

North Dakota Crime Victim Compensation Program (CVC) Mental Health Treatment Policy and Provider Verification Form

Mental Health Treatment Policy – This policy and provider verification form is to be given to the mental health provider treating the Claimant for the crime-related incident. The Provider Verification Form portion is to be returned with the billing invoice for reimbursement of services to the CVC program.

NOTE: The Claimant has received an Administrative Notice of Decision from the CVC program indicating the benefits approved. The Claimant should provide a copy of the Administrative Notice of Decision to the provider who is providing treatment services for the related crime incident.

Provider Qualifications

The North Dakota Crime Victim Compensation Program may provide compensation for mental health services if the provider meets one of the following criteria:

1. Holds a master's degree in counseling, psychology, social work, or a related field and is licensed or certified as a professional counselor, social worker, or therapist.
2. Holds a doctor's degree and is licensed or certified as a professional counselor, social worker, or therapist.
3. Is a student intern in an accredited graduate program supervised by a licensed clinician.
4. Is a licensed public or private hospital, clinic, or treatment facility.

Verification Requirements

A request for compensation for mental health services must include:

- A billing statement of itemized transactions containing the provider's name, business address, and telephone number.
- A treatment plan detailing the services provided. The provider verification portion below is sufficient for treatment plan.
- Other necessary information to determine if the services are directly related to the criminally injurious conduct.
- The provider's verification that the services rendered were directly related to the criminally injurious conduct and the number of treatment sessions necessary.

Treatment and Payment Limitations

Compensation for mental health services is subject to the following limitations:

1. **Covered Services:** Assessment, diagnosis, and treatment, including individual or group counseling sessions.
2. **Time and Session Limits:** Treatment must occur within a two-year period beginning on the date of the first session and is subject to the following limits:
 - **Adult victims:** Maximum of 30 sessions; total compensation may not exceed \$3,600.
 - **Minor victims:** Maximum of 40 sessions; total compensation may not exceed \$4,800.
 - **Individuals present at the crime scene or who discovered a homicide victim's body:** Maximum of 10 sessions; total compensation may not exceed \$1,200.
 - **Parent or guardian of a homicide victim:** Maximum of 10 sessions; total compensation may not exceed \$1,200.
 - **Parent or guardian of a minor victim:** Maximum of 10 sessions; total compensation may not exceed \$1,200.
 - **Additional Sessions:** If a provider substantiates the need for additional sessions, up to 10 additional sessions may be allowed, with an increased total compensation of up to \$1,200. These additional sessions must still fall within the two-year treatment period.

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3. Exclusions:

- Compensation will not be provided for mental health services used to determine a child's custody.
- Compensation will not be provided if the victim or claimant fails to comply with prescribed treatment or treatment recommendations.

4. Payments:

- Providers are reimbursed at 80 percent of patient responsibility amount or the percentage of time (if less than 80 percent) dedicated to counseling the victim specifically for crime-related matters. The 80 percent limitation is not applicable to providers who utilize a sliding fee schedule.

Provider Verification Form:

This form should accompany the services provided and submitted with invoices or billing statements showing itemized transactions. Invoices or statements showing itemized transactions can be submitted monthly or quarterly for reimbursement. **Incomplete form will result in denied payment of services.**

Provider Information

Provider Name: _____

Clinician: _____

Supervising Clinician (if applicable): _____

Telephone Number: _____

Please indicate the percentage of time dedicated to counseling the victim specifically for crime-related matters, excluding any pre-existing or concurrent conditions unrelated to the crime. _____% **(this must be completed)**

Patient Information

CVC Case Number or Victim Name: _____

Date of First Session: _____

Date of Last Session: _____

Diagnosis Code(s): _____

Number of Sessions Provided: _____

Treatment Verification:

I, _____ (clinician name), verify that the mental health services provided to the above-named victim or CVC Case Number listed are directly related to the criminally injurious conduct. I confirm that the treatment sessions are necessary for the patient's well-being and fall within the guidelines outlined in the North Dakota Crime Victim Compensation Program policy.

Clinician's Signature: _____ **Date:** _____