SERVICE AUTHORIZATIONS

PURPOSE

This policy contains service authorization requirements. Service authorizations are required for certain services before those services begin. Failure to obtain a required SA will result in denial of the service. Services paid without an approved SA are subject to recoupment.

> EFFECTIVE November 1, 2024, service authorizations are no longer required on most services. Service policies indicate which services still require service authorizations, please refer to individual service policies for more information.

Approved service authorizations are:

- Service and provider-specific
- Non-transferrable
- Only modifiable by written request from the provider. Modifications occur at the discretion of ND Medicaid.
    - Web-based (MMIS) SAs must be resubmitted. They cannot be altered online.

APPLICABILITY

This policy applies only to Traditional Medicaid member services which require service authorizations.

DEFINITIONS

Medicaid Management Information System (MMIS) – means North Dakota Medicaid's claims processing and information system. 1915(i) providers will enter service authorizations and claims into MMIS.

Place of Service (POS) Codes – means codes that identify the location a provider renders a service to members. Service authorizations require identification of at least one POS code where most services are expected to be rendered.

Requested Begin Date – anticipated start date of services.

Requested End Date – date services are anticipated to end.

Service authorization

Traditional Medicaid – means non-Expansion Medicaid. Expansion Medicaid is through our Managed Care Organization, Blue Cross Blue Shield ND.

SERVICE AUTHORIZATION (SA) REQUIREMENTS

- Multiple services can be included on one service authorization request.
- Each claim can only have one service authorization.
- A member's plan of care must be submitted with a service authorization.
- Service authorization numbers must be on all provider claims.
- Service authorizations must be approved by 1915(i) staff.

SA BEGIN DATE AND END DATES

Requested Begin Date: Providers will enter the anticipated start date of services. The requested begin date cannot be dated prior to the submission date of the service authorization request.

Service authorization approval or denial will be dated the date the authorization was submitted in MMIS by the provider, regardless of the requested begin date. Providers will not be reimbursed for services provided prior to the service authorization approval date.
See Retroactive Service Authorizations below for exceptions.

Requested End Date: The maximum time period a service authorization can be requested is to the end of the individual's 1915(i) eligibility period. The date of the end of the individual's 1915(i) eligibility period is generally available in the member's POC attachments in Therap. If needed, it can be obtained from the Customer Support Center.

Request Extending into Two Calendar Years: When the service authorization dates extend into two calendar years (i.e. 12/1/2022 - 11/30/2023), two service lines are required for the service requested with the calculated units requested.

For example: Line one dates of service: 12/1/2022-12/31/2022. Line two dates of service: 1/1/2023-11/30/2023.

RETROACTIVE SERVICE AUTHORIZATIONS

Retroactive or back-dating of service authorization requests are not allowed except in the following circumstances:

1. a member's Traditional Medicaid eligibility changes to Medicaid Expansion,
2. a member's Medicaid Expansion eligibility changes to Traditional Medicaid, and
3. urgent conditions with good cause.

Member's Traditional Medicaid Eligibility Changes to Medicaid Expansion: ND Medicaid will allow for retroactive eligibility to occur within a 12-month period. ND Medicaid will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional or Expansion coverage type to the other and in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate. In such circumstance, either coverage

type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

For example: A provider confirms a member's Traditional Medicaid eligibility on February 1st. The provider completes the service authorization submission process. The providers continue to check the Traditional member's eligibility prior to providing each service and provides services through April 1st.

On April 1st, it is discovered that the member's eligibility status had actually changed from Traditional to Expansion on March 1st. The Retroactive Eligibility Allowance will allow for the provider to submit service authorizations dated back to March 1st to the MCO for authorization. The provider will then submit claims for services dating back to March 1st when the member became Expansion eligible to the MCO for reimbursement.

Member's Medicaid Expansion Eligibility Changes to Traditional Medicaid: ND Medicaid allows for retroactive eligibility to occur within a 12-month period. ND Medicaid will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional or Expansion coverage type to the other and in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate. In such circumstance, either coverage type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

For example: A provider confirms the member's Expansion eligibility on February 1st. The provider completes the MCO's POC and service authorization submission process. The provider continues to check the Expansion member's eligibility prior to providing each service and provides services through April 1st.

On April 1st, it is discovered that the member's eligibility status had actually changed from Expansion to Traditional on March 1st. The Retroactive Eligibility Allowance will allow for the provider to submit the POC and service authorizations dated back to March 1st to the SMA for authorization. The provider will then submit claims for services dating back to March 1st when the member became Medicaid Traditional eligible to the SMA for reimbursement.

Urgent Conditions: Retroactive service authorizations due to urgent conditions with good cause may be submitted for consideration with a retroactive begin date of up to ninety (90) calendar days from the date the SFN 741 1915(i) Eligibility Application was submitted.

Retroactive requests past 90 calendar days from the date the SFN 741 1915(i) Eligibility Application was submitted will be approved from the date the

authorization was submitted in MMIS. Providers will not be reimbursed for services provided prior to the service authorization approval date.

If a member is determined ineligible for the 1915(i), Medicaid will not pay provider claims.

DOCUMENTATION

Before submitting SA documentation, please:

- Include relevant information to support the SA (i.e. the POC).
- Match requested date spans on all forms and documents.

Requests not meeting these criteria may be returned, denied, or rejected as incomplete. Providers may include letters or narrative with their request for service authorization; however, information supplied in a letter or narrative does not supplant the need for documentation supporting medical necessity in the medical record.

RESUBMISSIONS

Re-submissions will need to be updated for dates, documentation, and orders so they are current and complete. ND Medicaid does not keep documentation from earlier submissions. Decisions will be based on the newest date of submission.

DENIED SA REQUESTS

ND Medicaid includes an explanation of the reason for denial as well as instructions for Medicaid members to appeal within # of days. Provider may resubmit with updated POC at any time.

SA APPROVAL/DENIAL DATES

The date of service authorization submittal into MMIS is the date of approval or denial for the service authorization.

Providers who receive a denial for a service authorization request due to a submission error can resubmit an entirely new request with necessary corrections; denied requests cannot be amended.

APPEALING A DENIED SERVICE AUTHORIZATION

Members may request reconsideration of a denied service authorization if done in writing within 30 days from the date of the denial. Members must contact their provider and ask them to submit additional written information regarding the medical need for a service to ND Medicaid for reconsideration. Medicaid will reconsider the request, decide, and notify both the member and provider of its decision.

Members may also request a hearing if they believe ND Medicaid has made an error in denying the request for services. Requests for a hearing must be made by members in writing within 30 days from the date of the denial. Send hearing requests to:

Department of Human Services Attn: Appeals Supervisor 600 E Blvd Ave Dept 325 Bismarck ND 58505 0250 Fax: (701) 328-2173 E-mail: dhslau@nd.gov

The purpose of the hearing is to give members an opportunity to show Medicaid made an error in denying the service rather than dispute established program limits. Sufficient medical evidence must be provided to show that a service is medically necessary and an error was made.

1915(i) SERVICE LIMITS & CODES

See the Service Limits and Codes Spreadsheet located on the 1915(i) website for information you will need to complete service authorization requests.

The spreadsheet identifies the following for each of the 1915(i) services:

- **Description** – Brief description of the service.
- **Age -** Each service has specific age requirements.
- **Rate Type -** Each service has one or more rate types associated with it. Unit or monetary are examples of the various rate types.
- **Code and Modifier -** The "code" is referred to as the procedure code when entering service authorizations into MMIS.

  Each rate type within a service will have a code, and sometimes a modifier, associated with it. When there are multiple components to a service, each component will have its own code.
- **Service Limits -** Each service has one or more limits assigned to it.
- **Remote Support/Telehealth Limits, Codes & Modifier -** The majority of services allow remote service delivery with the established limits.
- **Provider Type -** The provider type for 1915(i) services is 049.
- **Specialty Code -** Each service has a specialty code associated with it.
- **Group Taxonomy -** A group taxonomy code is assigned to the group provider of each service.
- **Individual Taxonomy -** An individual taxonomy code is assigned to the individual provider of each service.
- **NPI Number -** Each group and individual provider must obtain a National provider ID (NPI).