directed treatment (must include two support or group sessions per week) in addition to other treatment services such as partial hospitalization or intensive outpatient treatment.»

3.2	<p><b>Clinically Managed Residential Withdrawal</b></p> <p>«Detoxification in an organized residential nonmedical setting delivered by appropriately trained staff who provide safe, 24-hour monitoring, observation, and support in a supervised environment for a client to achieve initial recovery from the effects of alcohol or another drug.»</p>	H0012«^»	1003	
3.5	<p><b>Clinically Managed High-Intensity Residential Services</b> «- Youth and Adult</p> <p>«Therapeutic community or residential treatment center offering continuous observation, monitoring, and treatment by allied professional staff designed to treat clients who are not sufficiently stable to benefit from outpatient treatment no matter how intensive and who have significant psychological and social problems.</p> <p>Onsite twenty-four hour per day clinical staff with specialized professional consultation.»</p>	H2036«^»	1002	«Residential program offered no less than 7 days per week. The number of hours of programming must be approved through the licensing process by the Behavioral Health Division.»
3.7	<p><b>Medically Monitored Intensive Inpatient Services</b> «– Youth and Adult</p> <p>Program providing a planned regimen of 24-hour professionally directed</p> <ul style="list-style-type: none"> <li>• evaluation</li> <li>• observation</li> <li>• medical monitoring, and</li> <li>• addiction treatment in an inpatient setting.»</li> </ul>	H0011«^»	1002	«Offer inpatient treatment program 7 days per week.»

<sup>T</sup> Indicates the service can be delivered via telehealth. See the Telehealth Chapter of the ND Medicaid General Information for Providers Manual for more information.

«^»Payment for ASAM 3.1, 3.2, and 3.5 is only for the service component. ND Medicaid payment is not available for room and board.

«Federal financial participation is not available for care or services to Medicaid members ages 21 to 64 residing in an Institution for Mental Disease (IMD); therefore ND Medicaid does not cover services for members ages 21 to 64 who reside in an IMD.

Programs must offer the required number of hours of programming required by ND Administrative Code 75-02-09.1 and must be approved through the licensing process by the Behavioral Health Division. The appropriate number of hours for the level of care must be included in the member’s plan of care.

If the member misses programming hours, the reason must be documented. For outpatient levels of care, the provider may only bill for days that the member received programming. For residential and inpatient levels of care, the provider may bill for every day the member stayed at the facility, as long as

- the appropriate number of hours of programming are offered, as detailed in the member's care plan, and
- if the member misses programming, the reason is documented. Providers must document programming hours not offered due to a holiday.»

## **PROVIDER ENROLLMENT**

«Licensed Addiction Counselors» and licensed addiction programs may enroll as Medicaid providers for American Society of Addiction Medicine (ASAM) levels of care 1, 2.1, 2.5, 3.1, 3.2, 3.5 and 3.7 as prescribed in «North Dakota Administrative Code chapter 75-09.1.»

### **«Providers billing ASAM 1**

LACs and licensed addiction programs must enroll the LAC rendering services.

### **Providers billing ASAM 2.1-3.7**

The licensed program must enroll as a group provider **and** the attending provider must enroll. Note: Licensed addiction programs are not required to enroll all members of the multidisciplinary team.»

The rendering or attending provider must be Medicaid-enrolled «and affiliated with the billing provider.

«Enrolled LACs are OLPs and may furnish non-ASAM services within their scope of practice according to State law.»

## **BILLING GUIDELINES**

LACs billing ASAM 1 must bill on a CMS 1500 or electronically via an 837P claim transaction. The appropriate rendering provider's NPI and taxonomy must be reported in box 24J of the CMS 1500 or the electronic equivalent of the 837P transaction.

Enrolled programs providing ASAM 2.1, 2.5, 3.1, 3.2, 3.5 and 3.7 must bill

on CMS 1450 (UB 04) or electronically via an 837I claim transaction. The appropriate attending provider's name and NPI must be reported in box 76 of the CMS 1450 (UB-04) of the electronic equivalent of the 837I transaction. IHS/638 facilities and FQHCs should refer to those respective chapters of the General Information for Providers manual for further instruction on how to bill for their services.

### **«ASSESSMENT AND PLAN OF CARE**

ND Medicaid members receiving SUD treatment services must have undergone a program-performed assessment in compliance with North Dakota Administrative Code § 75-09.1-01-14.»

ND Medicaid members receiving SUD treatment services must have an individualized plan of care/treatment plan that meets the requirements of ND Administrative Code 75-09.1-01-15. The ND Medicaid-enrolled «rendering or attending» provider overseeing the services must approve the plan of care.

### **SERVICES PROVIDED WITHIN A RECOGNIZED INDIAN RESERVATION**

Licensed addiction counselors, operating within their scope of practice, performing ASAM 1, and practicing within a recognized Indian reservation in North Dakota, are not required to have licensure prescribed in North Dakota Administrative Code chapter 75-09.1 for services provided within a recognized Indian reservation in North Dakota.

### **«DEFINITIONS**

*Attending provider* – Licensed practitioner, such as an LAC, who has overall responsibility for the patient's care and treatment reported on the claim. Attending providers are reported on claims for ASAM levels 2.1 and higher, as these claims are billed on a CMS 1450 (UB 04) or electronically via an 837I claim transaction.

*Institution for Mental Diseases (IMD)* - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Social Security Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. For more information see

the IMD Policy.

*Licensed Addiction Counselor (LAC)* – LACs, for purposes of this policy, include licensed clinical addiction counselors, licensed master addiction counselors and practitioners possessing a similar license in a border state and operating within their scope of practice in that state. Licensed addiction programs operating in a border state must provide documentation to the ND Medicaid Program of their state’s approval for the operation of the addiction program.

*Program* – means a person, partnership, association, corporation, or limited liability company that establishes, conducts, or maintains a substance use disorder treatment program for the care of individuals addicted to alcohol or other drugs.

*Rendering provider* - licensed practitioner, such as a licensed addiction counselor, who renders the service. Rendering providers are reported on claims for ASAM level 1 services, as these claims are billed on a CMS 1500 or electronically via an 837P claim transaction.»