SERVICE AUTHORIZATIONS

PURPOSE

Service authorizations (SA) are required for certain procedures, services, and items before being initiated, supplied, or performed. Failure to obtain a required SA will result in denial of the service or supply. Services or supplies paid without an approved SA are subject to recoupment.

Please review specific service policies or manuals for individual service authorization requirements. A list of services requiring service authorizations can be found here.

Approved service authorizations are:

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

DOCUMENTATION

Before submitting SA documentation, please:

- Ensure forms are complete and accurate.
- Include relevant information to support the SA. Highlighting documentation that specifically supports the SA's medical necessity will expedite the review process.
- Matching requested date spans on all forms and documents.
- Order/referral dates related to the SA requested dates.
- Medical documentation, including medical records, to support medical necessity.
- Other documentation required by ND Medicaid as listed in the service authorization criteria.

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.

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. Providers must include documentation supporting good cause in their request for consideration of a retroactive service authorization.

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

SUBMISSION
Service authorization forms can be found here. For Durable Medical Equipment Service Authorizations, please see these instructions for submitting through the MMIS Web Portal. Please follow directions on the service authorization form for proper submission.

ND Medicaid considers timely, retroactive, or extension SA requests if all required forms and supporting information are submitted. Incomplete submissions will be returned or denied.

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 new medical records or documentation at any time.

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.