



PROVIDER MANUAL

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NORTH
Dakota | Health & Human Services
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DEVELOPMENTAL DISABILITIES SECTION

1237 W. Divide Ave, Suite 1A

Bismarck ND 58501-1208

701.328.8930 | 711 (TTY)

dhsddreg@nd.gov

Table of Contents

SECTION I - INTRODUCTION	5
TRADITIONAL IID/DD HCBS WAIVER	5
MEDICAID STATE PLAN SERVICES	5
GENERAL FUND SERVICES	5
SECTION II - INDIVIDUAL ELIGIBILITY & ENROLLMENT	6
BIRTH THROUGH AGE TWO (NDAC 75-04-06-04)	6
AGE THREE AND UP (NDAC 75-04-06)	7
NOTIFICATION OF INDIVIDUAL ELIGIBILITY	8
TRADITIONAL IID/DD HCBS WAIVER	8
MEDICAID STATE PLAN SERVICES	9
GENERAL FUND SERVICES	9
SECTION III - SERVICES	10
TRADITIONAL IID/DD HCBS WAIVER	10
MEDICAID STATE PLAN SERVICES	10
GENERAL FUND SERVICES	10
SECTION IV - TERMINATION OF SERVICES	11
PROCEDURES PERTAINING TO DD LICENSED PROVIDERS VOLUNTARY DISCHARGE BY INDIVIDUAL	11
PROCEDURES PERTAINING TO DD LICENSED PROVIDERS INVOLUNTARY DISCHARGE OF INDIVIDUAL	11
TERMINATION PROCEDURES PERTAINING TO DD LICENSED PROVIDER	13
TERMINATION PROCEDURES PERTAINING TO QUALIFIED SERVICE PROVIDERS (QSPs)	13
SECTION V - DD PROVIDER LICENSING & ENROLLMENT	14
AGENCY LICENSING PROCESS	14
New Providers	14
Existing DD Providers/Annual Renewal/New Services	16
Change in Licensure	17
ACCREDITATION	18
DD LICENSED PROVIDER ENROLLMENT	19

QUALIFIED SERVICE PROVIDER (QSP) ENROLLMENT FOR TRADITIONAL IID/DD HCBS WAIVER SERVICES (HOMEMAKER & ADULT FOSTER CARE)	19
--	-----------

SECTION VI - PROVIDER REQUIREMENTS	20
---	-----------

INFORMING INDIVIDUALS OF THEIR RIGHTS	21
CONFIDENTIALITY REQUIREMENTS	21
CERTIFICATION	21
REQUIREMENTS FOR DD LICENSED PROVIDERS	22
PROVIDER INTEGRITY AUDIT	22
BUILDING DESIGN AND SAFETY REQUIREMENTS	22
INDIVIDUAL DOCUMENTATION AND REPORTING FOR DD LICENSED PROVIDERS	23
THERAP SOFTWARE	23
ABUSE AND NEGLECT REPORTING	24
DAY-TO-DAY MONITORING	24
PROVIDER SURVEY	24
ELECTRONIC VISIT VERIFICATION (EVV)	25
VIRTUAL SUPPORTS	26
HOME AND COMMUNITY BASED SERVICES IN ACUTE CARE HOSPITAL SETTING	27

SECTION VII - CENTER FOR MEDICARE AND MEDICAID (CMS) FINAL HOME AND COMMUNITY-BASED SERVICES (HCBS) RULES	29
--	-----------

SETTING REQUIREMENTS	29
PERSON-CENTERED SERVICE PLANNING REQUIREMENTS	30
ASSURING INITIAL COMPLIANCE	30
New Home and Community-Based Settings	30
Heightened Scrutiny	30
ASSURING ON-GOING COMPLIANCE	31
Provider Responsibilities	31
DD Program Manager Responsibilities	32
DD Section Responsibilities	32

SECTION VIII - SERVICE PLANNING	33
--	-----------

SECTION IX – STANDARDIZED ASSESSMENTS FOR RESOURCE ALLOCATION	34
--	-----------

SECTION X - AUTHORIZATION OF SERVICES	35
--	-----------

RESIDENTIAL HABILITATION, INDEPENDENT HABILITATION, DAY HABILITATION, PREVOCATIONAL SERVICES, INDIVIDUAL EMPLOYMENT, SMALL GROUP EMPLOYMENT, AND INTERMEDIATE CARE FACILITIES	35
IN-HOME SUPPORTS, PARENTING SUPPORTS, EXTENDED HOME HEALTH CARE (EHHC)	35
RESPITE	35
COMMUNITY TRANSITION SERVICES	35
SELF-DIRECTED SUPPORTS	35
ADULT FOSTER CARE (AFC), ADULT FOSTER CARE (AFC) RESPITE, & HOMEMAKER	36
INFANT DEVELOPMENT	36
PERSONAL CARE	36
SECTION 11 SERVICES	36
APPEALS	36

SECTION XI - RATES & BILLING GUIDANCE **38**

RATES	38
Residential Habilitation	38
Intermediate Care Facility (ICF/IID)	39
Independent Habilitation	40
Day Habilitation, Prevocational Services, Individual and Small Group Supported Employment, and Parenting Support	40
Adult Foster Care (AFC)	40
In-Home Supports	40
Respite	41
Family Care Option, Parenting Supports, and Extended Home Health Care	41
Community Transition Services	41
Homemaker Services	41
Infant Development Services	41
Self-Directed Supports	41
Additional considerations for Residential Habitation and ICF/IID services	42
Medical Acuity Payment Tiers	42
BILLING GUIDANCE	43

SECTION XII – DD SECTION INFORMATION **44**

SECTION XIII – SERVICE DESCRIPTIONS - APPENDIX A **45**

SECTION XIV – RATE GUIDELINES AND MATRIX - APPENDIX B **73**

SECTION XV – HE MMIS ENROLLMENT AND CLAIM SUBMISSION (VIA THERAPY OR MMIS PORTAL) - APPENDIX C **76**

SECTION XVI – LICENSING HANDBOOK & FORMS – APPENDIX D **118**

SECTION I - INTRODUCTION

This manual functions as a primary reference document for DD licensed providers delivering services covered by North Dakota's Department of Health and Human Services' ("Department") Developmental Disabilities Section ("DD Section"). The DD Section provides support and training to individuals and families in order to maximize community and family inclusion, independence, and self-sufficiency. The DD Section contracts with private, nonprofit, and for-profit organizations to provide an array of residential services, day services, and family support services.

This manual is intended to complement the federal and state rules and regulations, not to supplant it. Any lack of clarity or apparent conflict among the documents is certainly unintended. Should the reader observe such a situation, the federal and state rules and regulations are the final authority.

Traditional IID/DD HCBS Waiver

The Traditional Individuals Intellectual Disabilities/Developmental Disability Home and Community-Based Services Waiver ("Traditional IID/DD HCBS Waiver"), approved by the federal government, allows the state to use Medicaid funding to provide an array of services that allow eligible individuals of all ages the opportunity to receive home-and community-based alternatives to institutional placement. Services provided through the Traditional IID/DD HCBS Waiver are designed to support each individual's full access to the greater community, including opportunities to engage in community life and work in integrated employment settings. Services are arranged through a person-centered planning process that focuses on each individual's personal goals, support needs, and preferences.

You can view the waiver at the Developmental Disabilities website.

<https://www.hhs.nd.gov/dd>

Medicaid State Plan Services

Individuals who are eligible for Medicaid may also be eligible to receive services under the Medicaid State Plan. The Medicaid State Plan, approved by the federal government, provides traditional medical services such as physician services, lab, hospital, dental, occupational therapy, physical therapy, speech therapy, home health care, etc. Eligibility is determined by the Human Service Zone local office. In addition, Developmental Disabilities Program Managers (DDPMs) can assist eligible individuals to access services under the Medicaid State Plan, such as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) or personal care services.

For details on individual eligibility, covered services, and service limitations, refer to the Human Service Zone local office at <https://www.hhs.nd.gov/human-service/zones> and document available at <https://www.hhs.nd.gov/healthcare-coverage/medicaid>.

General Fund Services

General funds, approved by the North Dakota Legislature, are appropriated in limited circumstances only when a service does not qualify for federal Medicaid financial participation or an individual does not qualify for the ICF/IID level of care. For licensing, enrollment, and service authorization procedures, contact the local Regional Human Service Center.

SECTION II - INDIVIDUAL ELIGIBILITY & ENROLLMENT

ACCESS TO SERVICES

The Developmental Disabilities Program Manager (DDPM) has primary responsibility to provide assistance and support to individuals with an intellectual or developmental disability, or a related condition. The DDPM is an employee of the State of North Dakota Department of Health and Human Services. They are in one of the eight regional human service centers across the state. The DDPM is responsible to conduct activities such as intake, determination of eligibility including level of care determinations, assessment of service needs and referral to service providers. The DDPM monitors the plan and the provision of services to ensure that the supports meet the individual's needs and preferences and are delivered according to the individual's approved service plan. DD Program Management is claimed as an administrative activity through Medicaid under the waiver for specific activities. Targeted Case Management may be provided under the Medicaid State Plan for individuals receiving Personal Care under the MSP and no waiver services.

Link to regional human service centers: <https://www.hhs.nd.gov/dd-offices>

The criteria used to determine eligibility for IID/DD Medicaid services and IID/DD Program Management services are different. An individual may be eligible for IID/DD Program Management per North Dakota Administrative Code (NDAC) 75-04-06 but may not meet the criteria for services covered by Medicaid.

In these situations, the individual would be eligible to receive the service of DD Program Management, but could not access Title XIX Medicaid funding, i.e. Traditional IID/DD HCBS Waiver or Medicaid State Plan (MSP) services.

Link to DDPM eligibility process:

<https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/11.1.b.%20%20Process%20to%20Obtain%20DDPM%20and%20DD%20Services%209.28.23.pdf>

Birth through Age Two (NDAC 75-04-06-04)

1) Service eligibility for children from birth through age two is based on distinct and separate criteria designed to enable preventive services to be delivered. Young children may have conditions which could result in substantial functional limitations if early and appropriate intervention is not provided. The collective professional judgment of the team must be exercised to determine whether the child is high risk or developmentally delayed, and if the child may need early intervention services. If a child, from birth through age two, is either high risk or developmentally delayed, the child may be included on the caseload of an intellectual disabilities-developmental disabilities case manager and considered for those services designed to meet specific needs. Eligibility for continued service inclusion through intellectual disabilities-developmental disabilities case management must be redetermined by age three using criteria specified in section 75-04-06-02.1.

2) For purposes of this section:

- a. "Developmentally delayed" means a child, from birth through age two:
- (1) Who is performing twenty-five percent below age norms in two or more of the following areas:
 - (a) Cognitive development;
 - (b) Gross motor development;
 - (c) Fine motor development;
 - (d) Sensory processing (hearing, vision, haptic);
 - (e) Communication development (expressive or receptive);
 - (f) Social or emotional development; or
 - (g) Adaptive development; or
 - (2) Who is performing at fifty percent below age norms in one or more of the following areas:
 - (a) Cognitive development;
 - (b) Physical development, including vision and hearing;
 - (c) Communication development (expressive and receptive);
 - (d) Social or emotional development; or
 - (e) Adaptive development.
- b. "High risk" means a child, from birth through age two:
- (1) Who, based on a diagnosed physical or mental condition, has a high probability of becoming developmentally delayed; or
 - (2) Who, based on informed clinical opinion which is documented by qualitative and quantitative evaluation information, has a high probability of becoming developmentally delayed.

Age Three and Up (NDAC 75-04-06)

An individual is eligible for IID/DD Program Management services if he or she meets one of the three following criteria:

- 1) The individual has been diagnosed by an appropriately licensed professional with an intellectual disability, which is severe enough to constitute a developmental disability in accordance with the definition of developmental disability in North Dakota Century Code section 25-01.2-01;
- 2) The individual has been diagnosed by an appropriately licensed professional with a condition of intellectual disability, which is not severe enough to constitute a developmental disability, and the individual must be able to benefit from treatment and services; or
- 3) The individual has a condition, other than mental illness, severe enough to constitute a developmental disability, which results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with the condition of intellectual disability, and the individual must be able to benefit from services and intervention techniques which are so closely related to those applied to an individual with the condition of intellectual disability that provision is appropriate.

In order to assess an individual's eligibility, a DDPM will meet with the individual and legal decision maker to collect intake information to determine service needs, which includes completing the Progress

Assessment Review (PAR). The PAR is the tool used to determine if the individual meets ICF/IID Level of Care. The Regional Eligibility Team, comprised of at least three professionals at the Regional Human Service Center, is responsible for determining eligibility under NDAC 75-04-06.

Notification of Individual Eligibility

If an applicant is found to be eligible for IID/DD services, the DDPM contacts the individual to assist in selecting appropriate services and DD providers. Upon selection of services and providers, the DDPM refers the individual to the preferred providers to begin receiving services. Upon receiving a referral, the DD provider communicates with the DDPM on the agency's decision to provide their services.

If an applicant is determined not eligible for IID/DD services, the DDPM provides the applicant with a written notification of denial, which includes the reason for ineligibility and their right to appeal the decision.¹

All DD providers can confirm a individual's eligibility for services by:

- 1) *Contacting a DDPM at the appropriate Regional Human Service Center.*
- 2) *Referencing the individual's service plan.* The provider should check the frequency, amount, and funding source of the services prior to delivery.
- 3) *Contacting the AVR system (1-877-328-7098) to check the individual's Medicaid eligibility status.* It is recommended that the DD provider check the Medicaid eligibility at least once a month to ensure the individual remains eligible.

Traditional IID/DD HCBS Waiver

The number of individuals served under the Traditional IID/DD HCBS Waiver is limited to the capacity specified in the federally approved Traditional IID/DD HCBS Waiver. An eligible individual must meet all the following criteria:

- 1) Be a resident of North Dakota and be living in North Dakota;
- 2) Be eligible for North Dakota Medicaid;
- 3) Meet the eligibility criteria in NDAC 75-04-06;
- 4) Meet the ICF/IID level of care; and
- 5) Be in need of at least one monthly Traditional IID/DD HCBS Waiver service.

Along with eligibility under NDAC 75-04-06, a DDPM will complete the PAR to determine if the individual meets the criteria for ICF/IID level of care to access federal Medicaid funding under the Traditional IID/DD HCBS Waiver. The individual's PAR level ("the HCBS indicator") will determine if the individual is eligible for the ICF/IID level of care to access the Traditional IID/DD HCBS Waiver. If the individual is not already receiving Medicaid, the DDPM will assist the individual in the application process.

¹ Medicaid recipients have certain rights under the law and must be informed of their right to appeal whenever a service is denied, reduced, suspended or terminated or whenever they are denied the choice of Traditional IID/DD HCBS Waiver services or choice of qualified providers.

Eligible individuals will be enrolled in the Traditional IID/DD HCBS Waiver on a first-come, first-served basis until the Traditional IID/DD HCBS Waiver capacity is reached, excluding any reserved slots. When the enrollment capacity has been reached, the DD Section will keep a waiting list based on the date of application.

Medicaid State Plan Services

The Human Service Zone local office determines financial eligibility for Medicaid Health Care Coverage. Depending on an individual's amount of income (or for children, on their parent(s) or legal decision maker's income), individuals may be eligible for full Medicaid benefits or may be responsible for a portion of their medical bills, which is called their recipient liability. General Medicaid income eligibility levels change annually, and can be found on the DHHS website: <https://www.hhs.nd.gov/eligibility-and-how-apply>.

General Fund Services

In order to access services in this section, an individual must be eligible for DD Program Management per NDAC 75-04-06 and have a need for the service(s).

SECTION III - SERVICES

Traditional IID/DD HCBS Waiver

Below is a list of the provider-managed and self-directed services available under the Traditional IID/DD HCBS Waiver for eligible individuals.

For detailed information on covered services, service limitations, individual eligibility, DD provider qualifications, and recordkeeping requirements for each service, refer to the ***“Service Descriptions”- Appendix A.***

Provider-Managed Services Delivered by DD Licensed Providers

- Day Habilitation
- Independent Habilitation
- Individual Employment Supports
- Prevocational Services
- Residential Habilitation
- Small Group Employment Supports
- Family Support Services
 - In-Home Supports (IHS)
 - Family Care Option (FCO)
 - Extended Home Health Care (EHHC)
 - Parenting Supports
 - Respite
- Infant Development (ID)
- Community Transition Services

Provider-Managed Services Delivered by Qualified Service Providers (QSPs)

- Adult Foster Care (AFC)
 - Adult Foster Care (AFC) Respite
- Homemaker

Self-Directed Services

- Behavioral Consultation
- Environmental Modifications
- Equipment and Supplies
- In-Home Supports (IHS)
- Respite

Medicaid State Plan Services

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Personal Care Services

General Fund Services

- Corporate Guardianship
- Section 11 Funds

SECTION IV - TERMINATION OF SERVICES

This section details the procedure for termination of Traditional IID/DD HCBS Waiver, Medicaid State Plan, and General Fund.

Procedures Pertaining to DD Licensed Providers Voluntary Discharge by Individual

Individuals and/or their legal decision makers have the right to choose to participate in services and to select between services and providers. A voluntary discharge is when an individual chooses to exit services and/or chooses another DD licensed provider.

An in-person team meeting will be offered by the Program Coordinator prior to the termination of services. The individual and/or their legal decision maker will be invited to attend although they may choose not to. If a meeting is held, the following agenda items will be covered, and any discussion documented.

In any event, the DD licensed provider will write a “Discharge Summary” addressing each of the following areas:

- 1) Brief recapitulation of findings, events, and progress during the period of service to the individual;
- 2) Reasons for the discharge;
- 3) Potential impact the discharge may have on the individual;
- 4) Opportunities to prevent discharge, specific recommendations, and arrangements for alternative services; and
- 5) Termination of services on the Individual Service Plan (ISP) and Overall Service Plan (OSP).

The updated OSP that documents the discharge meeting and/or the Discharge Summary must be submitted to the individual and/or legal decision maker and DDPM within 10 business days following the meeting.

When an individual’s services are permanently terminated from a provider, the provider agency must unenroll the individual from the program(s) and must “discharge” the individual from Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the individual’s Therap file and information after the date of discharge from the provider.

Procedures Pertaining to DD Licensed Providers Involuntary Discharge of Individual

Involuntary discharge occurs when a DD licensed provider has decided to discontinue services and terminate supports even though the individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. DD licensed providers must have written policies and procedures that define the conditions of termination and transfer of individual services. Individuals and/or legal decision makers should receive

a copy of the provider's policy at the time of admission to the provider agency and again when discharge is being considered.

In the case of an involuntary discharge, the DD licensed provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting, and complete a written discharge summary. The written discharge notice must include the reason for the discharge, why the provider cannot continue to serve the individual, the provider's grievance policy, and the individual's right to appeal the provider's decision within the provider agency. A copy of this written discharge notice must be forwarded to the Developmental Disabilities Regional Program Administrator (DDRPA).

Any opportunities to prevent discharge and preserve the person's placement should be explored prior to the discharge by the provider. This includes contact with the regional Behavior Analyst and Clinical Assistance, Respite, and Evaluation Services (CAREs) team to request formal consultation and technical assistance. CAREs consultation is available for challenging behaviors and/or medical conditions. The request for additional assistance should be made as soon as the provider and team members are aware that the placement may be compromised. Seeking services from the CAREs team when concerns have been ongoing, and discharge is imminent is not acceptable.

The DD licensed provider must schedule an in-person team meeting and the meeting must be held before the provider issues the written 30-day discharge notice. It is the responsibility of the Program Coordinator to schedule the meeting. Participants must include the person and/or legal decision maker, DD Program Manager, and other team members.

The following agenda items should be covered during the discharge meeting and write a "Discharge Summary" addressing each of the following areas:

- a. Brief recapitulation of findings, events, and progress during the period of service to the individual;
- b. Reasons for the discharge;
- c. Potential impact the discharge may have on the individual; and
- d. Opportunities to prevent discharge, specific recommendations, and arrangements for alternative services.

The provider is responsible for documenting all discussions and decisions made during the discharge planning meeting in the individual's OSP. Following the meeting, the DD licensed provider must also prepare a "Discharge Summary". The discharge summary and the updated OSP must be submitted to the individual and/or the legal decision maker and the DDPM within ten (10) business days following the discharge meeting.

When an individual's services are permanently terminated from a provider, including death, the provider agency must unenroll the individual from the program(s) and must "discharge" the individual from Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the individual's Therap file and information after the date of discharge from the provider. If the individual dies while receiving services in an ICF, the provider may want to print off documentation before "discharge" of the individual in Therap, for Title XIX reviews.

Termination Procedures Pertaining to DD Licensed Provider

The Department may deny a license to an applicant or revoke an existing license upon a finding of noncompliance with the rules of the Department.

1. If the Department denies a license, the applicant may not reapply for a license for a period of six months from the date of denial. After the six-month period has elapsed, the applicant may submit a new application to the Department.
2. If the Department revokes a license, the licensee may not reapply for a license for a period of one year from the date of the revocation. After the one-year period has elapsed, the licensee may submit a new application to the Department.
3. A license denial or revocation may affect all or some of the services and facilities operated by a licensee, as determined by the Department.

Termination Procedures Pertaining to Qualified Service Providers (QSPs)

QSPs may be terminated by Medical Services/HCBS with input from Legal & the Fraud Unit. Basis for termination may include nonperformance of standard care, insufficient competencies, fraudulent billing practices, and abuse, neglect, or exploitation of a recipient. Reference NDAC 75-03-23-08 for additional information. QSPs may appeal such termination in accordance with NDAC 75-01-03.

SECTION V - DD PROVIDER LICENSING & ENROLLMENT

As stated in NDAC 75-04-01-18 “services provided to individuals eligible per NDAC 75-04-06 for Developmental Disabilities Program Management must be identified and licensed”.

The following services are subject to licensure through the DD Section:

- Residential Habilitation
- Day Habilitation
- Independent Habilitation
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Employment Supports
 - Small Group Employment Support
 - Individual Employment Support
- Prevocational Services
- Family Support Services
 - Parenting Supports
 - In-Home Supports (IHS)
 - Extended Home Health Care (EHHC)
 - Family Care Option (FCO)
 - Respite
- Infant Development (ID)
- Community Transition Services

Agency Licensing Process

New Providers

Providers that are not currently licensed by the DD Section to provide services to eligible individuals will be required to complete the following items:

- 1) Letter of Intent (SFN 1793)
 - All items contained on the form must be completed and sent to the DD Section
- 2) DD Provider Orientation
 - Upon receipt of the required Letter of Intent, the Licensing Administrator will inform the applicant of the next scheduled “New DD Provider Orientation” session provided by the DD Section. The applicant is required to attend the orientation in its entirety.
- 3) Council on Quality and Leadership (CQL) Systems Accreditation (provider is responsible for cost)
 - All DD licensed providers are required to be accredited. Once the New DD Provider Orientation is completed, the license applicant will contact the accreditation agency (CQL) to begin the process to obtain accreditation.

Once the Letter of Intent is submitted and applicant attend the DD Provider Orientation, the applicant is required to participate in several pre-application meetings with staff of the Developmental Disabilities Section and their contractors. The intent of these meetings is to provide the applicant with an overview of the ND DD service delivery system and acquaint them with the expectations and requirements that need to be fulfilled by the applicant to obtain a license to provide services. It is also important for the

applicant to know if the service the applicant is proposing to provide can be authorized and paid for by the department.

1) Abuse and Neglect Policy Overview

- Within three months of completing the New DD Provider Orientation, the provider will schedule the Abuse and Neglect training overview with assigned staff from the DD Section.

2) ND Community Staff Training Program

- Within four months of completing the New DD Provider Orientation the applicant will contact the director of staff training at the North Dakota Center for People with Disabilities (NDCPD) at Minot State University for instructions on the Guidelines and Syllabus and additional procedures required for staff training.

3) Person Centered Planning/QDDP

- The applicant will review the requirements for person-centered service plans (OSP, IFSP) policies and procedures and qualifications, roles, and responsibilities of the Qualified DD Professional (QDDP) and provide written verification that the material has been reviewed.
 - Review the OSP instructions
 - Complete the QDDP module through NDCPD

4) Introduction to Regional DD Program Management

- The applicant will schedule a meeting with the Regional DD Program Administrator (s) at the human service center(s) in which the applicant plans to provide services to: discuss the roles and responsibilities of regional DD program management; understand the local referral process, local monitoring requirements; DD program management resources; service authorization and approval; as well as the specific needs of the region(s) and provide written verification that the meeting was held.

Upon completion of the above items, the applicant will submit the licensure packet to the Licensing Administrator at the DD Section if the applicant is still interested in providing DD Licensed services in ND. The packet consists of the North Dakota DD Provider Application (SFN 1794). All the items contained on the form, required inspections, and New DD Provider Checklist, must be completed and sent to the DD Section before being licensed and before any services can be provided.

The application packet will be reviewed by the Licensing Administrator in the DD Section, and other DD staff as deemed appropriate, to determine if all necessary information is enclosed and the requirements for a license are met and in compliance with the licensing rules.

Arrangements for a site survey may be made if deemed necessary. This potential site survey will be scheduled for the mutual convenience of the provider and Licensing Review unless the effectiveness of the inspection would be substantially diminished by prearrangement.

- a. If deficiencies are found, concentrated efforts of the service provider for correction and compliance will be necessary.

For ICF/IID facilities, a certification survey will be conducted by the Health Facilities Unit and Life Safety.

Once review of the application and inspections (as appropriate) has begun, the applicant will be contacted regarding any follow-up questions or if any additional materials are required. A plan of correction may be issued to the applicant and any noted deficiencies must be remediated prior to issuing a licensure.

The length of time to complete the application review process is dependent on the completeness of the initial application/supplemental materials and the response time of the applicant to any request for updated or additional information. Per Administrative code, the DD Section has 60 days to review the application and its contents but may take longer depending upon information provided and any follow-up needed by either party. Incomplete applications will not be approved.

Upon completion of the review of the licensure packet and site visit, if appropriate, a determination to issue or deny a provisional license request will be made. If the requirements have been met, a provisional license certificate will be issued to the successful applicant. A provisional license will be issued until the next level of CQL accreditation is achieved. For initial applicants, a plan of correction will be required from the applicant to verify that the licensee will continue the accreditation process with The Council. The next level of accreditation must be obtained within one year of the issuance of the provisional license. The provider is responsible for initiating with CQL in the activities required for the next level of accreditation.

If the applicant will provide ICF/IID services, the approved Medicaid Agency Certification must be completed before the DD license is approved.

Existing DD Providers/Annual Renewal/New Services

Providers that are currently licensed by the DD Section to provide services to eligible individuals will be required to complete the following items:

- 1) 120 days prior to licensure expiration, a notice will be sent to the service provider containing a reminder of upcoming licensure expiration date(s) and the necessary requirements for re-licensure
- 2) The provider will submit the licensure packet SFN 1794 (i.e. application, required inspections, etc.) to the DD Section sixty (60) days prior to starting any approved services or expiration of an existing license. If a renewal licensure packet is not received sixty (60) days prior to the expiration date of the existing license, the DD Section will contact the provider to confirm the provider's intent to continue services. A provider's failure to submit the renewal licensure packet timely may result in the termination of services, which would result in the transition of individuals.
- 3) Once the application is returned to the DD Section, it will be reviewed, and a determination of compliance will be made. Arrangements for a site survey may be made if deemed necessary. This potential site survey will be scheduled for the mutual convenience of the provider and

Licensing Review unless the effectiveness of the inspection would be substantially diminished by prearrangement.

- a. If deficiencies are found, concentrated efforts of the service provider for correction and compliance will be necessary. This may result in a plan of correction for the provider.
- 4) Upon completion of the review of the licensure packet, a determination to issue or deny a license request is made. The following types of licenses may be issued pursuant to the license application review:
 - Unrestricted - issued to an applicant, which complies with the rules and regulations and has received, and maintains, accreditation from the Council on Quality and Leadership
 - Restricted - issued to a licensee with an acceptable plan of correction notwithstanding a finding of noncompliance with the rules of the department and North Dakota Century Code section 25-16-03
 - 5) The above licenses are issued for periods of up to one (1) year, are non-transferable, and are valid only for those services shown on the license certificate.
 - 6) Every five years, each provider will need to re-verify their information in HE MMIS. The DD Section will notify the DD provider of this requirement and the steps necessary.

Change in Licensure

Providers must request a change in licensure when there is a change of control or ownership of the licensed provider; to provide a new service they are not currently licensed for; to terminate a service they are currently licensed to provide; or to increase the licensed capacity. Each license certificate shows maximum capacity, so it is unnecessary to request a change in licensure should individual/resident census fall below that capacity shown.

Circumstances warranting a change in licensure will be either of a planned or an emergency nature. Simple changes (such as a request for an increase in licensed capacity) will result in the issuance of a revised certificate. More complex changes may result in the issuance of a restricted license. The following procedures apply to planned, emergency, or termination situations:

- 1) Planned
 - Licensee submits license application for service(s) affected with details of change, at least thirty (30) days prior to the change(s) taking place.
 - Upon review and approval by Licensing Administrator and the Regional Developmental Disabilities Program Administrator, a license certificate will be issued prior to the change.
- 2) Emergency

Licensee contacts licensing administrator to request verbal approval. Licensing administrator will document the verbal application and if appropriate grant approval. The licensee then forwards the hard copy application.

- Upon receipt and review of license application and approval of the Regional Developmental Disabilities Program Administrator, licensing administrator will issue a license certificate to accommodate the emergency.

3) Termination of Services

- Licensee submits license termination request for service(s) affected with details of discontinuance, at least thirty-days (30) prior to the termination of service(s).
- Upon receipt and review of license termination request, and approval of the Regional Developmental Disabilities Program Administrator, formal acknowledgment of license discontinuance will be issued to the licensee.

All forms pertaining to initial licensing or renewals can be accessed at:

<https://www.nd.gov/eforms>

Accreditation

All DD licensed providers are required to obtain and maintain accreditation as identified in NDAC 75-04-01-15. The costs for accreditation are the responsibility of the provider.

The following accreditation types are required for DD licensed providers.

- 1) Level 1 – providers that have never been licensed or have had a lapse in their license will be required to complete the Systems Accreditation™ through CQL.
- 2) Level 2 – providers that have completed the Level 1 accreditation will have one year to obtain this level of accreditation which is Quality Assurances Accreditation™ through CQL. In most cases this accreditation is awarded for a three-year term. This accreditation is necessary for a provider to receive an unrestricted license.
- 3) Level 3 - providers that have completed the Level 2 accreditation will have three years to obtain this level of accreditation which is Person-Centered Excellence Accreditation™ through CQL. Typically, this is a four-year term. In some cases, the Department or CQL may determine that it is necessary for the provider to re-complete Level 2 accreditation. It is expected that all DD licensed providers achieve and maintain the level 3 accreditation.

The accreditation process is focused on people living meaningful and fulfilling lives, and the efforts providers make during the process means better person-centered services for people supported. CQL's approach is to draw attention to the agency's strengths, highlight provider successes and help identify areas for quality improvement. When recommendations are made, agencies are expected to comply with those recommendations or demonstrate that progress is being made towards compliance with those recommendations.

If a provider does not maintain accreditation, a restricted license will be issued in accordance with NDAC 75-04-01-09 until the provider is in compliance with accreditation.

For detailed information on accreditation, refer to CQL's website at: <https://www.c-q-l.org/>.

DD Licensed Provider Enrollment

The provider will need to complete the following:

- 1) Medicaid Program Provider Agreement (SFN 615), Ownership Controlling Interest and Conviction Information (SFN 1168), W-9, and DD Purchase of Service Agreement; and
- 2) Health Enterprise MMIS Provider Enrollment Application (<https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>).

For detailed information on this section, refer Appendix D in this manual.

Qualified Service Provider (QSP) Enrollment for Traditional IID/DD HCBS Waiver Services (Homemaker & Adult Foster Care)

The following is required for services provided by a QSP:

- 1) Compliance with NDAC 75-03-23-07; and
- 2) Must enroll as Qualified Service Provider (QSP) with the State Medical Services Division ("Medical Service/HCBS") for Homemaker and the State Aging Services Unit for Adult Foster Care.

Prior to service delivery, QSPs must ensure that all direct service staff meet the certification and competency requirements described in NDAC 75-03-23-07.

For detailed information regarding required forms and staff qualifications, and renewal of QSP status, refer to the QSP information, available on the DHHS website: <http://www.nd.gov/dhs/services/adultsaging/providers.html>.

SECTION VI - PROVIDER REQUIREMENTS

As part of its quality improvement strategy, the DD Section is responsible for monitoring service implementation, individual safety and satisfaction, and integrity of submitted claims. All providers are required to adhere to the rules, standards, and documentation requirements described below. This list is not an all-inclusive list.

Rule	Rule Title and Reference
CFR Titles 34, 42, 45	Code of Federal Regulations most referenced relating to Developmental Disabilities and Home and Community-Based Services. Found at: https://www.ecfr.gov
Individuals with Disabilities Education Act (IDEA)	Found at: http://idea.ed.gov
The Rehabilitation Act of 1973	Found at: http://www.ed.gov/policy/speced/reg/narrative.html
NDCC 25-01.2	Developmental Disability Found at: http://www.legis.nd.gov/general-information/north-dakota-century-code
NDCC 25-16	Residential Care and Services for the Developmentally Disabled Found at: http://www.legis.nd.gov/cencode/t25c16.pdf?20141114093503
NDCC 25-16.1	Receivers for Developmentally Disabled Facilities Found at: http://www.legis.nd.gov/cencode/t25c16-1.pdf?20141114093656
NDCC 25-16.2	Work Activity Center Contract Awards Found at: http://www.legis.nd.gov/cencode/t25c16-2.pdf?20141114093719
NDCC 25-18	Fee for Service Rate Setting for Developmentally Disabled Facilities Found at: http://www.legis.nd.gov/cencode/t25c18.pdf?20141114093754
NDCC 50-06	Department of Human Services Found at: http://www.legis.nd.gov/cencode/t50c06.pdf
NDCC 50-06.2	Comprehensive Human Services Programs Found at: http://www.legis.nd.gov/cencode/t50c06-2.pdf
NDCC 50-11	Foster Care Homes for Children and Adults Found at: http://www.legis.nd.gov/cencode/t50c11.pdf
NDCC 50-24.1	Medical Assistance for Needy Persons Found at: http://www.legis.nd.gov/cencode/t50c24-1.pdf
NDAC 75-03-21	Licensing of Foster Homes for Adults Found at: http://www.legis.nd.gov/information/acdata/pdf/75-03-21.pdf

Rule	Rule Title and Reference
NDAC 75-03-23-07	Policy, rules and regulations for Qualified Service Providers (QSPs) Found at: http://www.legis.nd.gov/information/acdata/pdf/75-03-23.pdf
NDAC 75-04-01	Licensing of Programs and Services for Individuals With Developmental Disabilities Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
NDAC 75-04-05	Reimbursement for Providers of Services to Individuals With Developmental Disabilities Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
NDAC 74-04-06	Eligibility for Intellectual Disabilities-Developmental Disabilities Program Management Services Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
DD Section Policy	For detailed information on DD Section Policy, refer to the DD Bookshelf: https://www.nd.gov/dhs/policymanuals/816/816.htm , select "PI's/Outstanding PI's" on the left hand side.

Informing Individuals of Their Rights

Every DD licensed provider shall post conspicuously in public areas a summary of the rights defined in NDCC 25-01.2. Individual rights, such as the DD Bill of Rights, should be reviewed initially and an on an annual basis by the team during the person-centered planning process. In addition, upon commencement of services or as soon after commencement as the individual's condition permits, every individual eighteen (18) years of age or older, the parents or the custodian of all individuals under eighteen (18) years of age, and the guardian must be given written notice of the rights guaranteed by the aforementioned chapter.

Confidentiality Requirements

NDAC 75-04-01 requires DD licensed providers to maintain a confidentiality policy. Such policies must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DD licensed providers must update the DD Section of any change in the policy of confidentiality.

Certification

- 1) ICF/IID facilities are institutions that participate in Medicaid and must comply with specific Medicaid standards; meeting applicable requirements and evaluation of quality of care. The survey for the determination of standards, collectively known as the certification process, is done on behalf of CMS by individual State Survey Agencies. In North Dakota, it is completed by the Department of Health and Human Services, Health Facilities Unit.

Certification is completed initially and annually for each ICF/IID facility (home) based on the agency's ability to comply with Condition of Participation for ICF/IID's.

For more detailed information, refer to the DHHS website:

<https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/16.5.b.%20Title%20XIX%20Procedures%20for%20Providers.pdf>

Requirements for DD Licensed Providers

Licensees are required to record and report the following:

- 1) Documentation to demonstrate the right to receive payment for all services and supports and comply with all federal and state laws necessary to disclose the nature and extent of services provided and all information to support claims submitted by the provider.
- 2) Submit a statement of policies and procedures, and evidence of implementation to prove compliance with departmental rules and NDCC 25-01.2
- 3) Licensees shall maintain program records, fiscal records and supporting documentation identifying items, including:
 - a. Authorization from the DD Section for each individual whom service is being provided;
 - b. Attendance sheets and other records documenting the days and times that the individuals received the services/tasks from the licensee; and
 - c. Records of all bills submitted to the Department for payment.
- 4) Maintain supporting documentation and fiscal records ensuring that claims are coded and paid for in accordance with the Department's reimbursement methodology as defined in NDAC 75-04-05-08.
- 5) Retain a copy of the required records for six (6) years from the date of the bill unless an audit in process requires a longer retention.
- 6) Document compliance with the guarantees and assurances defined in NDAC 75-04-01.

Provider Integrity Audit

Federal regulations (42 CFR 456) stipulate that each State Medicaid Agency utilize surveillance and review process to protect the integrity of the program. The purpose of this requirement is to avoid unnecessary costs to the program due to fraud or abuse and assure that eligible recipients receive quality and cost-effective medical care.

The Medicaid State Plan and the Traditional IID/DD Home and Community-Based Services (HCBS) Waiver are the North Dakota Medicaid agency's agreements with the federal government that details Medicaid coverage and payment for services and program operations.

Annually, or as needed, the DD Section will determine audit topics relative to the services provided by the DD Section.

For detailed information on this section, refer to the DHHS website:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/dd-provider-integrity-manual.pdf>

Building Design and Safety Requirements

All DD licensed providers must ensure that the building meets the safety requirements and regulations, including local zoning laws, occupancy rates, life safety codes, sanitation, emergency plans, CMS Final Rule on HCBS setting and access to essential utilities as required by NDAC 75-04-01.

Group homes must satisfy additional building design and safety codes specified in NDAC 75-04-01-27 through 75-04-01-36. The “*Physical Standards Checklist*” for group homes is available at <http://www.nd.gov/eforms/Doc/sfn01555.pdf>. Group homes must allow for all bedrooms to have lockable doors, except where individuals may not lock their own rooms due to a specific assessed need or safety concern as consistent with their person-centered service plan. Please reference 42 CFR 441.301(c) (4)-(5) for additional details.

In accordance with NDAC 75-04-01-24, DD licensed providers must allow authorized representatives of the Department to inspect the service facilities and records. To prove compliance with safety requirements, the DD licensed provider must have a license or registration certificate issued pursuant to NDCC 50-11 or possess written statements by accredited professionals as described in NDAC 75-04-01-22.

Individual Documentation and Reporting for DD Licensed Providers

The DD Section requires providers to comply with the following data collection, documentation, and reporting requirements. Please reference NDAC 75-04-01, 75-04-05, and “*North Dakota Developmental Disabilities Service Description Manual*” for details. Please reference Medicaid Program Provider Agreement (SFN 615).

Therap Software

Therap, the Department’s official source of individual registration and record, is a HIPAA compliant, web-based case management system.

Required Therap modules for providers include:

- Overall Service Plan (OSP)
- Individualized Family Service Plan (IFSP)
- General Event Reporting (GER)
- Individual Referral
- Individual Data Form (IDF)
- Risk Management Assessment and Plan (RMAP)

Required Therap modules for Department staff include:

- Individual Eligibility
- Progress Assessment Review (PAR)
- Overall Service Plan (OSP)
- Individual Support Plan (ISP)
- Case Action
- Progress Notes
- Quality Enhancement Review (QER)
- Individual Referral
- Individual Authorizations
- Risk Management Assessment and Plan (RMAP)

Reference the Therap Website for how to tutorials <https://help.therapservices.net/app/north-dakota>. At the point of licensure, the Department will initiate the registration for Therap. The Therap Help Desk will contact the provider with security login information.

Abuse and Neglect Reporting

The Department is committed to ensuring that all individuals receiving DD services are treated with dignity and respect, receive services and supports designed to meet their individual needs, and are able to live safe and secure lives in their respective communities.

In accordance with DD Section policy and NDAC, DD licensed providers are required to report Serious Events and Reportable Incidents.

If a DD licensed provider fails to report any suspected incidents of abuse, neglect, or exploitation; the DD Section staff, Regional DD Program Management and/or P&A may launch a formal investigation. Applicable corrective action may include but is not limited to notification to the Health Facilities Unit for ICF/IID, notification of the CQL, licensure sanctions, and/or revocation of the provider's license.

For detailed information on this section, refer to the DD Bookshelf:

<http://www.nd.gov/dhs/policymanuals/816/816.htm>, select "PI's/Outstanding PI's" on the left hand side.

Day-to-Day Monitoring

All DD licensed providers are responsible for day-to-day monitoring and service plan implementation, and hence, must maintain the following individual documentation to facilitate census data auditing and periodic quality reviews.

The QDDP module, available through North Dakota Center for Persons with Disabilities (NDCPD), may include additional documentation requirements.

Maintain daily census records for all individuals, regardless of payer source. These records must include:

1. Identification of the individual;
2. Entries for all days that services are offered including the duration of service;
3. Identification of type of day, i.e., hospital, in-house.

Providers must record progress notes, including data, where applicable, to monitor progress towards goals and objectives. All notes must include the signature/initials of the staff member providing the service to verify that services were delivered for the identified individual.

Provider Survey

Survey Domains

The purpose of the survey is to determine compliance with federal and state standards; to assure health and welfare; and review quality of services. The survey reviews provider's Home and Community-Based Services Waiver in the following areas:

- Service Planning, Delivery, and Implementation;
- Rights;

- Provider Capabilities and Qualifications;
- Health and Safety;
- Financial Management.

Off-Site Desk Review

The off-site activities provide the surveyor with information that can be reviewed prior to the on-site in combination with other on-site activities, will provide background information, and is a time to collect and analyze data. This allows greater flexibility during the on-site review and facilitates a more efficient review. A sample of individuals is determined, and the provider will be notified 1 week prior to the on-site review. Off-site activities include but are not limited to:

- Provider will receive a letter requesting documents and information;
- Information and feedback are gathered from other entities (may include HSC, Licensing, CQL, Title XIX);
- Desk review of documents via Therap or by the provider;
- Guardian phone interviews.

On-Site Review

Surveys may begin with a brief entrance discussion for the purpose of introductions, organizational information, survey logistics, and finalization of schedules. Providers will be notified of the staff sample upon the arrival of the surveyor. On-site activities include but are not limited to:

- Observations in service settings;
- Review of personnel records and other supporting documentation as needed;
- Discussions with individuals and staff;
- Exit discussion at the conclusion of the survey to discuss preliminary findings.

Determination and Follow-Up Activities

After the completion of the on-site visit, a letter of findings and a written final report will be compiled and includes all areas surveyed. The report will address the provider's strengths, deficiencies cited, and summary of findings during the review.

- Provider will receive the final report within 15 business days of the on-site visit. Within 20 business days of the receipt of the final report, the provider must provide a plan of correction (POC) in response to any deficiency citations.
- The DD Section will notify the provider of the status of their submitted POC within 15 business days. All deficiencies must be corrected within 45 calendar days from the POC approval date. The DD Section will verify correction of all deficiencies.

For detailed information on this section, refer to the DHHS website:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/hcbs-provider-survey-handbook.pdf>

Electronic Visit Verification (EVV)

Section 12006(a) of the 21st Century Cures Act (link is external) mandates that states implement EVV for all Medicaid personal care services and home health services that require an in-home visit by a provider. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115 and home health services provided under Section 1905(a)(7) of the Social Security Act or a waiver. This is mandatory for Medicaid programs in all states.

The North Dakota Department of Health and Human Services has adopted an open EVV model. Providers may choose to use their own EVV system and will be required to submit data to a data aggregator. Providers will be responsible for working with the aggregator vendor to ensure it meets all requirements and for any interface costs (if any) charged by their vendors if they choose to use their own system.

The Department of Health and Human Services has contracted with [Therap LLC](#) as its EVV vendor and Sandata Technologies as the aggregator vendor.

Developmental Disability Services required for EVV

- Homemaker
- Independent Habilitation
- Extended Home Health Care
- In-home Support (provider managed and self-directed)
- Personal Care
- Respite (provider managed and self-directed)
- Adult Foster Care- Respite

For more information and updates to EVV visit <https://www.hhs.nd.gov/adults-and-aging/electronic-visit-verification-evv-system>.

Virtual Supports

The purpose of virtual supports is to maintain or improve an individual's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.

1. Virtual supports are not a distinct, separate service under the North Dakota 1915c Traditional IID/DD Home and Community Based Services Waiver (DD Waiver), but a method by which certain services may be delivered to an individual.
2. The purpose of virtual supports is to maintain or improve an individual's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.
3. Virtual supports are geared towards intentional learning (e.g., career planning, taking a cooking class, skill building) and can also be used towards helping a person do something more independently like remote job coaching.

Services Allowed for Virtual Supports

- Behavioral Consultation
- Independent Habilitation
- Individual Employment Services
- Parenting Supports
- Infant Development- Home Visits
- Infant Development- Early Childhood Special Education Consultation
- Infant Development- Nursing Consultation
- Infant Development- Occupational Therapy Consultation
- Infant Development- Physical Therapy Consultation
- Infant Development- Speech Consultation

- Infant Development- Social Work Consultation

For additional requirements, utilization, limits, and provider expectations, refer to the DHHS bookshelf for the [Virtual Supports Policy PI-23-13](#).

Home and Community Based Services in Acute Care Hospital Setting

In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.

The delivery of HCBS in acute care hospital setting is only applicable for individuals receiving Traditional IID/DD HCBS waiver services who are seeking or receiving treatment in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions, or injuries.

An individual can receive HCBS services in an acute care hospital setting if they are currently authorized for only the following Traditional IID/DD HCBS waiver services:

- Residential Habilitation
- Independent Habilitation
- In-Home Supports, and
- Respite.

Individuals may receive HCBS from their direct support professional while receiving medical care and treatment in an acute care hospital setting so long as the following conditions exist:

1. the need for direct supports in an acute care hospital setting is accurately documented in their Person-Centered Service Plan (PCSP);
2. the direct supports provided meets the need(s) of the individual that are not met through the provision of hospital services;
3. the direct supports do not substitute for services that the hospital is obligated to provide under Federal or State law, or under another applicable requirement; and
4. the direct supports are being provided to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.

This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law. The DD Licensed provider will coordinate with the hospital staff to determine what direct supports are necessary to meet the individual's needs.

If the individual is admitted to an acute care hospital setting, current DD services can continue to be authorized as the admission does not result in a screening to another level of care. The HCBS waiver level of care screening does not get terminated.

All Traditional IID/DD HCBS waiver rules and service limitations still apply.

Day to Day Documentation

All DD licensed providers are responsible for day-to-day monitoring and service plan implementation, and must maintain the following documentation to facilitate census data auditing and periodic quality

review if supports are provided in an acute hospital setting the documentation must include the location of the supports in addition to the following:

- Date of service
- Name of DD Licensed provider
- Name of the Service being provided with in/out times for each service
- Individual's name
- Staff who provided service (if using staff initials a legend of staff names must be provided)
- Summary of tasks and activities performed during that time (daily rate providers can meet the requirement by one itemized list of routine tasks and a single entry every day)
- The record should be written in clear language and without alterations

Service Plan Process and Documentation

During the annual service plan meeting or as needed the team will discuss and document the individual needs supports in a hospital setting to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.

- Overall Service Plan will be documented in the Emergency Backup plan section.
- IFSP will be documented in the Summary of Family Concerns, Priorities and Resources section.

Billing

Residential Habilitation-

- If direct supports for an individual are provided while in the hospital, a claim for Residential Habilitation can be submitted.
- If direct supports are NOT provided to the individual while in the hospital, a claim for Residential Habilitation Retainer can be submitted. (Limits still apply for only 30 per calendar year)

Independent Habilitation, In-Home Supports, and Respite-

- If direct supports for an individual are provided while in the hospital, a claim can be submitted.
- If direct supports are NOT provided to the individual while in the hospital, a claim cannot be submitted.

Census documentation will need to differentiate between hospital stay with no supports and hospital stay with supports.

SECTION VII - CENTER FOR MEDICARE AND MEDICAID (CMS) FINAL HOME AND COMMUNITY-BASED SERVICES (HCBS) RULES

The Centers for Medicare and Medicaid Services (CMS) issued regulations in March 2014 for Home and Community Based waiver services. CMS is part of the federal government that oversees the federal funding used to pay for waiver services. States and providers are required to follow federal regulations in order to receive funding.

The regulations impact where people work, live, and attend day services. The regulations ensure people have **full access** to the benefits of community living based on characteristics and individual experiences; people have the opportunity to receive service in the **most integrated** settings; people have maximum **choice and control** over their lives making big and small life decisions; and **rights are respected** and should be same as any citizen.

Home and community-based services **cannot** occur in the following settings:

- A nursing facility;
- An institution for mental diseases;
- An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- A hospital; or
- Any other locations that have qualities of an institutional setting.

Setting Requirements

The regulations require that all home and community-based settings meet certain qualifications, including:

1. The setting is integrated in the greater community AND supports full access to the greater community.
2. The setting is selected from options that include people without disabilities.
3. Setting must ensure people's rights are respected and promoted.
4. The setting encourages individual initiative, autonomy, and independence in making life choices.
5. The setting provides choice about services/supports and who provides them.
6. Provider owned or controlled residential settings must have a lease and lockable bedroom doors.
7. If there are any modifications to these regulations the provider must follow additional rules:
 - a. Base the restriction on a specific individual need.
 - b. Show that positive interventions have been tried but haven't worked.
 - c. Keep measuring with data collection to determine if restriction should continue.
 - d. Show that any modification is TEMPORARY and includes a fading plan.
 - e. Informed consent from person and legal decision maker.
 - f. Show the intervention will cause no harm.

Person-Centered Service Planning Requirements

The regulations ensure person-centered planning is:

- Developed through a person-centered process that is directed by the individual along with others chosen by the individual to contribute to the process;
- Assisting the individual in achieving their personal outcomes in the most integrated setting;
- Delivering services in a manner that reflects personal preferences and choices; and
- Assuring health and welfare.

Refer to the Overall Service Plan (OSP) instructions for directions on the planning process and documentation needed within the plan.

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/overall-service-plan-instructions-update.pdf>

Assuring Initial Compliance

New Home and Community-Based Settings

The provider is responsible to notify the DD Section of any new provider-owned residential setting or facility-based Day Supports setting prior to the setting being initiated, built, or purchased. The DD Section must be involved throughout the planning stages of the setting to ensure the setting will comply, such as physical location and design of the setting. A review must be conducted before the setting will be licensed.

This initial review is the first step in determining a waiver setting's compliance. The focus is on the setting's current physical characteristics and the location contributing to community integration and people's rights. This review will identify any potential for heightened scrutiny and/or characteristics that may be potentially institutional and/or isolating in nature. All settings must also comply with the Licensing Administrative Code.

Once the DD Section approves the setting, full compliance will be addressed through the person-centered planning process for each person on an initial and annual basis, speaking to the person's individual experiences.

Heightened Scrutiny

When a provider requests to enroll or add a setting that may fall under one of the three prongs below that will trigger the need for heightened scrutiny the DD Section will utilize a setting assessment tool to identify any institutional characteristics and ensures all regulations are evaluated. The assessment tool is completed onsite for each setting by the DD Section using observation and discussion with individuals, guardians, and provider staff. DD Section will work with the providers to complete the assessment tool and identify any areas of noncompliance, remediation efforts, and timelines for completion.

The three prongs include:

- 1) Settings in a publicly or privately-operated facility that provides inpatient institutional treatment;
- 2) Settings in a building on the grounds of, adjacent to, a public institution;
- 3) Settings with the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Providers will be given time to implement remediation efforts for any noncompliance identified. Once the provider informs the DD Section that they have implemented the necessary remediation efforts they will be required to submit an evidence package to the DD Section for review. The DD Section will review the evidence package, conduct a site visit, and gather feedback with individuals/legal decision makers to confirm remediation and compliance. The feedback will be gathered from individuals/legal decision makers in person or over the phone by the DD Section.

Once this process is complete, the information along with the information submitted in the evidence package will be reviewed by an internal HCBS settings committee. The committee will be comprised of a representative from the State's Aging Services Section, Developmental Disabilities Section, Medical Services Unit, and the State Risk Manager.

The committee will decide if the setting:

- a) Has successfully refuted the presumptively and now fully complies;
- b) With additional changes will fully comply; or
- c) Does not/cannot meet HCB settings requirements.

If it is determined that the setting has provided enough evidence that they fully comply the evidence package will be submitted for public comment for 30 days. After the public comment period, it will be submitted to CMS to see if they concur.

If a decision is made that the provider cannot meet the regulations, they will be issued a denial for that setting and a transition plan will be developed with the individual(s) and their team to assist with relocation efforts to a setting that complies. If any relocation of individuals is needed, the person-centered planning process will be followed.

Assuring On-going Compliance

Provider Responsibilities

- Complete a self-assessment initially and annually. The self-assessment is completed with individuals and information gathered is used as part of the person-centered service planning. The self-assessment captures individual experiences such as if the individual feels their privacy is respected, are they happy with where they live, what changes they want in their life, etc.
- Develop and implement agency policies and procedures that are aligned with the regulation.
- Implement person-centered service planning practices and develop service plans according to regulations. Person-centered practices encourage the individual to direct their supports and services; make informed choices; participate in the community; and live independently as possible.
- Achieve CQL accreditation initially and ongoing. The Personal Outcome Measure® tool focuses on the choices and control people have in their lives and evaluates people's quality of life that correspond to these requirements.
- Provide initial and annual training on the regulations to staff who are responsible to monitor service delivery.

DD Program Manager Responsibilities

- Assess and monitor the physical environment of the individual's home and day program setting where waiver services are provided.
- Assist individuals in exploring and making choices in service options, supports, and locations.
- Participate in the individual's person-centered service planning and approve service plans.
- Monitor service satisfaction and service plan implementation.

DD Section Responsibilities

- Assess and develop a Statewide Transition Plan to describe how programs meet the regulations and how to remediate areas that don't comply. The Statewide Transition Plan describes how the state will achieve and maintain compliance with the HCBS Settings Regulations.
- Conduct an on-site survey at provider service locations.
- Review provider policies and procedures ensuring that they align with the regulation.
- Conduct a case file review process to verify on-going compliance.
- Provide initial and annual training for DD Program Managers.
- Provide initial training for new providers.

For detailed information on this section, refer to the DHHS website: <https://www.hhs.nd.gov/human-services/hcbs>.

SECTION VIII - SERVICE PLANNING

The North Dakota DD Section is committed to ensuring that all individuals are afforded the opportunity to lead and/or participate in developing their service plan. The plan contains a section listing services, which is completed and authorized by the DDPM for payment of DD funded services.

The provider and the individual and/or legal decision maker are responsible for the general day-to-day monitoring and implementation of the service plan. DDPMs are responsible for ensuring the plan is developed in accordance with applicable policies and procedures, overseeing service plan implementation to ensure that services meet individual needs and goals, settings are appropriately integrated in the community and meet all federal requirements, backup plans are effective, individuals exercise their choice of provider, and health services identified in the service plan are accessible.

As part of the quality enhancement review (QER) process, DDPMs conduct face-to-face visits with individuals every ninety (90) days if receiving a Traditional IID/DD HCBS Waiver service and once a year if receiving an ICF/IID service to assess individual satisfaction and the appropriateness of the amount and frequency of service provision, discuss progress towards the individual's achievement of service outcomes defined in the service plan, and review any substantiated abuse or neglect claims. DDPMs will work with providers to resolve any problems that are identified. Issues that cannot be resolved by providers are reported to the Regional DD Program Administrator for remediation.

An Individual Service Plan (ISP) authorizing services is required for all provider managed, QSP and self-directed services. The Department is not financially liable for services prior to the effective date.

The individual's team must meet initially, annually, and as needed to discuss the individual's needs and identify which services are most appropriate to meet the individual's health and safety. The DDPM is responsible for entering the ISP information in the OSP.

For detailed information on this section, refer to the DHHS website:

<https://www.hhs.nd.gov/dd/information-dd-licensed-providers>

SECTION IX – STANDARDIZED ASSESSMENTS FOR RESOURCE ALLOCATION

An assessment is necessary to determine funding levels for individuals who are eligible for DD Services and choose one of the following services:

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (including individuals residing at Life Skills and Transition Center (LSTC),
- Residential Habilitation,
- Independent Habilitation,
- Day Habilitation,
- Prevocational Services,
- Small Group Employment, and/or
- Individual Employment.

Individuals who qualify for the above services are required to have a Support Intensity Scale (SIS) assessment if 16 or older or an Inventory for Individual and Agency Planning (ICAP) assessment for individuals under 16 years old. All assessments will be completed by a third-party vendor who is awarded a contract via a Request for Proposal (RFP) as directed by procurement policy.

The initial assessment will be completed within 90 days or at the time there are sufficient qualified responders of the individual beginning a qualified service. A reassessment of individual needs using the standardized assessment tool must be completed every thirty-six (36) months for a individual aged sixteen (16) or older, or every twelve (12) months for an individual under age sixteen (16).

If a major life-changing event occurs prior to the reassessment date, an individual or their authorized representative, or a provider organization may file a written request for an out of sequence reassessment to the appropriate regional service center. An out of sequence reassessment will reset the assessment effective date.

A individual or their authorized representative may request a reconsideration and/or appeal of the assessment if it is thought that there is an error in the information provided to complete the assessment, or if the procedures were not adhered to which could affect the assessment hours.

Individuals who are private paying for authorized services will not be required to participate in the assessment process. The individual's team will determine the number of staffing hours wanted to meet the individual's needs. The provider will use the rates identified in the rate matrix to determine the rate that the individual will be responsible to pay the provider.

To view the assessment policy, go to <https://www.hhs.nd.gov/information-dd-licensed-providers>.

SECTION X - AUTHORIZATION OF SERVICES

Individual Budget Amount (IBA)/service authorizations are required for all provider managed, QSP and self-directed services (see Table 3: Authorization Period). The Department is not financially liable for services prior to the effective date. In cases where an individual receives a service prior to the completion of the initial standardized assessment, the assessment score hours authorized for the individual shall apply from the first date the individual was authorized for that service.

Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment, Small Group Employment, and Intermediate Care Facilities

- The assessment score will be multiplied by a formula based on the selected service. This will provide the team the number of service hours per month.
- If the team determines that the assessment score hours are not adequate for the individual, the team will need to review the outlier policy. If the individual meets the criteria in the policy, the team will need to complete the outlier request form (SFN 1835).
- The DD Section will review all outlier requests and communicate its final decision to the DDPA who will inform the team of the decision.
- All IBA/service authorization templates (excluding QSP services) are available on the Therap system.

To view the multiplier calculator, outlier and assessment policy, go to <https://www.hhs.nd.gov/information-dd-licensed-providers>.

In-Home Supports, Parenting Supports, Extended Home Health Care (EHHC)

- The DDPM uses a service application form instead of the assessment tool to determine the amount and frequency of these services, not to exceed the limits established in the Traditional Waiver.
- The individual, family and DDPM will complete the *In-Home Support Application* annually which may include information on the individual's behavioral status, stress upon the family, and type and frequency of service required.

Respite

- The family, DDPM and other team members will discuss the needs of the individual and determine the chosen service delivery method(s). The DDPM will complete the service authorization based on the service delivery method(s) identified by the team.

Community Transition Services

- The individual, family, and DDPM will complete the *Transitional Budget Form* ([SFN 1862](#)) with necessary signatures.
- The Regional Staff will submit the form to the DD State Office for prior approval. This form serves as the pre-authorization for this service.

Self-Directed Supports

- Individuals have budget authority (authority to direct allotted funds) for all self-directed service options. Their financial management responsibilities include scheduling services, requiring

additional staff qualifications, recommending a service provider, substituting staff members, authorizing payments for goods and services, reviewing and approving provider invoices for services rendered, and determining staff wages. Individuals are free to select a wage rate above the established wage limits established by the State, but they may not reallocate funds assigned to each service. To assist with financial management, each individual is assigned a Fiscal Agent.

Adult Foster Care (AFC), Adult Foster Care (AFC) Respite, & Homemaker

- The authorized units for these services will be based the assessed need of the individual, the time frame in which the service can be provided, the maximum amount of service authorized, the tasks the QSP is authorized to provide, and the global and individual-specific endorsements required of the QSP. If a service is provided by multiple QSPs who meet the required endorsements, only one SFN 1810 detailing each provider's share of service units should be completed. This form is available online for download at <https://www.nd.gov/eforms/Doc/sfn01810.pdf>.

Infant Development

- The family, DDPM and other team members will discuss the needs of the individual and determine the frequency for each of the following: evaluation\assessment, home visit, consultations, and IFSP development. The DDPM will complete the service authorization based on the frequency identified by the team.

Personal Care

- The authorization process and related forms for Personal Care Services for an individual receiving this service through the DD Section can be found in the Personal Care Manual, Chapter 535.05 available at <http://www.nd.gov/dhs/policymanuals/53505/53505.htm>.

Section 11 Services

- The **DD Residential and Vocational** Administrator works with the DD regional human service center program administrator biennially to identify individuals eligible for the service. The DD Section contracts with Section 11 providers, based on individual need. No standard service authorization forms exist for Section 11 residential and employment services.

Appeals

- 1) An individual or individual authorized representative may appeal a denial, reduction, or termination of services. An appeal must be made within thirty days of the date of the notice of the denial, reduction, or termination. The individual or individual authorized representative shall submit the request for an appeal and hearing under North Dakota Century Code chapter 28-32 and chapter 75-01-03 to the appeals supervisor for the department of human services.
- 2) An individual or individual authorized representative may request an informal review within ten days of the date of the notice. A request for an informal review does not change the time within which the request for an appeal hearing must be filed.

For detailed information on appeals, refer to the DD Bookshelf:
<http://www.nd.gov/dhs/policymanuals/816/816.htm>, select “PI’s/Outstanding PI’s” on the left hand side.

Table 3: Authorization Period

Service	Individual Service Authorization Period
AFC, AFC Respite , Homemaker, Personal Care	Up to 6 months
Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment, Small Group Employment, and Intermediate Care Facilities	Up to 12 months
In-Home Supports, Parenting Supports, EHC	Up to 3 months*
Infant Development	Up to 6 months
Self-Directed Services	Up to 3 months*
Community Transition Services	Up to 90 days**
Respite	Up to 12 months***
<p>*Authorization period must end on March 31, June 30, September 30, and December 31. These cannot exceed 3 months.</p> <p>** 90 days from being screened to the waiver</p> <p>***Cannot cross State Fiscal Year (July 1- June 30)</p>	

SECTION XI - RATES & BILLING GUIDANCE

Rates

The DD Section will issue rate guidelines and matrix annually. Rate guidelines and NDAC are utilized by providers in developing and managing annual budgets.

At the completion of the state fiscal year (June 30), the DD Section will send notification to provider agencies with ICF/IID services. ICF/ID provider agencies are required to complete a statement of cost on the state identified forms and submit additional supporting documentation to determine the Upper Payment Limitation as required by Social Security Act section 1902(a)(30)(A).

For detailed information on this section, refer to the **“Rate Guidelines” - Appendix B.**

Residential Habilitation

This service is paid on a daily basis. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support vacancy factor and administrative costs. The “vacancy factor” is intended to cover costs when an individual is no longer in the setting with no intent to return.

- a. Night staff - The assessment score hours indicate the level of habilitative hours a person needs, including awake night hours. Sleep night hours are not considered habilitative and therefore a percentage was included in the program support component of the rate to account for sleep night hours.
- b. Room and board costs that the participant pays to the DD licensed provider are subject to the following limitations:
 - 1) Charges to individuals must not be greater than the individual’s Supplemental Security Income (SSI) less a predetermined amount for personal incidental expenses, plus the average dollar value of Supplemental Nutrition Assistance Program (SNAP) benefits received by the individual. Personal incidental expenses are valued at one hundred thirty-five dollars for group-home individuals.
 - 2) For residential units or individuals receiving rental assistance, the governmental unit providing the subsidy must establish the room charges.

Room and board rates must reflect the average dollar value of any energy assistance program benefits, if offered.
- c. A personal assistance retainer payment is allowed for reimbursement during a participant’s temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is away from the setting to ensure stability and continuity of staffing up to thirty calendar days per year per participant.
- d. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states’ Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.

- 1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Intermediate Care Facility (ICF/IID)

- a. This service is paid on a daily basis. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support, administrative, vacancy factor, and room and board costs. The “vacancy factor” is intended to cover costs when an individual is no longer in the setting with no intent to return.
- b. Providers may bill for 30 therapeutic absence days in a calendar year and up to 15 absence days for hospitalization per occurrence.
- c. Personal incidental expenses are valued at one hundred thirty-five dollars for ICF individuals.
- d. The Provider may request an ICF/IID Property Add On, for facilities newly acquired or built after January 1, 2010. The calculation will remove 1.9% of the room and board component from the rate matrix and the allowable expense for depreciation and interest will be calculated into the rate.

The provider will need to request approval of a project prior to any new facilities. The DD Section will review the project proposal to determine several factors:

1. Need within the state as it relates to the Departments approved budget and consumer population.
 2. Specifications of the facility are reasonable in relation to size and design.
 3. Upon completion of the project, the provider must submit the final costs of the project, bank amortization of the principle and interest costs for the life of the loan, and number of years for the depreciation.
 4. The request is only submitted initially and will be included in the Individual Budget Amount (IBA) with the admission and renewal of individuals to the qualifying location.
- e. ICF/IID Provider Assessment Tax, the quarterly rate may not exceed a rate calculated by the Department of Human Services as an annual aggregate of gross revenues as of 12/31 of the preceding year for all ICF/IID multiplied by 1-1/2 percent and divided by the licensed beds as of 12/31 of the preceding year. This will be included in the Individual Budget Amount (IBA) with the admission and renewal of individuals to the qualifying location.
 - f. ICF/IID Medically Involved or Medically Intensive Rate, if an individual meets criteria outlined in policy and the condition poses an additional program support cost to the ICF/IID, the provider may request an enhanced rate. The team may be included in the completion of the request, but is not required. The provider is responsible for completing this request and it does not automatically renew.

Independent Habilitation

- a. This service is paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
- b. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
 - 1. Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Day Habilitation, Prevocational Services, Individual and Small Group Supported Employment, and Parenting Support

- a. These services are paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.

Adult Foster Care (AFC)

- a. This service is paid on a daily rate. This service also includes a component of respite paid on a 15-minute unit.
- b. AFC rates are preauthorized by Department staff through an individual authorization.

In-Home Supports

- a. This service is paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
- b. The individual, family and DDPM will complete the In-Home Supports Application annually which may include information on the individual's behavioral status, stress upon the family, and type and frequency of service required not to exceed the limits established in the Traditional IID/DD HCBS Waiver.
- c. Each individual will receive an individualized authorization.
- d. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
 - 1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Respite

- a. These services are paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
- b. Each individual will receive an individualized authorization.
- c. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
 - 1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Family Care Option, Parenting Supports, and Extended Home Health Care

- a. The individual, family and DDPM meet annually to discuss information on the individual's behavioral status, stress upon the family, and type and frequency of service required not exceeding the limits established in the Traditional IID/DD HCBS Waiver.
- b. Each individual will receive an individualized authorization.

Community Transition Services

- a. Services are paid based on the cost of goods and/or services.
- b. Each individual will receive an individualized authorization.

Homemaker Services

- a. This service is paid on 15-minute units.
- b. Homemaker rates are preauthorized by Department staff through an individual authorization.

Infant Development Services

- a. This service is authorized on a fee-for-service basis. Services include four pay points.
- b. Infant Development services are preauthorized by Department staff through an individual authorization in Therap.

Self-Directed Supports

- a. Equipment & Supplies, Environmental Modification, Behavioral Consultation, Self-Directed In-Home Supports, and Self-Directed Respite are considered Self-Directed Services within the Traditional IID/DD HCBS Waiver.
- b. Services are paid based on the cost of goods and/or services.
- c. Families who choose to self-direct services must enroll with the Department's chosen Fiscal Agent vendor. After enrollment has been approved, families will be required to submit appropriate documentation for reimbursement of goods and/or services to the Fiscal Agent who will reimburse the families directly. The appropriate documentation may include a

- time sheet, identifying the service date, amount, and frequency; or a receipt of goods purchased, identifying date of purchase and amount.
- d. Budgets are preauthorized by Department staff through an individual authorization in Therap.
 - e. The individual, family and DDPM meet annually to discuss information on the individual's behavioral status, stress upon the family, and type and frequency of service required not exceeding the limits established in the Traditional IID/DD HCBS Waiver.
 - f. The Fiscal Agent will submit claims identifying the actual amount paid within the authorization limits and include the date or date range for the service or item to the HE MMIS. The amount claimed in HE MMIS must reflect what was paid to families and vendors within the individual authorization.

Additional considerations for Residential Habitation and ICF/IID services

Attending Physician Form

Federal regulation 42 CFR 456.360 requires that a physician certify the need for services in an intermediate care facility for each eligible recipient of Medical Assistance upon admission and at least every 365 days (may not exceed 365 days). This is to certify that the recipient named below requires, on an inpatient basis, ICF/IID level of care. SFN 1812 must be given to the certifying physician to sign at ICF/IID individual's annual exams certifying the need for the ICF/IID level of care. The form can be found here: <https://www.nd.gov/eforms/Doc/sfn01812.pdf>

Developmental Disabilities Providers are required to submit institutional claims utilizing the certifying physician information in the claim under the attending physician section. This information is to be included on the attending physician portion of the institutional claim in HE MMIS. If this information is not included in the attending physician portion of the institutional claim, the claim will be denied due to missing attending physician information.

Base Staffing Rate

New provider-owned group homes receive a base-staffing rate until fully occupied, or for three (3) months, whichever comes first. A base-staffing rate is based on minimum staffing levels identified in NDAC 75-04-05 and is effective as of the facility's date of licensure.

Non-school Days for 16-21 Add-on

When an individual is between the ages of 16 and 21 prior to the start of the school year, is eligible for Individuals with Disabilities Education Act (IDEA) and resides in residential habilitation or intermediate care facility for individuals with intellectual disabilities (ICF/IID), the individual will qualify for additional hours to account for non-school days. The DDPM will select the option to add additional staffing relating to non-school days in the web-based case management system worksheet process.

Medical Acuity Payment Tiers

Payment rates for Residential Habilitation, Day Habilitation, Prevocational Services, and Small Group Employment Support, may include a component for ongoing nursing support, higher credentialed staff, and increased programmatic oversight. There are 3 additional medical acuity tiers for the rate. The development of these tiers included a program support component to

represent the hours of nursing relative to the hours of direct support professionals at each acuity tier, then adjusted this ratio to account for higher relative wages for CNAs and RNs based on 2018 Bureau of Labor Statistics Data.

Billing Guidance

To be eligible for reimbursement, providers must meet the following requirements:

Summary of Requirements
Ensure the individual is eligible for the service (See Sections II.A and IV.A), and has a PCSP on file with the DD Section
Hold a valid provider license, if required (See Section VII), and/or be enrolled as a Qualified Service Provider
Have a current valid Medicaid <i>Agreement and Provider Addendum</i> agreement with the DD Section authorizing the payment
Use the accounting system prescribed by the DD Section
Enrolled in Health Enterprise Medicaid Management Information System (HE MMIS)
Participate in the program audit and utilization review process, and comply with documentation requirements established by the DD Section
A provider must obtain approval from the DD Section for additional square footage, increased occupancy/capacity, etc. for DD service reimbursed by the Department.

A provider must enroll in HE MMIS and comply with the requirement in Table 4 to submit a claim. During enrollment, a provider must create a username and password to be utilized when logging into the HE MMIS to submit claims. Once a provider is enrolled in HE MMIS, the provider will receive a provider number.

For detailed information on this section, refer to the ***“HE MMIS Enrollment and Claim Submission” - Appendix C.***

SECTION XII – DD SECTION INFORMATION

For further details or questions, contact the DD Section at:

ND Department of Health and Human Services

Developmental Disabilities Section

1237 W Divide Ave Ste 1A

Bismarck ND 58501-1208

Phone: (701)328-8930

Toll Free: 1-800-755-8529

Website: <https://www.hhs.nd.gov/dd>

SECTION XIII – SERVICE DESCRIPTIONS - APPENDIX A

This document contains information on the various services available to eligible participants of Developmental Disability (DD) services. There are four categories of services, grouped according to funding source. A list of all services contained in each of the categories is provided. In addition, specific information on each service follows the list of services within each category.

I. Eligibility and Access to Services	Page 46
II. Traditional IID/DD HCBS Waiver Services	Page 47
III. Medicaid State Plan Services	Page 73
IV. General Fund Services	Page 73

I. Eligibility and Access to Services

Description

The Developmental Disabilities Program Manager (DDPM) has primary responsibility to provide assistance and support to individuals with an intellectual or developmental disability, or a related condition.

The DDPM is an employee of the State of North Dakota Department of Health and Human Services. They are in one of the eight regional human service centers across the state. The DDPM is responsible to conduct activities such as intake, determination of eligibility including level of care determinations, assessment of service needs and referral to service providers. The DDPM monitors the plan and the provision of services to ensure that the supports meet the individual's needs and preferences and are delivered according to the individual's approved service plan.

II. Traditional IID/DD HCBS Waiver Services

Description

A Home and Community Based Service (HCBS) waiver is from the federal government which allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require institutional care to remain in their homes or communities. The HCBS waiver authority permits a state to offer home and community based services to individuals who: (a) are found to require a level of institutional care under the State plan; (b) are individuals of a target group that is included in the waiver; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community; and, (e) exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. It is entirely a state option to offer waiver services through its Medicaid program.

NDs Traditional waiver (target) group of individuals with an intellectual disability or developmental disability – individuals who otherwise would require the level of care furnished in an ICF/IID which is defined as serving persons with intellectual disabilities or persons with related conditions. States are advised that the ICF/IID level of care is reserved for persons with intellectual disability, or a related condition, as defined in 42 CFR 435.1010. Participants linked to the ICF/IID level of care must meet the “related condition” definition when they are not diagnosed as having an intellectual disability. Some persons, who might qualify as having a “developmental disability” under the Federal DD Assistance and Bill of Rights Act, may not meet ICF/IID level of care. While “Developmental Disability” and “Related Conditions” overlap, they are not equivalent. The definition of related conditions is at 42 CFR 435.1010 and is functional rather than tied to a fixed list of conditions.

The DD Section offers the HCBS (1915c) Traditional IID/DD waiver for individuals with intellectual disabilities (IID) and related conditions. The following services are offered under the Traditional waiver:

1. Day Habilitation
2. Independent Habilitation
3. Individual Employment Support
4. Prevocational Services
5. Small Group Employment Support
6. Homemaker
7. Residential Habilitation
8. Extended Home Health Care (EHHC)
9. Adult Foster Care (AFC)
10. Behavioral Consultation
11. Environmental Modifications
12. Equipment and Supplies
13. Family Care Option (FCO)
14. In-Home Supports (IHS)
15. Infant Development (ID)
16. Parenting Support
17. Community Transition Services
18. Respite

1. Day Habilitation	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Day Habilitation services are scheduled activities, formalized training, and staff supports typically provided in a non-residential setting to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities should focus on improving a participant’s sensorimotor, cognitive, communication and social interaction skills. The goal of this service is to enable the participant to attain or maintain his or her maximum physical, intellectual, emotional and social functional level. Day Habilitation services should facilitate and foster community participation as indicated in each participant’s person-centered service plan. Day Habilitation is coordinated with any needed therapies in the participant’s person-centered plan, such as physical, occupational, or speech therapy.</p> <p>Day habilitation services may also be used to provide retirement activities. As some participants age, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. For participants with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills.</p> <p>This service shall be provided in a non-residential setting, separate from the participant’s private residence or other residential living arrangement. However, this service may be furnished in a residence if the participant’s needs are documented in the participant’s person-centered service plan.</p> <p>Rates for Day Habilitation may include transportation costs to access program related activities in the community. Transportation does not include travel between the individual’s home and the day habilitation program site. Any transportation provided to an individual as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in the waiver.</p> <p>Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Day Habilitation rate. These tiers are based on the participant’s assessed medical needs.</p> <p>Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.</p> <p>A nurse assessment and care plan are required for the medical acuity tiers. The participant’s person-centered service plan must address medical needs. Nursing services must be within the scope of the State’s Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • An individual may be enrolled concurrently in Day Habilitation per DD Section policy. • Day Habilitation and hours of employment in Individual Employment Support, Small Group Employment Support and Prevocational Services combined cannot exceed 40 authorized hours per week. However, billing for services may not be duplicated for a time period (i.e. billed for both for 1 to 5 pm on April 1). • Day Habilitation shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, Respite or Homemaker services. • This service will not be authorized, nor payment made, for individuals who are eligible for services under the Individuals with Disabilities Education Act. • This service may not duplicate services provided under any other service in the waiver. • Day Habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purposes of producing goods or performing services). • Day Habilitation cannot be authorized on the individual service plan with Family Care Option. • The service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. 		

Service Unit

- 15 minutes

Provider Category

- Agency

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
 - For Medical Acuity Tiers, staff are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

2. Independent Habilitation	Provider Managed: Yes	Self-Directed: No
<p data-bbox="203 743 418 772">Service Description</p> <p data-bbox="203 808 1531 919">Independent Habilitation services are formalized training and staff supports provided for fewer than 24 hours per day based upon the participants needs. Independent Habilitation is typically not delivered on a daily basis. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant’s ability to independently reside and participate in an integrated community.</p> <p data-bbox="203 953 1555 1010">Independent Habilitation may be provided in community settings, residential settings leased, owned, or controlled by the provider agency, or in a private residence, provided that such services do not duplicate services furnished to a participant.</p> <p data-bbox="203 1012 1549 1094">Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.</p> <p data-bbox="203 1127 1084 1157">Independent Habilitation is to provide support for conditions specifically related to IID/DD.</p> <p data-bbox="203 1186 1120 1215">Multiple participants living in a single or a shared private residence are eligible for this service.</p> <p data-bbox="203 1245 1560 1356">This service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan. If the participant requires hands on assistance for a specific task, then virtual supports service delivery cannot be an option for that task but may be utilized for other tasks that do not need hands on support.</p> <p data-bbox="203 1390 1560 1591">A Virtual Support Checklist will be required to be completed by the DD Program Manager and the team during the person-centered planning process. This checklist will act as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of remote supports. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery. The Virtual Support Checklist will include consideration of the estimated hours/visits that virtual supports delivery will be utilized. The risk assessment and service plan require the team to develop a plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided.</p> <p data-bbox="203 1625 1555 1736">In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant’s dignity and privacy is not permitted. Virtual supports reinforce community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.</p> <p data-bbox="203 1770 1544 1850">The participant’s services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. The amount of time chosen shall be determined during the person- centered planning process and outlined in the Individual Service Plan. Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare).</p>		

HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, Independent Habilitation may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law

Limits on the amount, frequency, or duration of this service

- Payment for this service will not be made for routine care and supervision that is normally provided by the family for services furnished to a minor by the child's parent, adoptive parents, guardian, or stepparent.
- Payment for this service will not be made to others living in the same residence as the participant.
- Independent Habilitation shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
- Independent Habilitation service cannot be authorized on the individual service plan with In-Home Supports, Residential Habilitation, Adult Foster Care, Homemaker, Family Care Option, Parenting Support, **Extended Home Health Care, Behavioral Consultation, Respite**, or Medicaid State Plan Personal Care services.
- Independent Habilitation service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Independent Habilitation service payment does not include room and board or cost of facility maintenance and upkeep.
- Independent Habilitation service does not include payment for non-medical transportation costs.
- Independent Habilitation service cannot duplicate any other service in the waiver.

Service Unit

- 15 minutes

Service Delivery Method

- Provider Managed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

3. Individual Employment Support	Provider Managed: Yes	Self-Directed: No
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Service Description

Individual Employment Support services are long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting or self-employment. This service is designed for participants who need intensive ongoing support to perform in a work setting. Service includes on- or off-the-job employment-related support for participants needing intervention to assist them in obtaining or maintaining employment, in accordance with their person-centered service plan. Supports are provided on an individual basis. Participants are paid by the employer at or above minimum wage.

Individual Employment Support services are to provide support for conditions specifically related to IID/DD.

Transportation from a participant's residence to their workplace may be included in authorized services hours when a participant needs it as a support intervention for the participant to maintain employment. It is not allowed as a substitute for personal, public, or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation under any other service in this waiver or Medicaid State Plan.

This service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan. If the participant requires hands on assistance for a specific task, then virtual supports service delivery cannot be an option for that task but may be utilized for other tasks that do not need hands on support.

A Virtual Support Checklist will be required to be completed by the DD Program Manager and the team during the person-centered planning process. This checklist will act as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of remote supports. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery. The Virtual Support Checklist will include consideration of the estimated hours/visits that virtual supports delivery will be utilized. The risk assessment and service plan require the team to develop a plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided.

In virtual supports, the use of cameras in bathrooms or bedrooms is not permitted. Virtual supports reinforce community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.

The participant's services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. The amount of time chosen shall be determined during the person-centered planning process and outlined in the Individual Service Plan. Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

Limits on the amount, frequency, or duration of this service

- An individual may be enrolled concurrently in Individual Employment Support, Day Habilitation, Prevocational services, and Small Group Employment Support services and are subject to limitations stipulated in DD Section policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 to 5:00 p.m. on April 1).
- Individual Employment Support services direct intervention time can only be provided to one participant at a time.
- Hours **authorized** in Day Habilitation, Individual Employment Support, Prevocational Services, and Small Group Employment Support services may not exceed 40 cumulative hours per week per participant.
- Individual Employment Support shall not be furnished or billed at the same time of day as at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, **Respite**, or Homemaker services.
- Individual Employment Support services do not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- Individual Employment Support does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.
- Individual Employment Support services do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Individual Employment Support cannot duplicate services provided under any other service in the waiver.
- Individual Employment cannot be authorized on the individual service plan with Family Care Option.
- **This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.**
- **Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:**
 1. **Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or**
 2. **Payments that are passed through to users of supported employment services .**

Service Unit

- 15 minutes

Service Delivery Method

- Provider Managed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

4. Prevocational Services	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Prevocational Services are formalized training, experiences, and staff supports designed to prepare participants for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services may include training in effective communication within a work setting, workplace conduct and attire, following directions, attending to tasks, problem solving, and workplace safety. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the participant’s person-centered service plan.</p> <p>Prevocational Services are to provide support for conditions specifically related to IID/DD.</p> <p>Providers must, in consultation with each participant, develop employment outcomes that are consistent with the participant’s goals/outcomes in their person-centered service plan that outlines a pathway for transitioning to integrated employment. The person-centered plans must be updated annually, and documentation must include each participant’s progress toward completion of prevocational training.</p> <p>Individuals participating in this service may be compensated in accordance with applicable federal laws and regulations.</p> <p>Participation in Prevocational Services is not a required prerequisite for Individual Employment or Small Group Employment services.</p> <p>Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Prevocational Services rate. These tiers are based on the participant’s assessed medical needs.</p> <p>Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.</p> <p>A nurse assessment and care plan are required for the medical acuity tiers. The participant’s person-centered service plan must address medical needs. Nursing services must be within the scope of the State’s Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Prevocational Services are available to those receiving Day Habilitation, Individual Employment Support and Small Group Employment Support are subject to limitations stipulated in DD Section policy. Billing for services may not be duplicated in a time period (e.g. billed for more than one service for 1:00 p.m. to 5:00 p.m. on April 1) • Hours authorized in Day Habilitation, Individual Employment Support, Small Group Employment, and Prevocational Services may not exceed 40 cumulative hours per week per participant. • Prevocational Services are not to be furnished at the same time as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, Respite or Homemaker services • Prevocational Services does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA. • A participant’s need and desire for continued Prevocational Services shall be evaluated every twelve (12) months, or more frequently if requested by the participant and/or legal decision maker. • The Department will review the active progress made during the prior year on increasing work skills, time on tasks, or other job preparedness objectives. The Developmental Disabilities Program Administrator (DDPA) may approve two additional 12 months of prevocational training with submission of employment outcomes that are consistent with the participant’s goals/outcomes in their person-centered service plan. A participant who requests remaining in the service beyond the two additional approvals from the DDPA (36 months) must receive approval from the DD Section. • Transportation does not include travel between the participant's home and the Prevocational Services program site. • Any transportation provided to a participant as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in this waiver or Medicaid State Plan. • Prevocational Service may not duplicate services provided under any other service in the waiver. • Prevocational Services cannot be authorized on the individual service plan with Family Care Option. <p>Service Unit</p> <ul style="list-style-type: none"> • 15 minutes 		

Provider Type Title

- Agency: Licensed DD Provider

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

5. Small Group Employment Support	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Small Group Employment Support services are for long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting. Service includes on- or off-the-job employment-related support for small group participants needing intervention to assist them in obtaining and maintaining employment as a group, in accordance with their person-centered service plan. Supports are provided to groups of two (2) to eight (8) employed participants.</p> <p>The outcome of this service is sustained paid employment and work experience leading to further career development and individual intergraded community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.</p> <p>Participants are paid by the employer at or above minimum wage.</p> <p>Small Group Employment Support is to provide support for conditions specifically related to IID/DD.</p> <p>Transportation costs from a participant’s residence to their workplace may be included in the authorized service hours when a participant needs it as a support intervention for the participant to maintain employment. It is not allowed as a substitute for personal, public, or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation under any other service in this waiver or Medicaid State Plan.</p> <p>Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Small Group Employment Support rate. These tiers are based on the participant’s assessed medical needs.</p> <p>Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.</p> <p>A nurse assessment and care plan are required for the medical acuity tiers. The participant’s person-centered service plan must address medical needs. Nursing services must be within the scope of the State’s Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Group size is limited to no fewer than two (2) and no more than eight (8) participants. • Small Group Employment Support service may not be used to support a self-employed participant. • Small Group Employment Support is available to those receiving Day Habilitation, Prevocational services and Individual Employment Support services are subject to limitations stipulated in the DD Section policy. Billing for services may not be duplicated for a time period (i.e. billed for both for 1 to 5 pm on April 1). • Hours authorized in Day Habilitation, Individual Employment Support, Prevocational and Small Group Employment Support services cannot exceed 40 hours per week. • Small Group Employment Support service shall not be furnished or billed at the same time of day as other services that provides direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Respite Homemaker services. • Small Group Employment Support service does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. 		

- Small Group Employment Support service does not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Small Group Employment Support service may not duplicate under any other service in the waiver.
- Small Group Employment Support service does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.
- Small Group Employment Support cannot be authorized on the individual service plan with Family Care Option.

Service Unit

- 15 minutes

Service Delivery Method

- Provider Managed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
 - For Medical Acuity Tiers, staff are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

6. Homemaker	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>The purpose of Homemaker services is to complete tasks that an individual with a disability is not able to complete in order to maintain that individual’s home such as housework, meal preparation, laundry, shopping, communication, and managing money.</p> <p>Homemaker services are offered to participants living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the participant lives with a capable person or provider and requests this service, the assessment must identify why the capable person or provider cannot perform the task.</p> <p>Homemaker Services is to provide support for conditions specifically related to IID/DD.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Transportation or escorting the individual is not an allowable task under Homemaker services. • The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. • The service cap is different for agency providers than individual providers, as agency providers are allowed an administrative reimbursement. This cap may be increased as determined by legislative action. The DDPM informs a participant of the service cap. • Homemaker services cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option, or Adult Foster Care. • Homemaker services cannot be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Behavioral Consultation, Parenting Support, Extended Home Health Care, In-Home Supports, Day Habilitation, Prevocational Services, Small Group Employment Supports, Respite, or Individual Employment. • Homemaker services may not duplicate services provided under any other service in the waiver. • The service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. <p>Service Unit</p> <ul style="list-style-type: none"> • 15 minutes <p>Service Delivery Method</p> <ul style="list-style-type: none"> • Provider Managed <p>Provider Category</p>		

- Agency
- Individual

Provider Type Title

- Qualified Service Provider

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency and Individual: Must be an enrolled QSP, meeting requirements as stated in NDAC 75-03-23-07; <https://www.ndlegis.gov/information/acdata/pdf/75-03-23.pdf>

Verification of Provider Qualifications

- Entity Responsible: The North Dakota Medical Services Division is responsible for verification of provider qualifications.
- Frequency of Verification: At the time of initial application, re-enrollment every two years, and/or upon notification of provider status change.

7. Residential Habilitation	Provider Managed: Yes	Self-Directed: No
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Service Description

Residential Habilitation is formalized training and supports provide to participants who require some level of ongoing daily support. Residential Habilitation service is designed to assist with and develop self-help, socialization, **community inclusion, transportation, and adaptive skills that assist the participant to reside in the most integrated setting appropriate to their needs.** Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence.

Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.

Residential Habilitation service is used to assist with self-care and/or transfer a skill from the direct care staff to the participant.

Residential Habilitation service is to provide support for conditions specifically related to IID/DD.

Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Residential Habilitation rate. These tiers are based on the participant’s assessed medical needs.

Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

A nurse assessment and care plan are required for the medical acuity tiers. The participant’s person-centered service plan must address medical needs. Nursing services must be within the scope of the State’s Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota.

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, Residential Habilitation may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient’s functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

Limits on the amount, frequency, or duration of this service

- Payment for this service will not be made for routine care and supervision that is normally provided by the family for services furnished to a minor by the child’s parent, adoptive parents, guardian, or stepparent.
- Payment for this service will not be made to others living in the same residence as the participant.
- Residential Habilitation shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Residential Habilitation shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
- Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.

- Residential Habilitation service cannot be authorized on the individual service plan with In-Home Supports, Independent Habilitation, Adult Foster care, Homemaker, Parenting Support, Extended Home Health Care, Family Care Option, **Behavior Consultation, Respite**, or Medicaid State Plan Personal Care services.
- Residential Habilitation service cannot duplicate any other service in the waiver.
- Residential Habilitation rates do not include payment for non-medical transportation costs.

Service Unit

- Daily rate

Service Delivery Method

- Provider Managed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
 - For Medical Acuity Tiers, staff are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

8. Extended Home Health Care	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Extended Home Health Care provides skilled nursing tasks to eligible participants who have maximized the amount of service available under the Medicaid State Plan. A nurse assessment, nursing care plan, and an order written by the participant’s primary health care provider are required. The participant’s person-centered service plan must address medical necessity.</p> <p>Extended Home Health Care service is available only to participants living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.</p> <p>Services are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota and must be within the scope of the State’s Nurse Practice Act.</p> <p>Extended Home Health Care (EHHC) is not intended to replace the care and support provided by the primary caregiver or to provide care on a 24- hour basis. Provision of EHHC will consider the daily responsibilities the primary caregiver(s) will have and the care they will provide; unpaid supports that are available; and other services that are provided or available to the participant and primary caregiver.</p> <p>Extended Home Health Care service is to provide support for conditions specifically related to IID/DD.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • This service may not provide care or supervision to others in the home e.g., siblings of eligible participant. • This may not be provided in a group or facility- based setting. • This service is not authorized when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP. • This service cannot be provided by an individual living in the same home as the eligible participant. • Extended Home Health Care service cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option (FCO), Homemaker, or Adult Foster Care (AFC). • Extended Home Health Care service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan_Services, In-Home Supports, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, Infant Development, Respite, or Individual Employment. • Extended Home Health Care service cannot duplicate any other service in the waiver. <p>Service Unit</p> <ul style="list-style-type: none"> • 15 minutes <p>Service Delivery Method</p>		

- Provider Managed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- This Service can be provided by a relative.
- Certified as a Home Health Care provider under Medicare or licensed according to NDAC 75-04-01.

Verification of Provider Qualifications

- Entity Responsible: The DHHS Medical Services Division and the DD Section are responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

9. Adult Foster Care	Provider Managed: Yes	Self-Directed: No
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Service Description

Adult Foster Care (AFC) is provided to a participant for ADL’s, IADL’s and supportive services provided in a private home licensed to meet the specifications of AFC. Services include preparation of meals; general housekeeping; medication assistance; personal care assistance; assistance to access the community; and for social and leisure activities.

The total number of individuals who live in the home who are unrelated to the care provider cannot exceed four (4).

Non-medical transportation is a component of AFC and is included in the rate.

AFC is to provide support for conditions specifically related to IID/DD.

AFC Respite maybe be a component within this service.

Limits on the amount, frequency, or duration of this service

- AFC must be provided in a licensed AFC home. Services are provided to the extent permitted under state law.
- AFC cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, In-Home Supports, Family Care Option, EHHC, Homemaker services, Parenting Support, Equipment and Supplies, Environmental Modifications, Behavioral Consultation, or with Medicaid State Plan Personal Care services.
- *The waiver service of Respite cannot be authorized on the individual service plan with AFC as there is a respite component to AFC.*
- The participant pays for room and board costs which are not included in the AFC payment.
- *This service will only be provided in an individual Qualified Service Provider (QSP) Licensed Adult Foster Care home.*
- The cost of AFC is limited to a maximum monthly cap set by the Department or through legislative action.
- individual If the participant’s needs cannot be met within the allowed rate, the DDPM explores other waiver service options with the participant, including institutional placement. The DDPM makes participants aware of the service cap.
- AFC shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- AFC cannot duplicate any other service in the waiver.

Service Unit

- Daily rate (*Adult Foster care*)
- *15 min unit (AFC Respite)*

Service Delivery Method

- Provider Managed

Provider Category

- Individual

Provider Type Title

- Licensed AFC Provider

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant, a relative or a legal guardian of the participant.
- AFC is provided by an individual licensed as an Family Foster Home for Adults as stated in NDCC 50-11; <http://www.legis.nd.gov/cencode/t50c11.pdf?20140616141522> and NDAC 75-03-21; <http://www.legis.nd.gov/information/acdata/pdf/75-03-21.pdf>
- Individual must be enrolled as a QSP, meeting requirements as stated in NDAC 75-03-23-07; <https://www.ndlegis.gov/information/acdata/pdf/75-03-23.pdf>

Verification of Provider Qualifications

- Entity Responsible: State Medicaid Agency, Aging Services Section, and Medical Services Division.
- Frequency of Verification:
 - Initial licensing of an AFC home for adults is valid for one year. After the one-year initial licensing period, the home is re-licensed every two-year period and/or upon notification of provider status change.
 - QSP verification is at the time of initial application, re-enrollment every two years, and/or upon notification of provider status change.

10. Behavioral Consultation	Provider Managed: No	Self-Directed: Yes
<p>Service Description</p> <p>Behavioral Consultation is a service provided to meet the excess disability related expenses associated with maintaining a participant in their primary caregiver’s home and not covered through the Medicaid State Plan. The service provides expertise, training, and technical assistance in natural environments (home, grocery store, community) to assist primary caregivers, and other natural supports to develop an intervention plan designed to address target behaviors. The behavior support plan is determined and written by the behavioral consultant with input from the participant’s team and incorporated into the participant’s person-centered service plan.</p> <p>Allowable Activities covered are:</p> <ul style="list-style-type: none">• Observing the participant to determine the needs;• Assessing current interventions for effectiveness;• Developing a written intervention plan which clearly delineates the interventions, activities, and expected outcomes to be carried out by family members, support staff, and natural supports in the intervention plan;• Training of primary caregiver to implement the specific interventions/support techniques delineated in the intervention plan;• Observing, recording data and monitoring implementation of therapeutic interventions/support strategies;• Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes;• Providing training and technical assistance to primary caregiver(s) to instruct them on the implementation of the participant’s intervention plan; and/or;• Participating in team meetings. <p>The behavior support plan is determined and written by the behavioral consultant with input from the participant’s team and incorporated into the participant’s person-centered service plan.</p> <p>Behavioral Consultation services are to provide support for conditions specifically related to IID/DD.</p> <p>This service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan. If the participant requires hands on assistance for a specific task, then virtual supports service delivery cannot be an option for that task but may be utilized for other tasks that do not need hands on support.</p> <p>A Virtual Support Checklist will be required to be completed by the DD Program Manager and the team during the person-centered planning process. This checklist will act as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of remote supports. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery. The Virtual Support Checklist will include consideration of the estimated hours/visits that virtual supports delivery will be utilized. The risk assessment and service plan require the team to develop a plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided.</p> <p>In virtual supports, the use of cameras in bathrooms are not permitted. Use of cameras in bedrooms impacting the participant’s dignity and privacy is not permitted.</p>		

Virtual supports reinforce community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.

The participant’s services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. The amount of time chosen shall be determined during the person- centered planning process and outlined in the Individual Service Plan. Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

Limits on the amount, frequency, or duration of this service

- Limitations are for the development and the evaluation of the plan and training of the primary caregiver.
- Behavioral Consultation service does not include implementation of the plan by the behavior consultants or training of the staff.
- Behavioral Consultation service excludes services provided through the Individual Education Plan (IEP).
- Behavioral Consultation service is limited to \$5,200 per participant per State Fiscal Year, unless an exception is approved by the DHHS/DD Section to prevent imminent institutionalization. Given that this is a self-directed service, the participant\legal decision maker must choose a service provider who meets Department set parameters of the provider’s specifications of the service. The participant\legal decision maker chooses the appropriate provider dependent on the participant’s budget and the provider rates.
- Behavioral Consultation service is not available for individuals receiving Residential Habilitation or Independent Habilitation as behavioral consultation is included as a professional service.
- Behavioral Consultation services cannot be provided in a foster care setting, but may be authorized in the natural family home when the participant is present and the requirements above are met.
- Behavioral Consultation services cannot be authorized on the individual service plan with Infant Development.
- Behavioral Consultation service may not be provided in a clinical setting or a school.
- Behavioral Consultation service shall not be furnished or billed at the same time of day as another service that provides direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Extended Home Health Care, Parenting Support, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, **Respite** or Individual Employment.
- Behavioral Consultation service may not duplicate any other service in the waiver.

Service Unit

- Dollar amount

Service Delivery Method

- Participant Directed

Provider Category

- Individual

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant, a relative or a legal guardian of the participant.
- License - a current licensed ND Behavior Analyst, ND Registered Behavioral Analyst, ND Psychiatrist or Psychologist
- Certificate - currently certified ND Behavior Modifications Specialists or QDDP employed not contracted by a licensed DD Provider.

Verification of Provider Qualifications

- Entity Responsible: State Medicaid Agency, DD Section, DDPM.
- Frequency of Verification: Annually

11. Environmental Modifications	Provider Managed: No	Self-Directed: Yes
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Service Description

Environmental Modifications service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid Sate Plan to maintain a participant living in their own home or in the home of their primary caregiver. A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The home must be owned **or rented** by the participant or the participant’s primary caregiver.

Environmental Modifications service consists of modifications made to a participant's home or vehicle. Home Modifications are age-appropriate physical modifications identified in the participant's plan of care developed by the participant's team, which are necessary to ensure the health, welfare, and safety of the participant or/and enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the participant.

An environmental modification provided to a participant must:

- relate specifically to, and be primarily for, the participant's disability;
- any modifications must be done primarily for the participant with the disability;
- not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
- and not be in the form of room and board or general maintenance.

Environmental Modifications service covers purchases, installation, and as necessary, the repair of the following home modifications which are not covered under the Medicaid State Plan:

- Permanent ramps
- Permanent lifts, elevators, manual, or other electronic lifts,
- Modifications and/or additions to bathroom facilities
 - Shower modifications
 - Sink modifications
 - Bathtub modifications
 - Toilet modifications
 - Water faucet controls
- Improve access/ease of mobility, excluding locks,
 - Widening of doorways/hallways,
 - turnaround space modifications
 - floor coverings
- Specialized accessibility/safety adaptations/additions
 - Electrical wiring
 - Fire safety or others emergency adaptations
 - Windows modifications
 - Modifications to meet egress regulations if there are no other egress options available in the structure
 - Automatic door openers/doorbells
 - Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
 - Durable wall finishes.
- Modifications and/or additions to kitchen facilities
 - Sink modifications
 - Water faucet controls
 - Counter/cupboard modifications

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community and are required by the participant's plan of care. The installations of these items are included. The waiver participant or primary caregiver must own the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Covered Vehicle Modifications are:

- Door modifications
- Installation of raised roof or related alterations to existing raised roof system to increase head clearance
- Lifting devices
- Devices for securing wheelchairs or scooters
- Handrails and grab bars
- Seating modifications
- Lowering of the floor of the vehicle

Environmental Modifications service is to provide support for conditions specifically related to IID/DD.

Limits on the amount, frequency, or duration of this service

- For Environmental Modification services the amount will not exceed \$40,000 per participant for the duration of the waiver period. The authorization database will track the amount authorized and utilized to prevent over-expenditure.
- Requests for home modifications (environmental modification) anticipated to exceed \$500, three estimates are required to determine the most cost-efficient material for the adaptation to meet the participant's needs. All requests are reviewed on a case-by-case basis to determine if the request is reasonable and appropriate.
- Items that are not of direct or remedial benefit to the participant are excluded from this service.
- Repair of items purchased through the waiver or purchased prior to waiver participation is covered, as long as the item is identified within this service definition, determined by the team and appropriate professional to be necessary, and the cost of the repair does not exceed the cost of purchasing a replacement piece of the item.
- Environmental Modification service cannot duplicate any other service in the waiver.

Home Modifications:

- **If the home is rented by the participant or the participant's primary caregiver, a written approval from the landlord of any modification must be submitted with the request.**
- **The base product and one repairs, not covered under the of warranty, of the home modification which is are cost efficient and continue to appropriately meets the needs of the participant will be covered.** Home modifications are limited to remodels of an existing structure (home the participant is living in). Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary, to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Home modifications will not be approved for new construction (building a new house) or unfinished area (i.e. basement).
- Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as roof repair, general plumbing, swimming pools/hot tub/spa, central air conditioning, **fencing, outdoor seating or recreation areas**, service & maintenance contracts and extended warranties, etc.
- Home modifications purchased for exclusive use at the home school are not covered. Waiver funding will not be used to replace home modifications that have not been reasonably cared for and maintained. All services shall be provided in accordance with applicable State or local building codes.

Vehicle Modifications:

- The cost of purchasing a vehicle with adaptations; service and maintenance contracts; and extended warranties, are not covered. Adaptations for a vehicle purchased, rented, or leased for exclusive use at the school/home school are not covered.
- **The base product and repairs, not covered under the warranty, of the vehicle modification which is are cost efficient and continue to appropriately meets the needs of the participant will be covered.** Payment may not be made to adapt vehicles that are owned or leased by paid providers of waiver services.

Service Unit

- Dollar amount

Service Delivery Method

- Participant Directed

Provider Category

- Individual
- Vendor

Provider Type Title

- Individual
- Vendor

Provider Qualifications

- Individual
 - This service cannot be provided by a person who is legally responsible for the participant, **relative**, or a legal guardian of the participant.
 - The participant and/or legal decision maker, along with the Team members will identify the appropriate Environmental Modifications within the participant's Plan. In addition to identifying the appropriate environmental modifications, the team determines if the adaptations can be made by family members, i.e. a father building a ramp according to ADA specifications. In those specific circumstances, the participant and/or legal decision maker obtains the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

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- The Team will consider the technical and safety requirements of specific environmental modifications when they consider recommending individual vs. agency provider specifications, i.e. installation of a van lift would only be authorized through a vendor authorized by the manufacturer.
- The following standards must be followed as applicable:
 - Building permits;
 - The Vendor must be bonded and licensed to practice the profession;
 - The Vendor must be enrolled with the ND Secretary of State; and
 - The Vendor must be in good standing with ND Workforce Safety.
 - The Vendor must follow the Americans with Disabilities Act guidelines.
 - The Vendor must provide the item approved in the participant’s plan, or be recommended by a licensed professional, and selected by an individual or legal decision maker as cost effective.
- Vendor:
 - NDCC 43-07; <https://www.ndlegis.gov/cencode/t43c07.pdf>
 - NDCC 43-09; <https://www.ndlegis.gov/cencode/t43c09.pdf>
 - NDCC 43-18; <https://www.ndlegis.gov/cencode/t43c18.pdf>
 - The participant and/or legal decision maker along with team members will identify the appropriate environmental modifications within the participant's plan. The participant and/or legal decision maker obtains the material and finds an appropriate professional who is or will be enrolled with the Fiscal Agent.
 - As applicable: building permits, Bonded and Licensed to practice profession, enrolled with ND Secretary of State, and in good standing with Workforce Safety. Americans with Disabilities Act guidelines will be followed.
 - The participant and/or legal decision maker must select a vendor who will provide the item approved in the participants plan or recommended by an appropriate professional and selected by the participant or legal decision maker as cost effective.

Verification of Provider Qualifications

- Entity Responsible: Fiscal Agent and participant or primary caregiver
- Frequency of Verification: Prior to Modifications

12. Equipment and Supplies	Provider Managed: No	Self-Directed: Yes
<p>Service Description</p> <p>Equipment and Supplies service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a participant in their home. Equipment and Supplies enable a participant to remain in and be supported in their home, preventing, or delaying unwanted out of home placement or imminent institutionalization. Individual needs identified through the planning process in the following areas can be addressed through the individual budget process.</p> <p>The participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participants plan.</p> <p>Equipment and Supplies service covers purchases of the following which are not covered under the Medicaid State Plan:</p> <ul style="list-style-type: none"> • devices, controls, or appliances, specified in the participant's plan, that enable participants to increase their ability to perform activities of daily living (i.e. switches, grab devices, portable ramps, and lifts); • devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; • items necessary for life support including ancillary supplies and equipment necessary to the proper functioning of such items; • Assistive technology device means an application or software item, or piece of equipment, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. • Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: <ul style="list-style-type: none"> ○ the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; ○ services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; ○ services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 		

- ongoing training and technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- ongoing training and technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants; and
- Personal Emergency Monitoring Response System is an electronic device or control that enables waiver participants to secure help in an emergency, be monitored to maintain health safety, or promote independence without paid staff. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep, and maintenance of devices/systems are provided;
- Personal Tracking System is a device or control for the waiver participant that enables them to be located or monitored when there is a health and safety risk related to the participant's disability. Installation, upkeep, and maintenance of devices/systems are provided; and
 - 1)Remote Monitoring devices and activities are not permissible in bathrooms or bedrooms when participant's dignity and privacy is impacted. Devices can be placed in a location that may be secured by the parent/guardian and either out of sight or visible depending on the participant's needs. A team meeting with the parent/guardian, participant, and DDPM prior to the use of remote monitoring activities will act as a safeguard to ensure remote monitoring can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion, including health and welfare.
 - 2)Remote monitoring reinforces community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.
 - 3)The informed consent will be obtained from the Primary Care giver/participant when they sign the Person-Centered Plan of Care. Primary caregiver/Participant will have ultimate authority on when device is needed for participant and who needs to be aware of the monitor being used. Service Plan will also have written back-up plan due to failure of equipment.
- Specialized Medical supplies gloves, diapers, wipes, hospital bed, and nutritional supplements.
- Equipment and Supplies service is to provide for conditions specifically related to IID/DD.

Limits on the amount, frequency, or duration of this service

- All equipment and supplies shall meet applicable standards of manufacture, design, and installation.
- Equipment and Supplies service is limited to \$5,000 per participant per approved waiver year with a maximum of \$25,000 per waiver period, unless an exception is approved by the DHHS/DD to prevent imminent institutionalization. The authorization database will track the amount authorized and utilized to prevent over expenditure.
- Experimental or prohibited treatments are excluded. These include treatments not generally accepted by the medical community as effective and proven, not recognized by professional medical organizations as conforming to accepted medical practice, not approved by FDA or other requisite government body, are in clinical trials or further study or are rarely used, novel, or unknown and lack authoritative evidence of safety and efficacy.
- A written recommendation must be obtained by an appropriate professional (OT, PT, SLP, etc.) and three separate trials of equipment, when appropriate, to ensure that the equipment will meet the needs of the participant prior to consideration for approval.
- Generic devices and items (e. g. tablets, computers, printers, ancillary items, exercise equipment, cell phones, home security systems) are not allowed.
- Nutritional supplements are only covered when they constitute 51% or more of nutritional intake to ensure that it is not duplicated under the Medicaid State Plan.
- Equipment and Supplies service cannot duplicate any other service in the waiver.

Service Unit

- Dollar amount

Service Delivery Method

- Participant Directed

Provider Category

- Agency

Provider Type Title

- Vendor

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant, relative, or a legal guardian of the participant.
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- Participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participant’s Plan.
- The participant and/or legal decision maker will obtain the equipment and supplies from a provider who is enrolled with the ND Secretary of State and with the Fiscal Agent.
- The vendor must provide the item approved in the participant’s plan.

Verification of Provider Qualifications

- Entity Responsible: The Fiscal Agent
- Frequency of Verification: Quarterly or as needed

13. Family Care Option	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Family Care Option service is care for a child in a family home setting that meets the minimum licensing requirements for foster home. This service may be provided on a part-time or full-time basis for an eligible child under the age of 21, who cannot remain in their natural family home on a full-time basis.</p> <p>Family Care Option focuses on close communication and coordination with families and the school system during the transition period. Support is provided as physical or verbal assistance to complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, and show preference.</p> <p>Family Care Option service helps to develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes, and avocation; and aid involvement in family routines and participation in community experiences and activities.</p> <p>Family Care Option is voluntary placement by the natural family. The natural family retains all decision-making authority and all legal, education, medical, and financial responsibility. Family Care Option is available only if the child is receiving the proper parental care and education necessary for the child’s physical, mental or emotional health as referenced in NDCC 27-20-02 (5); and is not considered boarding care according to the definition of the North Dakota Department of Public Instruction</p> <p>Participants may receive Day Habilitation outside the facility if the outcomes are consistent with the habilitation described in the participants plan and the service originates from the licensed day program.</p> <p>Participants receiving services in Family Care Option must have an active IEP (Individual Education Plan).</p> <p>Family Care Option service is to provide for conditions specifically related to IID/DD.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Family Care Option is not provided in group residential settings. • Family Care Option cannot be authorized on the individual service plan with Adult Foster Care, Residential Habilitation, or Independent Habilitation service. • IHS, Homemaker, Respite, and EHC cannot be provided in the Family Care Option setting but may be authorized in the natural family home when the participant is present, and the requirements are met. • To avoid duplication service is not available to children under the custody of the Human Service Zone. • Family Care Option service will not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan <u>Services, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.</u> • Family Care Option service cannot duplicate any other service in the waiver. <p>Service Unit</p> <ul style="list-style-type: none"> • Daily rate 		

Provider Type Title

- Agency: Licensed DD Provider

Provider Qualifications

- This service may be provided by a relative but cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

14. In-Home Supports	Provider Managed: Yes	Self-Directed: Yes
<p>Service Description</p> <p>In-Home Support service provides support to meet the excess care needs related to the participant’s disability. In-Home Supports (IHS) benefits the primary caregiver by providing relief care (respite) when the primary caregiver is not present or when the primary caregiver is present and needs a second pair of hands to assist the participant in activities of daily living and maintaining health and safety. The service plan team determines the appropriate tasks or activities that are provided by IHS staff and this is included in the participant’s person-centered plan.</p> <p>In-Home Supports benefits the primary caregiver by assisting the participant in activities of daily living such as eating, drinking, toileting, and physical functioning; improving and maintaining mobility and physical functioning when these tasks require more than one person to accomplish. It may also include assisting the participant with maintaining health and personal safety while the primary caregiver is home and attending to other household task and children and no other natural support is available.</p> <p>In-Home Support can be provided to the participant while the primary caregiver is either away from the home or is home, but unavailable to care for the participant. The team determines the appropriate tasks or activities that are provided during the primary caregiver’s presence or absence and this is included in the participant’s person-centered service plan.</p> <p>The participants receiving In Home Supports (IHS) are supported in the home and community in which they live or in the home of the support staff, if the home is approved by the legal decision maker.</p> <p>In-Home Supports service is to provide for conditions specifically related to IID/DD.</p> <p>In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, In-Home Supports may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient’s functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • In-Home Support service is limited to a total of 300 hours per month per participant regardless of the delivery method unless an exception is approved by the DD Section. • In- Home Supports may not be provided by primary caregiver, legally responsible person, or legal guardian. • IHS may not be provided to a group of participants or in a facility-based setting (i.e. day habilitation, daycare, school). • IHS cannot be authorized or provided when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP or when the participant is receiving home schooling. • IHS cannot be provided for the purposes of administering a specialized curriculum or service that is not specifically authorized on the participant’s service plan (ISP section of the plan). • An IHS participant can be authorized to receive both provider managed and self-directed at the same time but cannot be furnished or billed at the same time of day. The authorized amounts are not transferable between the different service delivery methods (i.e self-directed, provider managed). • For families who have more than one participant in the household receiving this service, each participant’s individual needs are evaluated by the Team to determine if the total number of hours and staff can be combined to still ensure each participant’s health and safety. 		

- In-Home Support payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid.
- IHS cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation or Adult Foster Care.
- In-Home Support cannot be provided in a Family Care Option setting but may be authorized in the natural family home when the participant is present, and the requirements are met.
- In-Home Support service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Extended Home Health Care, Parenting Support, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, **Respite**, or Individual Employment.
- In-Home Support service cannot duplicate services provided under any other service in the waiver.
- **This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.**

Service Unit

- 15 minutes

Service Delivery Method

- Participant-Directed
- Provider Managed

Provider Category

- Agency
- individual

Provider Type Title

- Agency: Licensed DD Provider
- Individual – self directed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency
 - Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
- Individual
 - Must be 18 years or older; and
 - Must meet qualifications as listed in the participant’s plan.

Verification of Provider Qualifications

- Entity Responsible:
 - Agency: The Developmental Disabilities Section is responsible for licensing verification.
 - Individual: Fiscal Agent verifies initial proof of age and basic competencies
- Frequency of Verification:
 - Agency – Annually
 - Individual - At annually the DDPM will verify specific qualifications identified by the family in the participant’s plan and update as needed.

15. Infant Development	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Infant Development service is only available to infants/toddlers age birth through two years of age. This service is a home-based, family focused service that provides information, support, and training to assist primary caregiver(s) in maximizing the child's development utilizing a parent-coaching model. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The primary caregivers, infant development professionals, and DDPM serve as a team and determine services necessary to meet the child and caregiver needs, along with the frequency and duration of services.</p> <ul style="list-style-type: none"> • Home visit: Home visitors coach the primary caregiver(s) on how to address the identified needs for their child. <ul style="list-style-type: none"> ○ Home Visits must be scheduled at least once a month but may be scheduled multiple times a week. The expectation is that home visits will last about an hour and take place in the child’s natural environments. 		

- **Consults:** Consults allow the opportunity for other members of the Team to coach both the primary caregiver(s) and home visitor in the area of their specialty.
 - The team will determine the expertise needed and what areas of consult are required to meet the child and family's needs and outcomes. The Individual Family Service Plan (IFSP) outcomes determine the frequency of consults needed to meet the outcomes.
- **Evaluation/Assessment:** An evaluation is completed to determine eligibility for Developmental Disabilities Program Management (DDPM), as well as for Infant Development services, when a child applies for services.
 - An assessment is completed annually, after a child is eligible for services, to determine progress made on the outcomes, as well as to offer information for updating the plan.
 - Evaluations and Assessments must be conducted by at least two qualified ID personnel of different disciplines (either contracted or employed) from the Core Evaluation/Assessment Team.
- An Individual Family Service Plan (IFSP) is developed to identify services and learning opportunities to support the family in meeting the needs of their child, enhance their child's development, and increase the child's and family's participation in everyday routines and activities within the home and community. **Plan Development/Update:** The plan directs supports and services, in relation to the prioritized concerns and outcomes of the primary caregiver(s) and rest of the team.
 - Initial meetings must take place within 45 days of referral
 - Plans must be developed annually
 - Periodic reviews must occur at least every 6 months, however, can be more frequent to address child and family needs/concerns

Infant Development service is to provide for conditions specifically related to IID/DD.

Limits on the amount, frequency, or duration of this service

- Infant Development services serves children birth through 2 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction
- Infant Development does not provide direct therapies nor can it be provided at the same time as other waiver services.
- Home visits cannot be conducted over the phone.
- Nursing consultations can only be billed when needed to ensure the child's health and welfare while participating in another Early Intervention service.
- Infant Development service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Self-Directed Services, Family Care Option, **Respite**, or Extended Home Health Care.
- Infant Development service cannot duplicate any other service in the waiver.
- Infant Development cannot be authorized on the individual service plan with Behavioral Consultation, Residential Habilitation, Independent Habilitation, Parenting Support, Adult Foster Care, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

Service Unit

- Pay point for Home Visit, Consultation, Evaluation\Assessment, IFSP Updates Development

Provider Type Title

- Licensed DD Provider

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant, a relative or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
- Infant Development programs must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to infants and toddlers.

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

16. Parenting Support	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Parenting Support services assists participants who are, or will be, parents in developing appropriate parenting skills. Parenting Support is different from other family support programs as the participant is the parent rather than the child. Participants receive individualized training that focuses on the developmental needs, health and welfare needs of their child. Close coordination is maintained with informal supports and other formal supports.</p> <p>Parenting Support service is to provide for conditions specifically related to IID/DD.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Support is available from the first trimester, until the eligible participant’s child is 18 years of age. • Parenting Support service cannot be authorized on the individual service plan with Residential Habilitation or Independent Habilitation. • Parenting Support is limited to an average of four (4) hours of individualized child-focused direct training per week during a quarter. • If the eligible participant (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training, but group training and support activities will be provided. • Parenting Support shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Family Care Option, Extended Home Health Care, Adult Foster Care, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment. • Parenting Support service cannot duplicate any other service in the waiver. <p>Service Unit</p> <ul style="list-style-type: none"> • 15 minutes <p>Service Delivery Method</p> <ul style="list-style-type: none"> • Provider Managed <p>Provider Qualifications</p> <ul style="list-style-type: none"> • This service cannot be provided by a person who is legally responsible for the participant, a relative or a legal guardian of the participant. • Agency: Licensed according to NDAC 75-04-01; http://www.legis.nd.gov/information/acdata/html/75-04.html <p>Verification of Provider Qualifications</p> <ul style="list-style-type: none"> • Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification. • Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change. 		

17. Community Transition Services	Provider Managed: Yes	Self-Directed: No
<p>Service Description</p> <p>Community Transition Services is a one-time cost for non-recurring set-up expenses for participants who are transitioning from an institution to a home and community-based setting where the participant wishes to reside. Allowable community transition services are those where the participant is directly responsible for their living expenses and includes:</p> <ul style="list-style-type: none"> • essential household furnishings and moving expense required to occupy and use within their home; including furniture, window coverings, food preparation items and bed/bath linens; • set-up fees or deposits for utility or service access, including telephone, electricity, heating and water, and security deposits. <p>Items purchased via this service are the property of the participant.</p> <p>Limits on the amount, frequency, or duration of this service</p> <ul style="list-style-type: none"> • Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. 		

- Community Transition Services may be utilized for qualifying expenses up to 180 consecutive days prior to admission to the waiver and 90 days after the date the participant became eligible for the waiver.
- One-time transition costs are limited up to \$3000 per eligible participant per waiver period.
- Community Transition Services are subject to prior authorization and funds are furnished only to the extent that they are necessary as identified in the service plan. The state utilizes a transitional budget form that details an inventory of expenses deemed necessary to move from an institution and establish a home in the community. The funds are only available if the individual is unable to meet such expenses or when the services are not able to be obtained from other sources.
- The participant must be reasonably expected to be eligible for and to enroll in the waiver.
- This service is limited to participants coming from a ND Medicaid Institutional setting who have resided there for a minimum of 60 consecutive days.
- This service cannot duplicate any other service in this waiver.
- This service is limited to participants who are moving into a setting with 6 or fewer people.

Service Unit

- Dollar amount

Service Delivery Method

- Provider Managed

Provider Category

- Agency

Provider Type Title

- Agency

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant, a relative or a legal guardian of the participant.
- Agency: Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>

Verification of Provider Qualifications

- Entity Responsible: The Developmental Disabilities Section is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

18. Respite	Provider Managed: Yes	Self-Directed: Yes
<p>Service Description</p> <p>Respite services are services provided to the participant that give temporary relief to the primary caregiver from daily stress, care demands and to prevent or delay unwanted out of home placement. Temporary means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).</p> <p>A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.</p> <p>The team determines the activities and amounts of respite during the person-centered planning process and are specified in the individual plan of service.</p> <p>Respite may be provided in or out of the participant’s home. The participants receiving Respite may be supported in their home, home of the support staff, camp, or other community settings, if approved by the legal decision maker.</p> <p>In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, Respite may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient’s functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.</p> <p>This service is to provide support for conditions specifically related to IID/DD.</p>		

Limits on the amount, frequency, or duration of this service

- Hours of support will be limited to a total of 600 hours per State Fiscal Year per participant.
- Respite may not be provided by primary caregiver, legally responsible person, or legal guardian.
- Respite shall not be used as day/childcare.
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the primary caregiver to go to work or to attend school nor for the purpose of providing extra help while the primary caregiver is present.
- Respite may not include the cost of registration fees or the cost of recreational activities (for example, camp)
- Other family members (such as siblings of the participant) may not receive more than general supervision from the provider while Respite care is being provided/billed for the waiver participant(s)
- Respite cannot be authorized or provided when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP or when the participant is receiving home schooling.
- Respite may not be provided to a group of participants, in a facility-based program (i.e., day habilitation, daycare, school), or in Residential Habilitation or Independent Habilitation settings.
- For families who have more than one participant in the household receiving this service, each participant's individual needs are evaluated by the team to determine if the total number of hours and staff can be combined to still ensure each participant's health and safety.
- Respite can be authorized to receive both provider-managed and self-directed at the same time. The authorized amounts are not transferable between the different service delivery methods (i.e., self-directed, provider managed).
- This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Infant Development, Medicaid State Plan Services, In-Home Supports, Self-Directed Services, Day Habilitation, Prevocational Services, Small Group Employment Supports, Individual Employment Support, Homemaker, or Extended Home Health Care.
- Respite cannot be provided to participants receiving Adult Foster Care, Residential Habilitation, or Independent Habilitation.
- Respite cannot be provided in a Family Care Option setting but may be authorized in the natural family home when the participant is present and the requirements above are met.
- To avoid duplication, this service is not available to participants under the custody of county social services.
- This service cannot duplicate any other service in this waiver.
- This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Unit

- 15 minutes

Service Delivery Method

- Participant-Directed
- Provider Managed

Provider Category

- Agency
- individual

Provider Type Title

- Agency: Licensed DD Provider
- Individual – self directed

Provider Qualifications

- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency
 - Licensed according to NDAC 75-04-01; <http://www.legis.nd.gov/information/acdata/html/75-04.html>
- Individual
 - Must be 18 years or older and
 - Must meet qualifications as listed in the participant's plan.

Verification of Provider Qualifications

- Entity Responsible:
 - Agency: The Developmental Disabilities Section is responsible for licensing verification.
 - Individual: Fiscal Agent verifies initial proof of age and basic competencies
- Frequency of Verification:
 - Agency – Annually

- Individual - At annually the DDPM will verify specific qualifications identified by the family in the participant's plan and update as needed.

III. Medicaid State Plan (MSP)

Description

Medicaid State Plan was authorized in 1966 for the purpose of providing an effective base upon which to provide comprehensive and uniform medical services that enable persons previously limited by their circumstances to receive needed medical care. It is within this broad concept that the Medicaid Program in North Dakota participates with the medical community in attempting to strengthen existing medical services in the state.

Funding is shared by federal and state governments, with eligibility for Medicaid is determined at the Human Service Zone.

1. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Description

A group residential facility licensed as a certified health care facility for individuals with intellectual disabilities and related conditions. The programming provided in this type of residence is for individuals with extensive needs. Direct care staff is on duty 24 hours per day. Each individual must receive a continuous active treatment program, which includes an aggressive and consistent program of education, health services, and related services directed toward acquisition of skills for the individual to function with as much self-determination and independence as possible.

The day/employment support component for individuals residing in an ICF/IID is included in the rate.

2. Personal Care Services

Description

Medicaid State Plan Personal Care (MSP PC)

Personal Care services are provided under the Medicaid (MA) State Plan. Under the MA state plan, Personal Care is available to more individuals, as the eligibility criteria under the state plan does not require the person meet the Nursing Facility or ICF/ID level of care required under the waivers, unless the person needs an enhanced level of personal care services (Level B and Level C).

DDPMs are responsible to provide case management activities associated with Personal Care through the state plan for individuals who are eligible for and receiving DD Program Management. This includes individuals who reside in Basic Care facilities.

Personal Care is self-directed and does not include internal program coordination. The DDPM provides all case management activities. The individual, guardian, and/or natural support system are responsible for all other coordination. The DDPM is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual in obtaining a qualified service provider (QSP), monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

In order to receive Personal Care under the Medicaid State Plan:

1. An individual must be eligible for Medicaid and
2. Meet the minimum eligibility requirements for the personal care services per the Personal Care Eligibility and Needs assessment for DD.

Services consisting of a range of assistance, provided to an individual with disabilities or conditions that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the forms of hands-on assistance or cueing so that the individual can perform a task without direct assistance. Tasks may include assistance with bathing, toileting, transferring, eating, dressing, mobility, meal preparation, laundry, medication assistance, shopping, money management, hair, nail, and teeth care, etc. Services provided must be essential to the health and welfare of the individual, rather than the individual's family.

3. Targeted Case Management with Personal Care Services

Description

The focus or purpose of **Targeted Case Management (TCM)** is to identify what the person needs to remain in their home or community and be linked to those services and programs.

An assessment must be completed, and a Care Plan developed. The individual's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.

Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The individual must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Individuals must also check and sign acknowledgment that if they are on Medicaid, they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.

Activities of Targeted Case Management

- 1-Assessment/Reassessment
- 2-Care Plan Development
- 3-Referral and Related Activities
- 4-Monitoring and Follow-up Activities

Targeted Case Management (TCM) Eligibility Requirements:

The individual receiving TCM will need to meet the following criteria:

- Medicaid recipient.
- Not currently be covered under any other case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose.
- Not a recipient of HCBS (1915c) waiver service.
- Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.
- Has "long-term care need." Document the required "long-term care need" on the Application for Services, [SFN 1047](#). The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.
- Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.
- The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.

IV. General Fund Services

Description

General funds are state dollars designated by the ND legislature to provide services within the limits of legislative appropriation. In DD, general funds have been appropriated in limited circumstances only when a service does not qualify for federal Medicaid financial participation, or an individual does not qualify for the ICF/IID level of care to access Medicaid financial participation through the waiver.

General Fund Services under the DD Section are:

- **Section 11 Funds**
- **Corporate Guardianship**

1. Section 11 Funds

Description

General designated by the ND legislature to provide residential, and employment supports to individuals who do not meet the level of care to access federal funding under the Traditional DD HCBS Waiver.

2. Corporate Guardianship

Description

A service purchased on behalf of individuals eligible for developmental disabilities program management services when a district court has determined that the individual requires a guardian. When no one else is available to serve as the guardian for an eligible individual age 18 and older, Catholic Charities of North Dakota Corporate Guardianship Program will serve as the guardian through a contract with the Developmental Disabilities Section.

SECTION XIV – RATE GUIDELINES AND MATRIX - APPENDIX B

2023/2024 Salary Reimbursement Levels

Direct Care Staffing effective 7/1/2023 through 6/30/2024

Provider Managed In-Home Support & Parenting Supports

\$8.14/hour Administration

\$4.10/hour Program Coordination

		Salary Allowance	Salary & Fringe
		\$20.37	\$27.09
	Annual	\$42,370	\$56,347

\$9.83 15 min rate

Self Directed In-Home Supports

		Salary Allowance	Salary & Fringe
		\$20.37	\$27.09
	Annual	\$42,370	\$56,347

Family Care Option

\$10.71/day Administration

\$4.84/day Program Coordination

Infant Development Fee-For-Service Rates for 2023-2024

Activity	
Evaluation	\$538.50
Individual Family Service Plan	\$521.53
Home Visits	\$157.25
Consultation	\$326.94

DD Provider Extended Home Health Care Rate for 2023-2024

\$10.67 15 min rate

State of North Dakota
Rate Matrix
Fully Loaded Hour Value: "The Brick"

Effective
July 1, 2023

2%
Vacancy

Column Reference :	O	D	E	F	G	H	I	J	K	L	M	N	O		
Component Driven Service		Wage	ERE	D X E ERE \$	D + F Sub	Relief Staff	G x H Relief \$	G + I Sub	P S	D x K PS \$	J + L Sub	General & Admin	With V Factor	F %	At Funded %
Residential Services															
ICF-ID	d	\$19.63	35.1%	\$6.89	\$26.52	14.0%	\$3.71	\$30.23	87.2%	\$17.12	\$47.35	\$52.34	\$53.41	89.7%	\$47.91
ICF-ID Medically Involved	d	\$19.63	35.1%	\$6.89	\$26.52	14.0%	\$3.70	\$30.22	166.0%	\$32.59	\$62.81	\$69.43	\$70.85	89.7%	\$63.35
ICF-ID Medically Intensive	d	\$19.63	35.1%	\$6.89	\$26.52	14.0%	\$3.70	\$30.22	244.0%	\$47.90	\$78.12	\$86.35	\$88.11	89.7%	\$79.04
Residential Habilitation	d	\$19.71	35.1%	\$6.92	\$26.63	14.0%	\$3.73	\$30.36	39.6%	\$7.81	\$38.17	\$42.19	\$43.05	91.6%	\$39.43
*Res Medical Acuity - Level 1	d	\$19.71	35.1%	\$6.92	\$26.63	14.0%	\$3.73	\$30.36	42.7%	\$8.42	\$38.78	\$42.87	\$43.74	91.6%	\$40.07
*Res Medical Acuity - Level 2	d	\$19.71	35.1%	\$6.92	\$26.63	14.0%	\$3.73	\$30.36	64.7%	\$12.75	\$43.11	\$47.65	\$48.62	91.6%	\$44.54
*Res Medical Acuity - Level 3	d	\$19.71	35.1%	\$6.92	\$26.63	14.0%	\$3.73	\$30.36	92.1%	\$18.15	\$48.31	\$53.62	\$54.71	91.6%	\$50.12
Independent Habilitation	h	\$19.74	35.1%	\$6.93	\$26.67	14.0%	\$3.73	\$30.40	36.1%	\$7.13	\$37.53	\$41.49	\$41.49	100.0%	\$41.49
Vocational/Day Services															
Day Habilitation	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	56.7%	\$11.16	\$41.48	\$45.86	\$45.86	100.0%	\$45.86
Prevocational Services	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	56.7%	\$11.16	\$41.48	\$45.86	\$45.86	100.0%	\$45.86
Small Group Employment Supports	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	56.7%	\$11.16	\$41.48	\$45.86	\$45.86	100.0%	\$45.86
*Day/Voc Medical Acuity - Level 1	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	63.6%	\$12.52	\$42.84	\$47.36	\$47.36	100.0%	\$47.36
*Day/Voc Medical Acuity - Level 2	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	69.4%	\$13.66	\$43.98	\$48.62	\$48.62	100.0%	\$48.62
*Day/Voc Medical Acuity - Level 3	h	\$19.69	35.1%	\$6.91	\$26.60	14.0%	\$3.72	\$30.32	77.8%	\$15.32	\$45.64	\$50.45	\$50.45	100.0%	\$50.45
Individual Employment Supports	h	\$25.85	35.1%	\$9.07	\$34.92	14.0%	\$4.89	\$39.81	23.1%	\$5.97	\$45.78	\$50.67	\$50.67	100.0%	\$50.67

* Medical Acuity Tiers may be applied to individuals with a SIS Medical Score of 15 or higher and is available to a qualifying provider in Residential Habilitation, Day Habilitation, Prevocational Services, and Small Group Employment Supports only.

6/21/2023 - All rates have been adjusted to include a 2% legislatively approved inflationary adjustment and the equivalent of a one dollar per hour increase to direct care staff and indirect program support staff of licensed developmental disability providers.
Developmental disability providers shall provide a report to the department of health and human services as determined by the department.

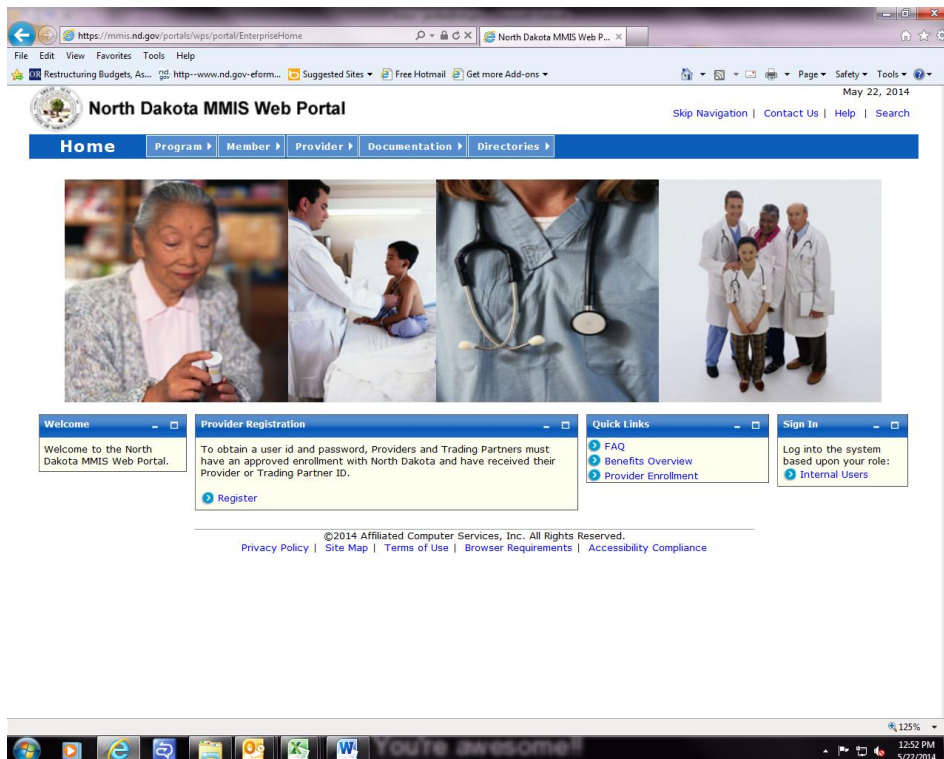
Understanding the components of the rate matrix:

- *Direct service staff wage (column D - wage) – staff who are performing tasks in the furtherance of the objectives of the service.*
- *Employment related expenses (column E - ERE) – all the benefits received by employees of the agency. This includes discretionary and non-discretionary benefits.*
- *Relief staff (column H) – a provision included in the rate to add 14% to provide funds to hire staff as direct service staff when other staff members are not available to work (i.e., vacation, sick leave).*
- *Program related expenditures (column K - PS) – expenditures that support the objectives and the provision of the service but cannot be tied to a particular person receiving services. These are considered “indirect” expenditures (i.e., supervision of direct service staff, supplies related to the service, consultative services to general staff, facility costs, **training**).*
- *General and administrative expenditures (column N – general & admin) – expenditures that are related to the cost of being in business. These have nothing to do with the program, service or the product offered. They tend to include administrative salaries, insurance, travel, office expenses, lease or rental costs for office space, etc.*

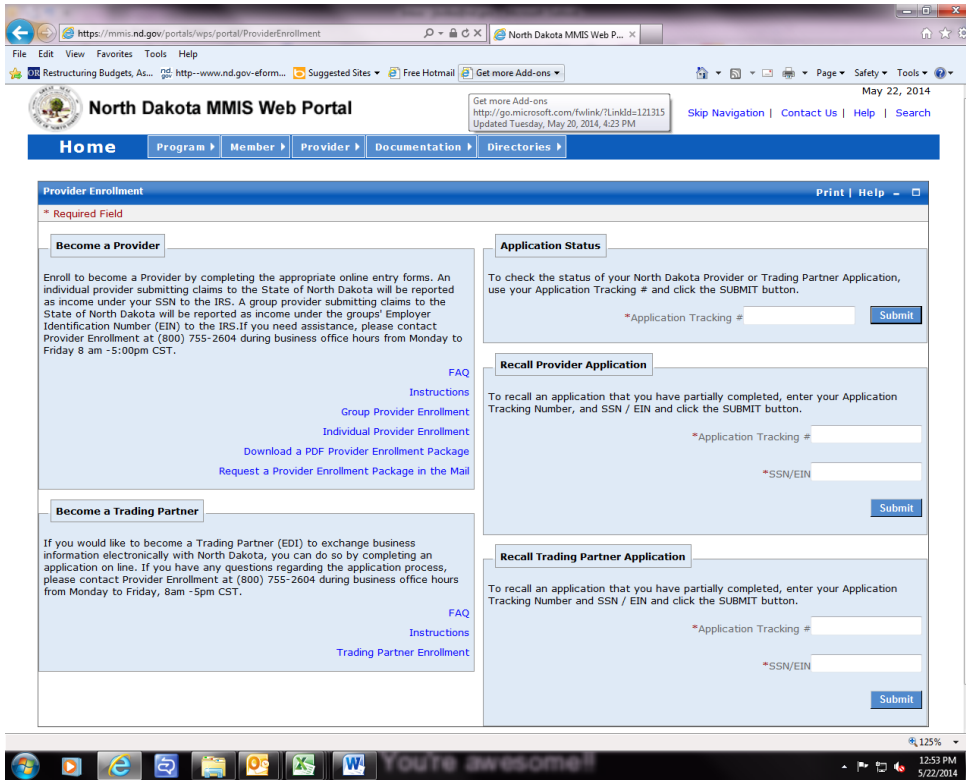
SECTION XV – HE MMIS ENROLLMENT AND CLAIM SUBMISSION (VIA THERAP OR MMIS PORTAL) - APPENDIX C

How to enroll as a DD provider in Enterprise:

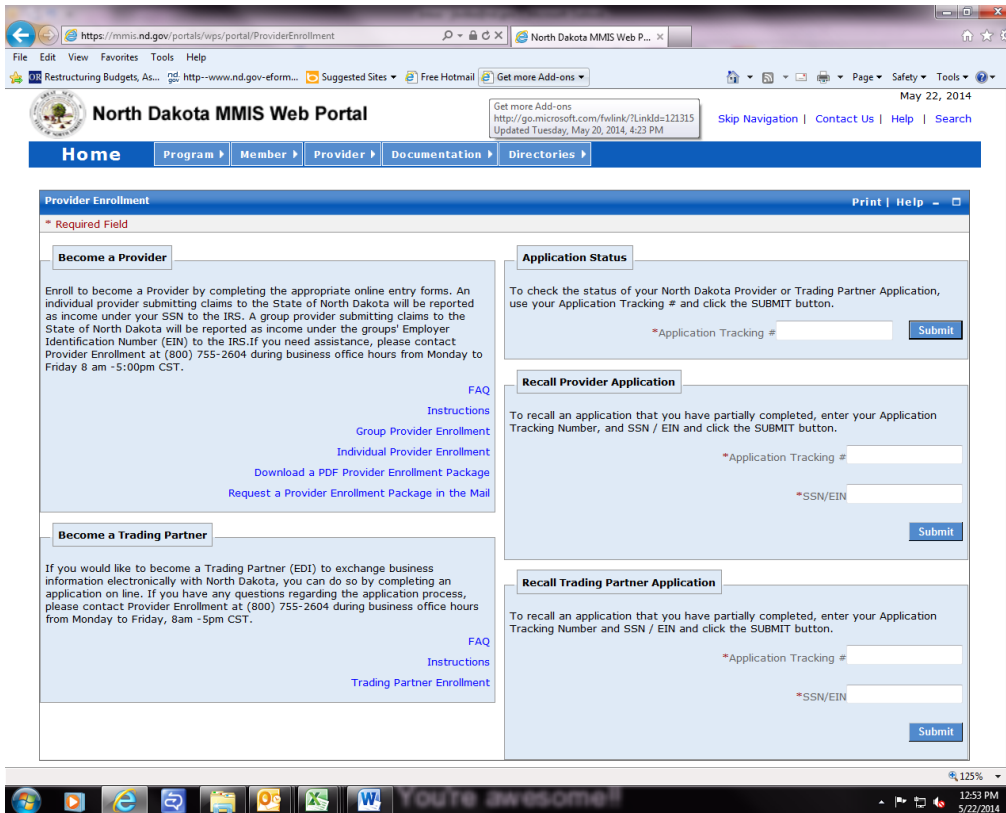
1. Become licensed by the DHHS-DD Section.
2. Complete a SFN 615 & DD Provider Addendum with DHHS (contact the DD Section).
3. Go to <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome> to complete provider enrollment on the enterprise system to receive payment for services rendered
4. Select “Provider Enrollment” under Quick Links



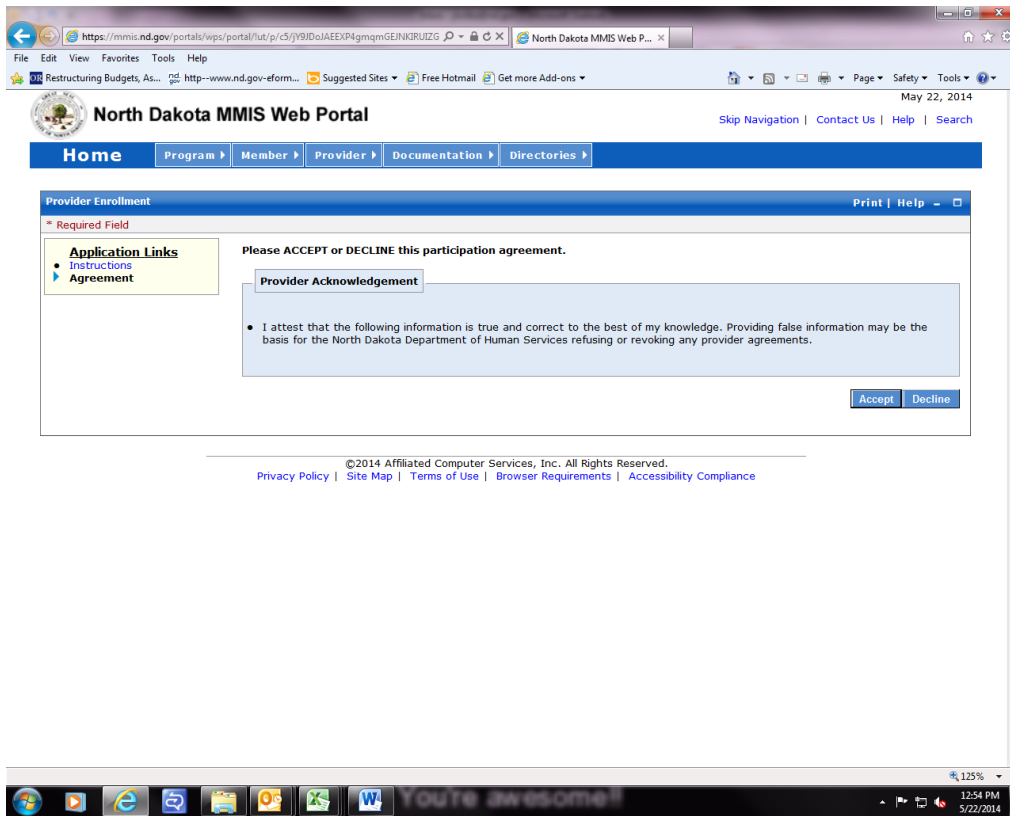
5. Select "Group Provider Enrollment" under Become a Provider section



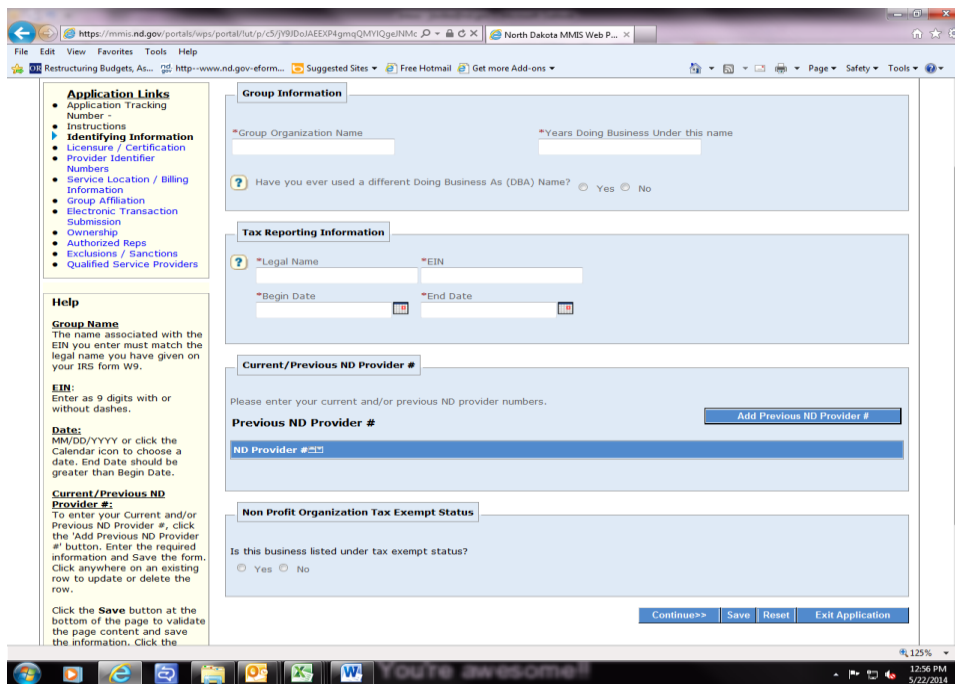
6. Select "Continue"



7. Select "Accept"



8. Complete identifying information section of application. After completing select "Save", then "Continue". Do NOT use any commas, periods, hyphens, etc. in this screen. End date use "12/31/9999"



9. Complete “Licensure/Certification” section of application.
 - a. Provider Type is 039-Developmental Disabilities.
 - b. Select “Add Licensure/Certification”

The screenshot shows the North Dakota MMIS Web Portal interface. The main content area is titled "Licensure / Certification" and contains several sections:

- Provider Type:** A dropdown menu with "039-Developmental Disabilities" selected.
- License and Certification List:** A table with columns: License Number, Certification Number, State, Lic/Cert Agency, Effective Date, and Expiration Date. An "Add Licensure / Certification" button is present.
- Board Certified Specialty List:** A section with a note: "Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility." Below it is a table with columns: Specialty, Provider Type, Certification #, State, Board name, Begin Date, and End Date. An "Add Specialty" button is present.
- Taxonomy:** A text input field.

On the left side, there is a navigation menu with "Licensure / Certification" selected. Below it, there is a "Help" section with instructions for "Provider Type", "Licensure/Certification, Specialty & Taxonomy", and "Taxonomy".

- i. Select “License”
- ii. License number is “DD00000”
- iii. Licensing Agency is “Developmental Disabilities
- iv. Effective Date is the date the license issued by DD is effective
- v. Expiration date coincides with your license issued by the DD Section
- vi. State is North Dakota
- vii. Select “Save” in the small box

Application Links

- Application Tracking Number -
- Instructions
- Identifying Information
- Licensure / Certification**
 - Provider Identifier Numbers
 - Service Location / Billing Information
 - Group Affiliation
 - Electronic Transaction Submission
 - Ownership
 - Authorized Reps
 - Exclusions / Sanctions
 - Qualified Service Providers

Help

Provider Type
Select a Provider Type from the available list.

Licensure/Certification, Specialty & Taxonomy:
To add Licensure, Certification, Specialty and/or Taxonomy information, click the appropriate "Add" button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

Taxonomy
Enter as 10 digits/alpha characters.

Date
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDD/YYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button to move onto the next step. If you choose to Exit Application, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

For additional Enrollment Help, click the Help link on the blue bar at the top of this form.

Provider Type

*Provider Type
Developmental Disabilities

Licensure and Certification - Section 2

Licensure and Certification List Add Licensure / Certification

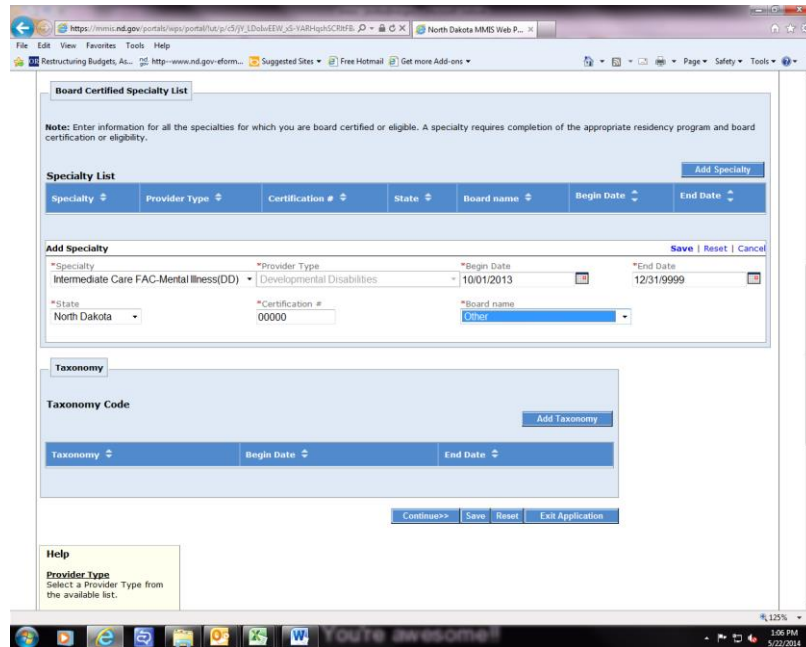
License Number	Certification #	State	Licensing Agency	Effective Date	Expiration Date
Add Licensure and Certification Save Reset Cancel					
<p>*Add all licenses and certificates. For each instance, indicate if you are entering a license or a certification. Are you adding License or Certification information?</p> <p><input checked="" type="radio"/> License <input type="radio"/> Certification</p> <p>*Provider Type Developmental Disabilities</p> <p>*License Number DD00000</p> <p>*Licensing Agency Developmental Disabilities</p> <p>*Effective Date 01/01/2020</p> <p>*Expiration Date 12/31/9999</p> <p>State North Dakota</p>					

Board Certified Specialty List

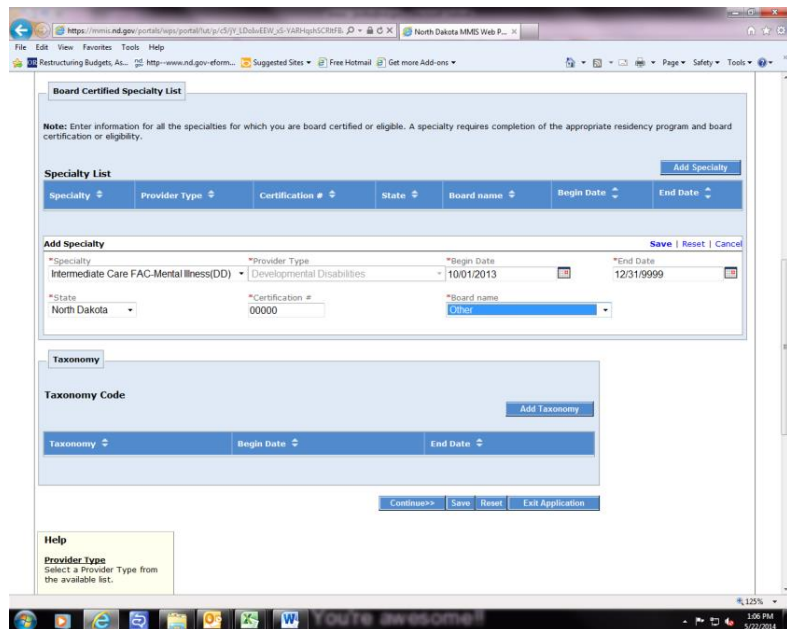
Specialty List Add Specialty

Specialty	Provider Type	Certification #	State	Board name	Begin Date	End Date
Taxonomy						
Taxonomy Code Add Taxonomy						
Taxonomy		Begin Date			End Date	

- i. Select "Add Specialty"
- ii. Choose correct Specialty from drop down box.
 - a. List of type 039 specialties can be found here:
<https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf>
- iii. Begin Date is the date the agency was approved to provide the selected specialty.
- iv. End date is 12/31/9999
- v. State is North Dakota
- vi. Certification # is 00000
- vii. Board Name is "Other"
- viii. Select "Save" within box.



- ix. Select “Add Taxonomy”
 - a. Add Taxonomy number.
 - i. List of taxonomies for provider type 039 can be found here:
<https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf>
 - b. Begin Date is the date the license began
 - c. End Date is 12/31/9999
 - d. Select “Save” within box.



- x. Select “Save” overall, then select “Continue”.

10. Complete “Provider Identifier Numbers” page of application.

a. Select “Add NPI” and enter the number then “Save” with in the box.

b. Select “Save” overall, then select “Continue”

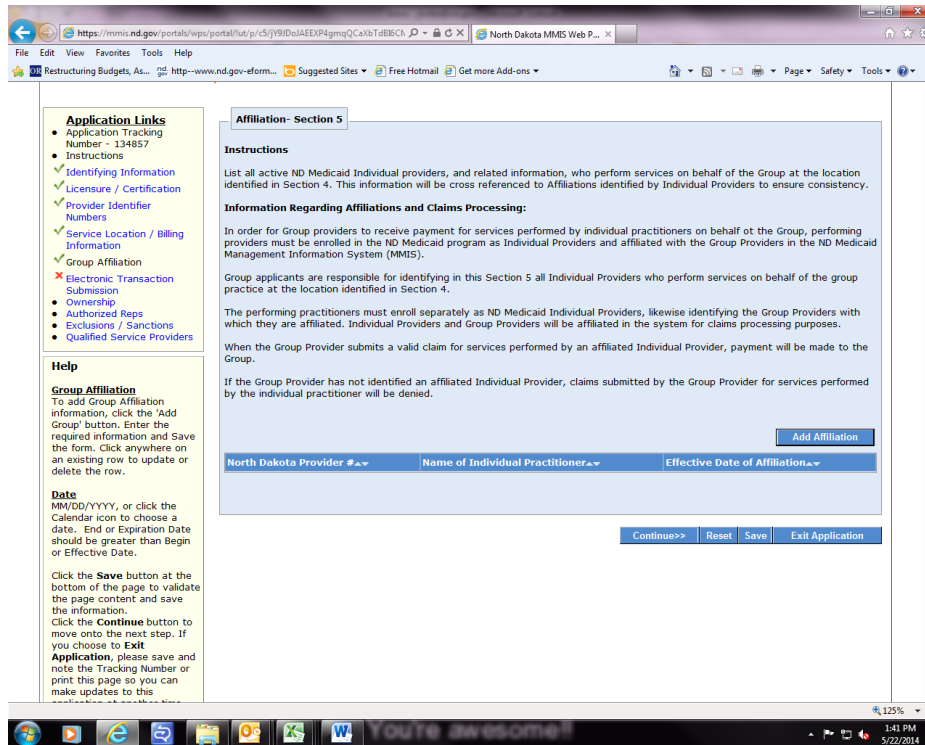
11. Complete “Service Location/Billing Information” section of the application.

a. Answer with the best possible answer.

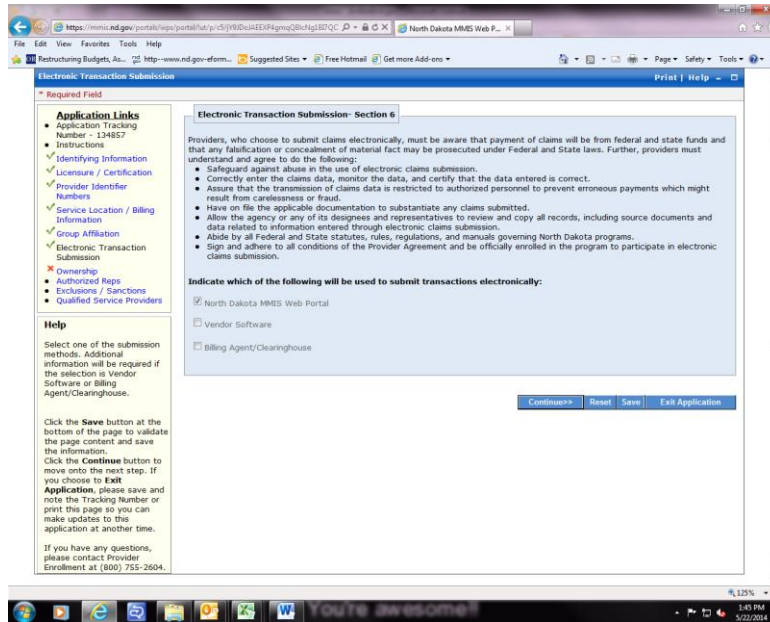
b. This is where you will enter your banking information if you wish to receive Electronic Funds Transfer (EFT) payments versus a paper check.

c. Select “Save” overall, then “Continue”.

12. Select “Continue” on the “Group Affiliation” section of the application. It is not something DD or ICF providers need to fill out.



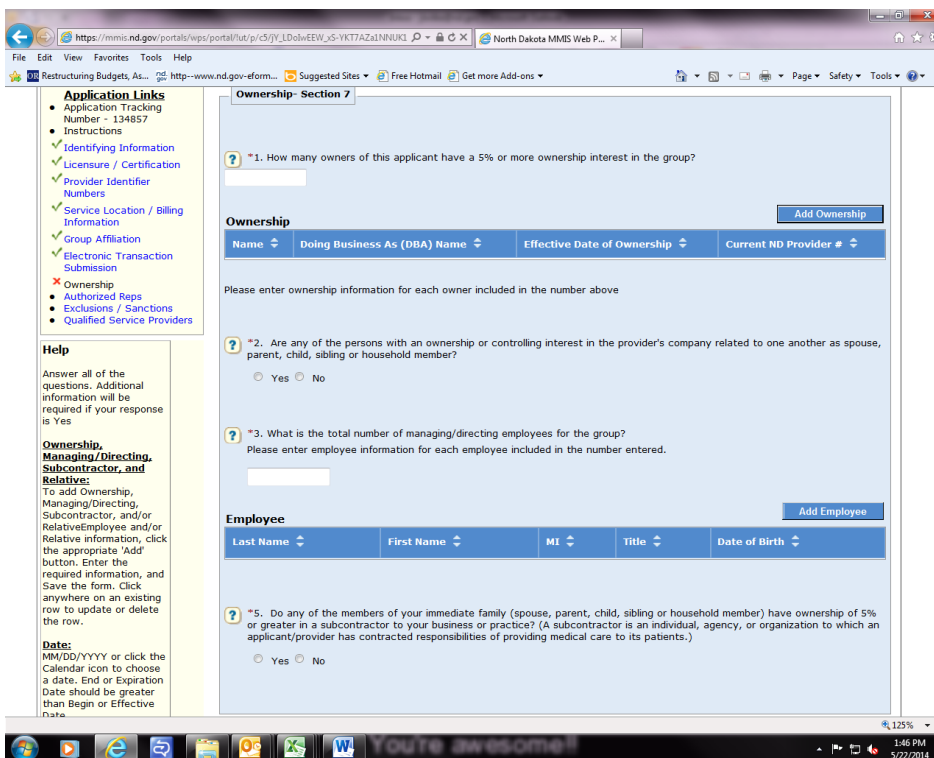
13. Complete the “Electronic Transaction Submission” section of the application.
- Select “North Dakota MMIS Web Portal” if you submit your own claims through the MMIS web portal.
 - Select “Vendor Software” if you use Noridian or have your own software you use to submit claims.
 - Select “Billing Agent/Clearinghouse” if you use any company besides Noridian to submit claims. i.e. Therap
 - If this option is selected – complete a SFN 583: <https://www.nd.gov/eforms/Doc/sfn00583.pdf>
 - Fill out information as best to your knowledge. This information will be used to create a Trading Partner.



d. Select "Save" overall, then "Continue"

14. Complete "Ownership" section of application if it is applicable to your agency.

a. Fill in applicable information. Also, complete SFN 1168 and send to the DD Licensing Administrator with the DD Section.



a. Select "Save" overall, then "Continue"

15. Complete “Authorized Reps” section of the application as it relates to your agency.
 - a. Fill in applicable information.

The screenshot shows the North Dakota MMIS Web Portal interface. At the top, there is a navigation bar with links for Home, Program, Member, Provider, Documentation, and Directories. The main content area is titled "Authorized Reps" and includes a "Print | Help" link. A sidebar on the left contains "Application Links" (Application Tracking, Instructions, Identifying Information, Licensure / Certification, Provider Identifier Numbers, Service Location / Billing Information, Group Affiliation, Electronic Transaction Submission, Ownership, Authorized Reps, Exclusions / Sanctions, Qualified Service Providers) and a "Help" section. The main form area has two sections: "Authorized Representatives" with a table for adding representatives and "Pharmacist In Charge" with a form for entering pharmacist information. The bottom of the screen shows a Windows taskbar with the time 1:47 PM on 5/22/2014.

- b. Select “Save” overall, then “Continue”

16. Complete “Exclusions/Sanctions” section of the application as it relates to your agency.

Exclusions / Sanctions Print | Help

Required Field

Application Links

- Application Tracking Number - 134857
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location / Billing Information
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Authorized Reps
- Exclusions / Sanctions**
- Qualified Service Providers

Help

Answer all of the questions. Additional information will be required if your response is Yes.

Name and Federal Program
To add Name and Federal Program information, click the appropriate 'Add' button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

Date
MM/DD/YYYY or click the Calendar icon to choose a date.

Click the **Save** button at the

Exclusion / Sanction- Section 7

? *1.Are any of the named owners related to owners of the subcontractor as spouse, parent, child, sibling or household member?
 Yes No

? *2.Is the group chain affiliated?
 Yes No

? *3.Is the group operated by a management company or leased in whole or part by another organization?
 Yes No

? *4.Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to involvement of such individuals, or organization in any of the programs established by Medicare, Medicaid, and State Health Insurance Programs?
 Yes No

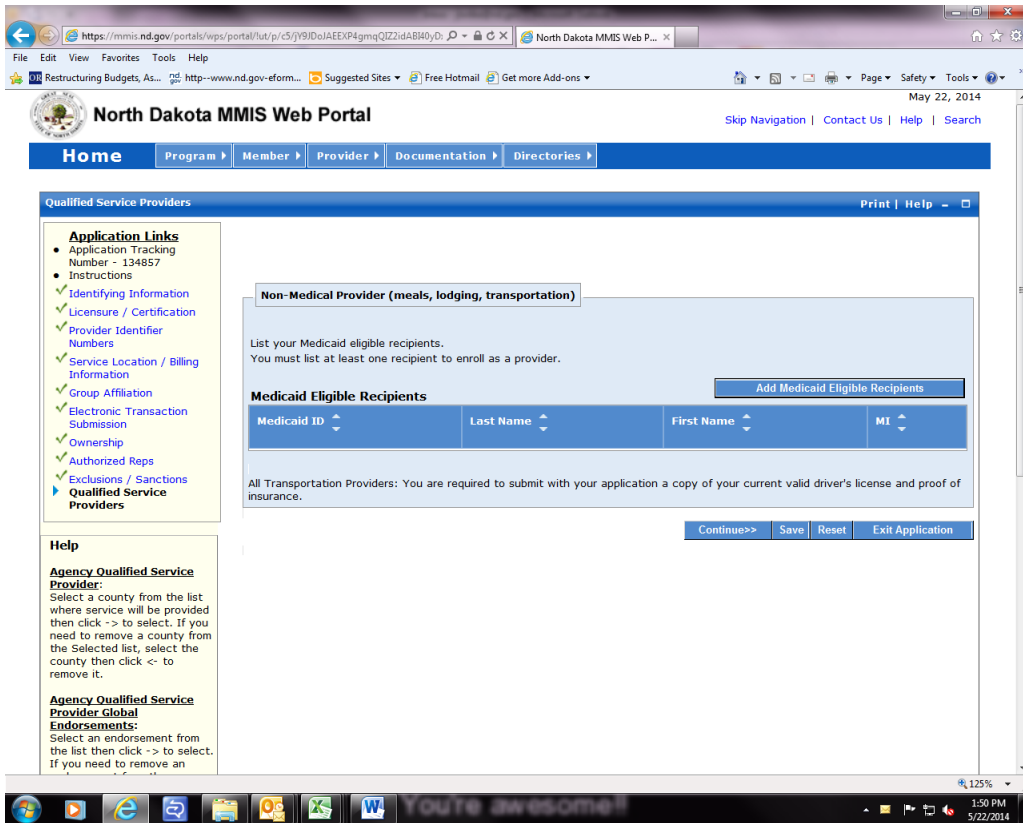
? *5.Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid, and State Health Insurance Program?
 Yes No

? *6.Has any family or household member or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from State or Federal programs due to fraud, obstruction of an investigation or a controlled substance violation?
 Yes No

? *7.Does the applicant under any name or business identity, have any outstanding overpayments with any state or federal program?

- a. Select “Save” overall, then “Continue”.

17. Select “Continue” on the “Qualified Service Providers” section of the application. It is not something DD or ICF providers need to fill out.



18. Complete “Submit Application” section of the application.
 - a. If you’d like to access your remittance advices, submit claims, etc. through the internet complete the “Register for Web Access” section. If you would not like this option, choose “No”.

The screenshot shows the 'North Dakota MMIS Web Portal' with the 'Provider Enrollment - Submit Application Step 1' form. The form is divided into several sections:

- Application Links:** A list of links with checkmarks, including 'Application Tracking Number - 134857', 'Instructions', 'Identifying Information', 'Licensure / Certification', 'Provider Identifier Numbers', 'Service Location / Billing Information', 'Group Affiliation', 'Electronic Transaction Submission', 'Ownership', 'Authorized Reps', 'Exclusions / Sanctions', and 'Qualified Service Providers'. 'Submit Application' is highlighted with a blue arrow.
- Provider Agreement:** A section titled 'Provider Agreement' with a sub-header 'Provider Agreement'. It contains text: 'Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.' Below this are links for 'Medicaid and Basic Care Assistance Programs Provider Agreement', 'Medicaid Program Provider Agreement', 'Pharmacy Agreement/Medical Assistance Program', 'PCCM Agreement', and 'EDI Trading Partner Agreement'.
- Register for Web Access:** A section titled 'Register for Web Access' with a sub-header 'Register for Web Access'. It contains text: 'Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location. Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advices.' Below this are radio buttons for 'Yes' (selected) and 'No'.
- Validate Application:** A section titled 'Validate Application' with a sub-header 'Validate Application'. It contains text: 'Click the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.'

The form also includes input fields for: *Organization Name, *Organization Description, *User ID, Prefix, *Last Name, *First Name, MI, Suffix, *Phone #, Ext, and Email Address.

- b. Select “Save” overall, then “Validate Application”.
- c. After reading, select “I have read and agree to all terms and conditions stated in the Provider Agreement”.
- d. Enter “Requested Claim Submission Effective Date”
- e. Select “Confirm Submit”
- f. Your application is now submitted, print a copy for your records by selecting “Print Application”
- g. Select “Exit application”

MMIS Organizational Administrator Role, Waiver Service Billing Instructions for Completing Claim Form via MMIS Web Portal & Member look up

DD Provider - Login

North Dakota MMIS Web Portal

Jul 15, 2015

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Welcome to the North Dakota MMIS Web Portal.

Provider Registration

To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.

Register

Quick Links

- FAQ
- Find a Healthcare Provider
- Benefits Overview
- Provider Enrollment
- Report Fraud & Abuse

Sign In

Log into the system based upon your role:

- Providers
- Members
- Internal Users

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- Login in by selecting “**Providers**” in the sign in box on the right hand side of the webpage.
- <https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>

DD Provider - Login

North Dakota MMIS Web Portal

Jul 15, 2015

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Quick Links

- Enrollment
- ProviderManuals
- FAQ
- Billing Manuals
- Messages & Announcements

News

Governor's Task Force on Access to Affordable Health Insurance.

Provider

The ACS Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

ProviderLogin

To access secure areas of the portal, please log in by entering your User ID and Password.

User ID:

* Password:

Forgot User Name or Password ?

Login Reset

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- Enter User ID and Password combination and select “Login”.

DD Provider – Organization Administrator

North Dakota MMIS Web Portal

Jul 15, 2015

Skip Navigation | Contact Us | Help | Search | Log out

Home Member Provider Claims EDI Authorizations My Account

Change Password

Manage Users

Reset AVR PIN

Provider Message Center

Status	From	Date	Subject
No Data			

0-0 of 0

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- As an organization administrator you can add, change, or delete additional accounts by selecting **My Account**, then **Manage Users**.

DD Provider – Organization Administrator

- To add a new user click on the **“Add New User”** in the upper right hand corner.
- To change or delete a user you can either search by name or user ID in the tabs **“Name”** or **“ID”**.

DD Provider – Organization Administrator

- All fields with red asterisk must be filled in.
- Different roles can be assigned. It is recommended to have two or three organization administrators roles.
- After you click on **“Add”** in the upper right hand corner there should be a response of **“The user is created successfully”**
- Note: User ID must have the first letter of the first name and the last name. It must be a minimum of 6 characters and a maximum of 20 characters.

DD Provider – Organization Administrator

North Dakota MMIS Web Portal

Home Member Provider Claims EDI Authorizations My Account

Message Users

Required Field Has not logged in for 30 days Has not logged in for 60 days Has not logged in for 90 days

Name ID

Last Name First Name MI

Email

Designated as a Supervisor

User Status

Active

Inactive

Locked

Has not logged in for 30 days

Has not logged in for 60 days

Has not logged in for 90 days

Reset Search

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- You can view/edit users by searching by name – i.e. Wilke, Jamie – select “Name” tab in the yellow box
- You can view/edit users by searching by user ID – i.e. jwilke – select the “ID” tab in the yellow box
- Either option is also how to reset passwords or deactivate user.

DD Provider – Organization Administrator

North Dakota MMIS Web Portal

Home Member Provider Claims EDI Authorizations My Account

Manage Users

Required Field

View / Edit User

Please enter the following information about the user you would like to edit.

User ID: JWLKE

User Status: Active

Organization: Minot Vocational Adjustment Workshop

Last Login:

Password Expiry:

Prefix Last Name First Name MI Suffix

Phone / Ext Email

701-328-8929 jwilke@nd.gov

What roles will this user have in the organization?

Available	Selected
ND-PharmacyProviderUser	Provider-BillingStaff
Provider-AuthzStaff	Provider-FinancialStaff
Provider-EligibilityStaff	
Provider-EnrollmentStaff	
Provider-FES	
Provider-OrganizationAdministrator	
Provider-PrimaryAccountHolder	
Provider-TradingPartnerEnrollment	

Cancel Reset Deactivate Reset Password Save

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- To reset password click on the “Reset Password” button, then click on the “Save” button.
- To deactivate account click on the “Deactivate” button, then click on the “Save” button.

DD Provider – User Password Change

North Dakota MMIS Web Portal

Jul 15, 2015

Skip navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EDI | Authorizations | My Account

Change Password

Manage Users

Reset AVR, P3I

Print | Help

Change | Cancel

Required field

- Password must be a minimum of 8 characters and maximum of 14 characters.
- Password must be different from your last 26 passwords.
- Password cannot use any 4 characters that match your userid.
- Password cannot contain user's first name or last name.
- Password must contain at least 3 of the 4 following types:
 - Uppercase letters
 - Lowercase letters
 - Numbers
 - Non-Alphanumeric (! , \$, # , @ or %)

*Current Password

*New Password

*Confirm New Password

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- To change your own password select **"My Account"**, **"Change Password"**. Fill out the three boxes as instructed. Then click on **"Change"**.

DD Provider – Service Authorizations

- There is no change to the service authorization process for DD providers
 - Authorizations will continue to be inputted into Therap by DDPMs.

Step 1: Obtain National Provider Identifier (NPI) number.

Q. What is an NPI Number?

A. 10-digit numeric identifier that will not change, even if your name, address, taxonomy, or other identifiers change. **It will be required to bill DD services electronically in MMIS as of January 1, 2021.**

Before applying for an NPI, you will need to know the taxonomy code you should use and that you are applying for a Type 2 NPI: Organizational Providers (Group).

- **NPI Type 2: Organizational Providers (Group)**
- Resource: NPI What you Need to know
 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPI-What-You-Need-To-Know.pdf>
 - Frequently Asked Questions:
<https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html>

Taxonomy Codes

01

A taxonomy code describes the Individual Provider or Organization/ Group type, classification, and the area of specialization.

02

In the NPI application you will be asked to identify a taxonomy code.

03

DD Taxonomy Codes:

Provider Type	Provider Specialty Code	Taxonomy Code
39-DD	620-Day Habilitation	251S00000X
39-DD	379-Family Support Services (DD)	251S00000X
39-DD	555-Individual Employment Support	251S00000X
39-DD	621-Independent Habilitation	251S00000X
39-DD	372-Infant Development (DD)	252Y00000X
39-DD	369-Intermedicate Care Facilities for Individuals with Intellectual Disabilities -(ICF/IID) (DD)	315P00000X
39-DD	557-Prevocational Services	251S00000X
39-DD	622-Residential Habilitation	251S00000X
39-DD	501-Self-Directed Supports	251S00000X
39-DD	556-Small Group Employment Support	251S00000X

DD Provider- Service Codes (Professional Claims)

Billing codes for developmental disability services			
	DD Billing Codes in MMIS		
Service type	HCPC code	Modifier	Billing unit
Day Habilitation	T2021		15 min
Prevocational Services	T2047		15 min
Individual Employment Supports	T2019		15 min
Small Group Employment Supports	T2019	HQ	15 min
Homemaker	S5130		15 min
Residential Habilitation	T2016		daily
Residential Habilitation- Retainer	T2016	U5	daily
Independent Habilitation	T2017		15 min
Extended Home Health Care	G0300		15 min
Adult Family Foster Care	S5140		daily
Adult Family Foster Care-Respite Care	S5150		15 min
Behavioral Consultation	S5131		per diem
Environmental Modifications	S5165		each
Equipment & Supplies	T2028		each
Family Care Option I	T2033		daily
In-Home Supports			
In Home Supports Provider	S5125		15 min
In Home Supports Provider- secondary staff	S5125	XP	15 min
In Home Supports Self-Directed	S5126		per diem
Respite			
Respite Provider	S5150		15 min
Respite Provider- secondary staff	S5150	XP	15 min
Respite Self-Directed	S5151		Per diem
Infant Development			
Evaluations /Assessments	T1023		each
Individual Family Support Program	T2024		each
Home Visits	S5111		each
Consultations	T2025		each
Parenting Support	S5120		15 min
Community Transition Services	T5999		each

- **DD Provider –Professional Claim Submission**

For DOS after 1/1/2020, all services, except for ICFs, must be submitted using a professional claim form. If you choose to do your own billing, outside of Therap, you will be required to enter claims on this claim type which requires an NPI, taxonomy, place of service, billing and rendering provider, a primary diagnosis, etc. If you use Therap for billing, all these items will be prepopulated for you.

- **Creating a Professional Claim**

- ND Health Enterprise Web Portal Professional Claim Form Submission Instructions:

<https://www.hhs.nd.gov/sites/www/files/documents/ND%20MMIS%20Web%20Portal%20Professional%20Claim%20Form%20Submission%20Instructions.pdf>

- **Creating a Claim Template**

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/training-mmis-portal-template-training.pdf>

- **Submitting a Claim Adjustment or Voiding a Claim**

- <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/training-mmis-portal-adjust-void-claim.pdf>

- **Submitting an Attachment to a Claim**

- <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-attachments-fact-sheet.pdf>

DD Provider – View Submitted Claims

The screenshot shows the North Dakota MMIS Web Portal interface. At the top, there is a navigation bar with tabs for Home, Member, Provider, Claims, EDI, Authorizations, and My Account. The 'Claims' tab is selected, and a dropdown menu is open, showing options: Create Claims, Manage Claims, Create Templates, Manage Templates, Claim Status Inquiry, Payment Inquiry, and 1099 Inquiry. The 'Manage Claims' option is highlighted, and a sub-menu is visible with options: Edit / Delete Saved Claim and View Submitted Claims. On the left, there is a 'Quick Links' section with various links like Add Service Location, Trading Partner Enrollment, etc. Below the navigation bar, there is a 'Provider Message' section with a 'Status' dropdown and a list of messages, including one from 'Labissoniere, Lisa'.

- To view a submitted claim go to **“Claims”**, **“Manage Claims”**, and **“View Submitted Claim”**.

DD Provider – View Submitted Claims

The screenshot shows the search form for submitted claims in the North Dakota MMIS Web Portal. The page title is 'Search for Submitted Claims'. There is a 'Required Field' section with a text input field for 'Billing Provider ID'. Below this is an 'Additional Information' section with several date input fields: 'Member ID', 'Claim Submission Begin Date', 'Claim Submission End Date', 'Claim Service Period Begin Date', and 'Claim Service Period End Date'. A note states: 'If only the Begin Date (and no End Date) is entered, the End Date will be the same as the Begin Date. Note: Submitted claims are only kept on record for 30 business days after the date of submission.' At the bottom right, there are 'Search' and 'Reset' buttons. The footer contains copyright information for 2015 Affiliated Computer Services, Inc. and links to Privacy Policy, Site Map, Terms of Use, Browser Requirements, and Accessibility Compliance.

- Input the Member ID number and click on **“Submit”**.
- There is an option to customize claim submission date ranges and claim service period date ranges. If this is desired enter the Member ID and the date ranges desired, then click on **“Submit”**.

DD Provider – View Submitted Claims

North Dakota MMIS Web Portal Jul 30, 2015
Skip Navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EOI | Authorizations | My Account

Search for Submitted Claims Print | Help

*** Required Field**

To conduct a search for previously submitted claims, enter information in any or all of the additional information fields, and click "Search". If only the Provider Number is used to perform the search, all existing claims associated with that provider will be returned, up to a maximum number of 100 results. If there are likely more than 100 results, please refine your search criteria by entering more specific information in the additional information fields below.

Billing Provider ID

*Billing Provider ID
[Redacted]

Additional Information

Member ID
[Redacted]

If only the Begin Date (and no End Date) is entered, the End Date will be the same as the Begin Date. Note: Submitted claims are only kept on record for 30 business days after the date of submission.

Claim Submission Begin Date [] Claim Submission End Date []
 Claim Service Period Begin Date [] Claim Service Period End Date []

Search Search

SEARCH RESULTS

Below is a list of claims that met your search criteria for the selected Provider ID. Click on a row to view details associated with that claim.

Provider ID: 1456394

Member Name	Member ID	Claim Service Period Begin Date	Total Charges	Form Type	Form Sub Type	Claim Submission Date	Last Updated By
[Redacted]	[Redacted]	08/01/2014	\$3,900.00	Professional	HCBS/DD	07/30/2015	[Redacted]
[Redacted]	[Redacted]	08/01/2014	\$4,613.28	Professional	HCBS/DD	07/29/2015	[Redacted]

1 - 2 of 2

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- If there is more than one submitted claim for the Member ID for the selected date range a list will populate. Select which claim you want to view by clicking on the blue hyperlink in the Member Name section. Due to HIPAA reasons this section has been blacked out.

DD Provider – View Submitted Claims

North Dakota MMIS Web Portal Jul 30, 2015
Skip Navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EOI | Authorizations | My Account

View Submitted HCBS/DD Claim Print | Help

*** Required Field**

Void/Replace

Is this a void/replacement?
 Yes No

Billing Provider

Please enter either a Provider Organization Name or Provider Last Name and First Name.

*Provider Number [Redacted] OR Last Name [] First Name [] MI []

Member

*Member ID Number [Redacted] *Member's Last Name [Redacted] *First Name [Redacted] MI [Redacted]

Billing Period

*Begin Date [08/01/2014] *End Date [08/31/2014]

Line Items

Total Submitted Charges: \$3500.00

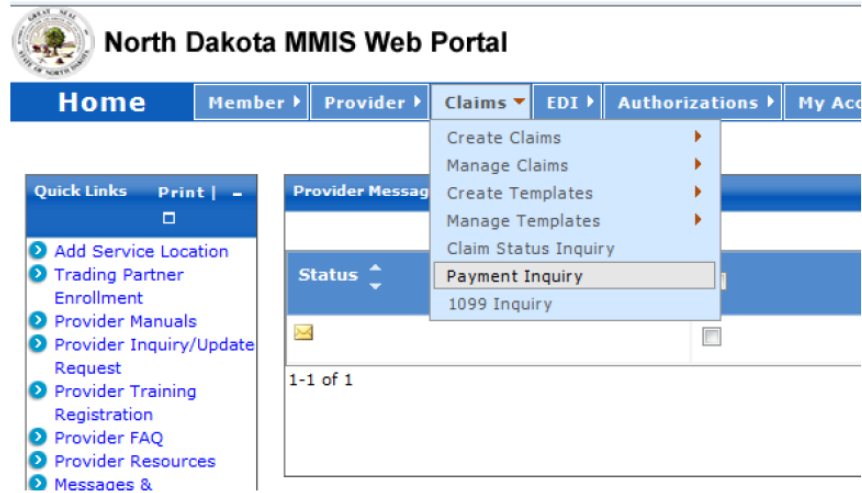
LI	Service Begin Date	Service End Date	Procedure Code	Units	Billed Amount	Action
2	[]	[]	[]	[]	[]	[+]
1	08/01/2014	08/31/2014	W090	31	\$3,900.00	[] []

Cancel

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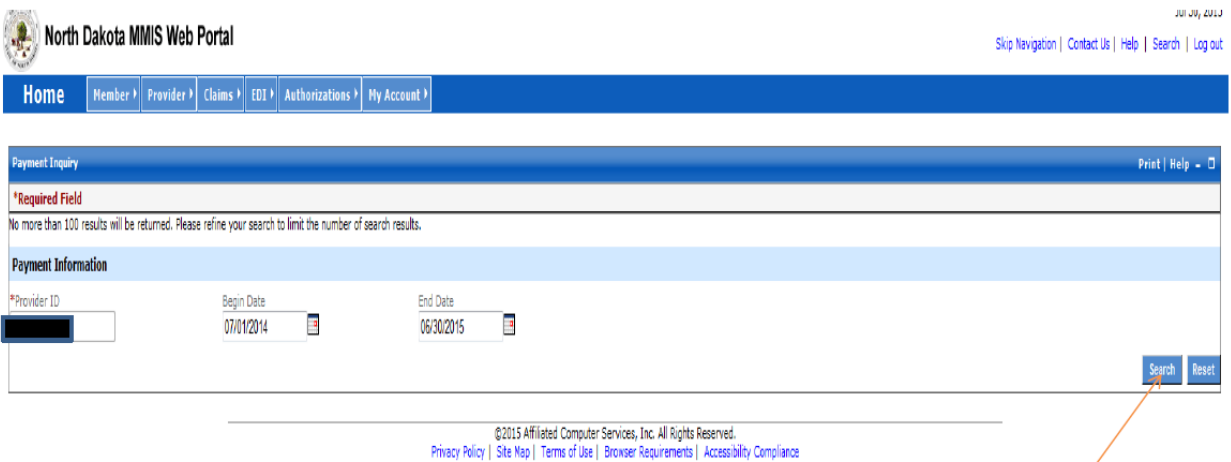
- The screen above will show once you select a claim from the list on the previous page.

DD Provider – View Remittance Advice



- To view a submitted claim go to **“Claims”** and **“Payment Inquiry”**.

DD Provider – View Remittance Advice



- Select desired date range for remittance advices (RA) and click on **“Select”**.
- If there is more than one RA a list will appear. Select the RA you want to view by clicking on the blue hyperlink.

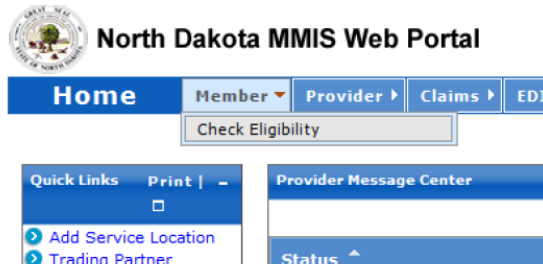
DD Providers – Common Remark Codes

Some Common Remark Codes

- MA133
 - Claim overlaps Inpatient Stay
- 204
 - This service/equipment/drug is not covered under the patient's current benefit plan
 - No DD waiver screening or Medicaid/Part C
- N129
 - Not eligible due to Member's age
- 26
 - Expenses Incurred prior to coverage
 - No Medicaid for the dates of service billed
- 27
 - Expense incurred after coverage terminated
 - No Medicaid for the dates of service billed
- 16/A1
 - Claim/service lacks information or has submission/billing errors
 - You do not need to pay attention to this code. It is only an accompanying remark.
- N54
 - Claim information is inconsistent with pre-certified/authorized services.
- N820
 - Unmatched Units- The EVV units billed, do not match the EVV data received by the aggregator.
 - If billing outside of Therap, check rounding rules.
 - Check data in Therap to ensure all visits for the day are in accepted/sent status to aggregator.
- N821
 - No Visit Found- EVV visit not found in the aggregator.
 - Check data in Therap to make sure it is in sent status.
 - Check data in Therap to ensure all visits for the day are in accepted/sent status to aggregator.
- 198/119

- Precertification/authorization exceeded/Benefit maximum for this time period or occurrence has been reached.
 - Check preauth/authorization for Units authorized
 - Contact ddclaimsupport@nd.gov if the amounts you have billed are less than the approved authorized amounts
-
- Full list of denial codes can be found: <https://x12.org/codes>
 - There is a link for reason codes and remark codes that will provide an explanation.
 - There may be more than one Remark Code assigned to a claim on the Remittance Advice.
 - All Billing and Case Action questions should be sent to ddclaimsupport@nd.gov

DD Provider – Member Look up



- To check for client eligibility for Medicaid and the amount of Recipient Liability (RL) select “**Member**” and “**Check Eligibility**”

DD Provider – Member Look up

North Dakota MMIS Web Portal Jul 30, 2015
[Skip Navigation](#) | [Contact Us](#) | [Help](#) | [Search](#) | [Log out](#)

Home [Member](#) [Provider](#) [Claims](#) [EDI](#) [Authorizations](#) [My Account](#)

Check Eligibility Print | Help

* Required Field

Eligibility Inquiry

Requester

Provider ID: [Redacted] Provider Name: [Redacted] Payer ID: [Redacted] Payer Name: North Dakota Medicaid

To inquire about a specific member's eligibility, you must enter at least 3 of the following criteria:
 1. Member ID
 2. Date of Birth
 3. Last Name
 4. First Name

Use of member SSN, gender and middle initial is optional.
 Note: If the Service From Date and Service To Date are left blank, the dates will be defaulted to current date.

Member Information

Member ID	Date of Birth	Last Name	First Name	MI	Gender	SSN	Service From Date	Service To Date	Inq Type	Action
1	[Date Picker]	[Text]	[Text]	[Text]	[Dropdown]	[Text]	[Date Picker]	[Date Picker]	30	[+]

Eligibility Confirmation Print | Help

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- Enter the member ID, date of birth, last name, first name, and dates of service to view eligibility and click on **“Search”**.

DD Provider – Member Look up

Search Results

Please click on a row to view the member's eligibility detail.

Member ID	Date of Birth	Last Name	First Name	MI	Gender	SSN	Service From Date	Service To Date	TPL
[Redacted]	07/31/2014	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	07/31/2014	12/31/2014	Y

1 - 1 of 1

Eligibility Confirmation Print | Help

* Required Field

Service From Date: 07/31/2014 Service To Date: 12/31/2014 Confirmation Number: [Redacted]
 Eligibility As of date: 07/01/2014 Eligibility Status: Yes Last RPTD Date: [Redacted]

Member Information

Name: [Redacted] Suffix: [Redacted] Date of Birth: [Redacted] Date of Death: [Redacted] Member ID: 000205209
 Street Address: [Redacted] P.O.Box: [Redacted] City: [Redacted] State: [Redacted] Zip: [Redacted]

Eligibility Status

Program Code: [Redacted] Case Number: [Redacted] Case Head Of Household: [Redacted]

1 - 1 of 1

Benefit Plan

Plan Description	Plan From	Plan To
Medicaid Fee For Service	07/01/2014	12/31/2014

1 - 1 of 1

Primary Care Provider

Provider ID	Provider Name	Plan Description	Organization Name
0 - 0 of 0			

0 - 0 of 0

Other General Information

Is there Any Recipient Liability Involved? **No** Is there any Long Term Care involved? **No** Has the Recipient Liability Amount been met? **Yes** Recipient Liability Amount **0.00**

- Recipient Liability information is shown in the **“Other General Information”** section.
- The AVRS phone system can also be used to receive this information.

Intermediate Care Facilities (ICF) Billing Instructions for Completing the UB04 Claim Form via MMIS Web Portal

Intermediate Care Facility (ICF) Web Portal Billing Instructions

North Dakota MMIS Web Portal

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Welcome
Welcome to the North Dakota MMIS Web Portal.

Provider Registration
To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.
Register

Quick Links
FAQ
Find a Healthcare Provider
Benefits Overview
Provider Enrollment
Report Fraud & Abuse

Sign In
Log into the system based upon your role:
Providers
Members
Internal Users

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- In the “Sign In” block, select “Providers”

Intermediate Care Facility (ICF) Web Portal Billing Instructions

North Dakota MMIS Web Portal

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Quick Links
Enrollment
ProviderManuals
FAQ
Billing Manuals
Messages & Announcements
News
Governor's Task Force on Access to Affordable Health Insurance.

Provider
The ACS Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

ProviderLogin
To access secure areas of the portal, please log in by entering your User ID and Password.
* User ID:
* Password:
Forgot User Name or Password?
Login Reset

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- Enter your User ID and Password
- Select “Login”

Intermediate Care Facility (ICF) Web Portal Billing Instructions

North Dakota MMIS Web Portal

Skip Navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EDI | Authorizations | My Account

Quick Links: Add Service Location, Trading Partner Enrollment, Provider Manuals, Provider Inquiry/Update Request, Provider Training Registration, Provider FAQ, Provider Resources, Messages & Announcements

News: Governor's Task Force on Access to Affordable Health Insurance

Provider Message Center

Status	From	Date	Subject
No Data			
0-0 of 0			

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- Select the option you want to perform
- For Claims Entry
 - Click on the “Claims” tab on the menu line

Intermediate Care Facility (ICF) Web Portal Billing Instructions

North Dakota MMIS Web Portal

Skip Navigation | Contact Us | Help | Search | Log out

Home | Member | Provider | Claims | EDI | Authorizations | My Account

Claims Main Page

The menu options allow you to create, edit, delete, submit and resubmit 837 Professional, Institutional and Dental claims. They also provide you with the means of creating, saving, editing and deleting claim templates, which are partially completed claim forms containing information regularly used in various types of claims (such as a provider's address or identifying information).

Claims

- 1099 Inquiry
- Claim Status Inquiry
- Payment Inquiry

Create Claims	Manage Claims	Create Templates	Manage Templates
<ul style="list-style-type: none"> • Professional Claim • Institutional Claim • Dental Claim • HCBS/DD Claim • Travel/Lodging Claim • Claim from Template • Claim from Processed Claim 	<ul style="list-style-type: none"> • Edit / Delete Saved Claim • View Submitted Claims 	<ul style="list-style-type: none"> • Professional Template • Institutional Template • Dental Template • HCBS/DD Template • Travel/Lodging Template 	<ul style="list-style-type: none"> • View / Edit / Delete Template

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- Under the heading “Create Claims” select “Institutional Claim”

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Basic Claim Info Other Claim Info

Provider Member **Basic Claim** Service Line Items

? Is this a void/replacement?
 Yes No

Submitter Information

Submitter ID
 WHERON

- The “New Institutional Claim” screen will appear
 - Is this a void/replacement?
 - This field will default to “No.” Select “Yes” **only** if you are voiding or replacing a previously processed claim.
- Submitter Information
 - This section will auto-fill with your user information based on your User ID

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Provider Information

Go to [Other Claim Info](#) to enter information for other providers.

Billing Provider

Note: Healthcare Providers are required to submit National Provider ID.

Medicaid Provider ID National Provider ID Taxonomy Code *Tax ID Location Number

Additional Billing Provider Information

Currency Code

*Org/Last Name

*Address 1 *City State Zip and Extension Country Subdivision Code

Address 2

Contact Information

? Is the Billing Provider Address also the Pay-To Address?
 Yes No

Attending Provider

Rendering Provider

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Provider Information

Go to [Other Claim Info](#) to enter information for other providers.

Billing Provider

Note: Healthcare Providers are required to submit National Provider ID.

Medicaid Provider ID National Provider ID Taxonomy Code *Tax ID Location Number

- Billing Provider
 - **REQUIRED**
 - Medicaid Provider ID and National Provider ID will auto-fill based on your User ID
 - Enter the Intermediate Care Facility (ICF) Taxonomy Code **315P00000X**
 - Enter your Tax ID
 - Enter the Location Number **BI** (Billing)

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Additional Billing Provider Information

Currency Code

*Org/Last Name

*Address 1 *City State Zip and Extension Country Subdivision Code

Address 2

- Additional Billing Provider Information
 - **REQUIRED**
 - Enter your facility name, address, city, state, and zip code

Intermediate Care Facility (ICF) Web Portal Billing Instructions

The screenshot shows a form titled "Is the Billing Provider Address also the Pay-To Address?". Below the title are two radio buttons: "Yes" and "No", with "No" selected. Underneath is a section titled "Pay-To Address" with several input fields: "Address 1", "City", "State" (a dropdown menu), "Zip and Extension", "Country", and "Subdivision Code". There is also an "Address 2" field below the others.

- Is the Billing Provider also the Pay-To Address?
 - Will default to “Yes”
 - If Pay-To Address is different, select “No”
 - Complete the Pay-To Address section with the facility name, address, city, state, and zip code

Intermediate Care Facility (ICF) Web Portal Billing Instructions

The screenshot shows a form titled "Attending Provider" with a dropdown arrow on the left. Below the title are four input fields: "Medicaid Provider ID", "National Provider ID", "Taxonomy Code", and "Location Code".

- Attending Provider
 - **REQUIRED**
 - Enter the Attending Provider’s Medicaid Provider ID
 - Enter the Attending Provider’s NPI
 - Enter the Attending Provider’s Taxonomy Code
 - Enter the Location Code **AT** (Attending)

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Member Information

*Member ID *Last Name First Name MI Suffix *Date of Birth *Gender SSN

Property Casualty Number

- Member Information
 - **REQUIRED**
 - Enter the member's 9-digit ID number (Do not use spaces, -, or /.)
 - Enter the member's last name
 - Enter the member's first name
 - Enter the member's date of birth
 - Use format: MM/DD/YYYY
 - Enter the member's gender
 - F = Female
 - M = Male

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Member Address

*Address 1 *City State Zip and Extension Country Subdivision Code

Address 2

- Member Address
 - **REQUIRED**
 - Enter the member's address, city, state, and zip code

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Subscriber Information

Other Insurance Information

? *Does the member have other insurance?

Yes No

Subscriber Information

Other Insurance Information

? *Does the member have other insurance?

Yes No

Note: Please go to the [Other Claim Info Tab](#) in the Coordination of Benefits Section.

- Other Insurance Information
 - **REQUIRED**
 - Does the member have other insurance?
 - Select “Yes” or “No”
 - If you select “Yes” you must complete the Other Claim Info tab with the Other Insurance information

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Claim Information

Go to [Other Claim Info](#) to include the following claim level information:
Specialized Services, Misc. Claim, Service Facility, Coordination of Benefits and Adjustments.

Claim Data

<p>*Statement From Date <input style="width: 100%;" type="text"/></p>	<p>*Statement To Date <input style="width: 100%;" type="text"/></p>	<p>*Total Claim Charge Amount \$ <input style="width: 100%;" type="text"/></p>
<p>*Patient Account# <input style="width: 100%;" type="text"/></p>	<p>*Type of Bill <input style="width: 100%;" type="text"/> <small>First 2 Type of Bill digits.</small></p>	<p>*Claim Frequency Code <input style="width: 100%;" type="text"/> <small>Last Type of Bill digits; automatically populated on resubmission.</small></p>
<p>*Patient Status <input style="width: 100%;" type="text"/></p>	<p>Admission Type <input style="width: 100%;" type="text"/></p>	<p>Admission Source <input style="width: 100%;" type="text"/></p>
<p>Admission Date / Hour:Minute <input style="width: 100%;" type="text"/> hh ; mm</p>	<p>Discharge Hour:Minute <input style="width: 100%;" type="text"/> hh ; mm</p>	
<p>*Medicare Assignment Code <input style="width: 100%;" type="text"/></p>	<p>*Benefits Assignment Certification <input style="width: 100%;" type="text"/></p>	
<p>*Release of Information Code <input style="width: 100%;" type="text"/></p>		

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Claim Data		
*Statement From Date <input type="text"/>	*Statement To Date <input type="text"/>	*Total Claim Charge Amount \$ <input type="text"/>
*Patient Account# <input type="text"/>	*Type of Bill ▼ First 2 Type of Bill digits.	*Claim Frequency Code ▼ Last Type of Bill digits; automatically populated on resubmission.

- Claim Information - Bill for only one (1) month at a time
 - **REQUIRED**
 - Statement From Date
 - Use format: MM/DD/YYYY
 - Statement To Date
 - Use format: MM/DD/YYYY
 - Total Claim Charge Amount
 - Enter the total amount billed

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Claim Data		
*Statement From Date <input type="text"/>	*Statement To Date <input type="text"/>	*Total Claim Charge Amount \$ <input type="text"/>
*Patient Account# <input type="text"/>	*Type of Bill ▼ First 2 Type of Bill digits.	*Claim Frequency Code ▼ Last Type of Bill digits; automatically populated on resubmission.

- Claim Information (continued)
 - **REQUIRED**
 - Patient Account #
 - Enter the internal patient account number
 - Type of Bill
 - Select **21** for Intermediate Care Facility
 - Claim Frequency Code
 - Select the last digit 1-8 for the specific bill type
 - See "Bill Type List" pages 26-28

Intermediate Care Facility (ICF) Web Portal Billing Instructions

*Patient Status Admission Type Admission Source

Admission Date / Hour:Minute hh : mm Discharge Hour:Minute hh : mm

- Claim Information (continued)
 - **REQUIRED**
 - Patient Status
 - Select the appropriate status from the dropdown menu
 - Admission Type
 - Select the appropriate type from the dropdown menu
 - Admission Date/Hour:Minute
 - Use date format: MM/DD/YYYY
 - Use military format: HH:MM
 - Example: 4:15pm = HH:MM = 16:15
 - SITUATIONAL – Discharge Hour:Minute
 - If patient is other than “Still a Patient” you **must** enter the hour:minute patient was discharged
 - Use military format: HH:MM
 - Example: 4:15pm = HH:MM = 16:15

Intermediate Care Facility (ICF) Web Portal Billing Instructions

*Medicare Assignment Code *Benefits Assignment Certification

*Release of Information Code

- Claim Information (continued)
 - **REQUIRED**
 - Medicare Assignment Code
 - Select the appropriate code from the dropdown menu
 - Benefits Assignment Certification
 - Select the appropriate response from the dropdown menu
 - Release of Information Code
 - Select the appropriate code from the dropdown menu

Intermediate Care Facility (ICF) Web Portal Billing Instructions

The screenshot shows a web portal interface for 'Value Information'. At the top right is an 'Add Value' button. Below it is a table with two columns: 'Value Code' and 'Value Amount'. The table is currently empty, displaying 'No Data'. Below the table is a 'New Value' section with a 'Save | Reset | Cancel' button. This section contains two input fields: '*Value Code' and '*Value Amount' with a '\$' symbol.

- Value Information
 - **REQUIRED**
 - Click on the “+” next to the heading
 - Enter the value code **80** and/or **81**
 - 80 = Covered Days
 - 81 = Non-Covered Days
 - Value Code 80 should equal the sum of the revenue code units
 - Enter the value amount
 - Value amount should be entered as a dollar amount
 - Example: 30 days = 30.00
 - SAVE value
 - Click on “Save” at the top right of the section

Intermediate Care Facility (ICF) Web Portal Billing Instructions

The screenshot shows a web portal interface for 'Diagnosis Information'. It includes a 'Version #' field, a radio button for 'ICD-09', a '*Principal Diagnosis Code' field, a 'Principal Diagnosis POA Code' dropdown menu, and an 'Admitting Diagnosis Code' field.

- Diagnosis Information
 - **REQUIRED**
 - Click on the “+” next to the heading
 - Version #
 - 09 – Ninth Revision (ICD-9-CM)
 - 10 – Tenth Revision (ICD-10-CM)
 - Principal Diagnosis Code
 - Enter the diagnosis code for the member’s primary condition
 - ICD-9 codes for date(s) of service prior to September 30, 2015
 - ICD-10 codes for date(s) of service on or after October 1, 2015

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Basic Line Item Information

Total Claim Charge Amount: \$0.00 [Add Service Line Item](#)

Line #	Rev Code	Proc Code	Modifiers				Service Dates		Unit Qualifier	Units	Line Item Charge Amount \$	Non-covered Charges \$
			1	2	3	4	Begin	End				
No Data												

New Line Item [Save](#) | [Save & Add Other SvcInfo/TPL](#) | [Reset](#) | [Cancel](#)

Service Date Begin: Service Date End:

*Revenue Code: Procedure Code:

Modifiers: 1. 2. 3. 4.

*Unit Qualifier: *Service Units:

*Line Item Charge Amount: \$ Non-Covered Line Charges: \$

Procedure Description:

[Additional Service Line Information](#)

Is there additional line-specific information/TPL to be entered?
 Yes No

Intermediate Care Facility (ICF) Web Portal Billing Instructions

New Line Item [Save](#) | [Save & Add Other SvcInfo/TPL](#) | [Reset](#)

Service Date Begin: Service Date End:

*Revenue Code: Procedure Code:

Modifiers: 1. 2. 3. 4.

*Unit Qualifier: *Service Units:

*Line Item Charge Amount: \$ Non-Covered Line Charges: \$

Procedure Description:

- Basic Line Item Information
 - **REQUIRED**
 - New Line Item
 - Service Date Begin
 - Use format: MM/DD/YYYY
 - Service Date End
 - Use format: MM/DD/YYYY

- Revenue Code
 - Must be 4 digits
 - 0110 In-House Medicaid Days
 - 0180 Therapeutic Leave Days
 - 0185 Hospital Leave Days

Intermediate Care Facility (ICF) Web Portal Billing Instructions

New Line Item					Save Save & Add Other SvcInfo/TPL Reset
Service Date Begin <input type="text"/>	Service Date End <input type="text"/>	*Revenue Code <input type="text"/>	Procedure Code <input type="text"/>	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	
*Unit Qualifier <input type="text"/>	*Service Units <input type="text"/>	*Line Item Charge Amount \$ <input type="text"/>	Non-Covered Line Charges \$ <input type="text"/>	Procedure Description <input type="text"/>	

- Basic Line Item Information (continued)
 - **REQUIRED**
 - Unit Qualifier
 - Select DAYS as the appropriate unit from the dropdown menu
 - Service Units
 - Enter the number of units for the revenue code
 - The number of units billed must include the day of discharge or death
 - A separate line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed
 - Line Item Charge Amount
 - Enter the total charges for the line item
 - SAVE LINE ITEM – small SAVE at the top right of the New Line Item Section
 - If there is more than one line item to be billed, select “Add Service Line Item” and follow the above instructions
 - Enter each line item separately and SAVE each line item before entering a new line item

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Submit Claim Save Claim Reset Cancel
--

- When all information is entered on the claim , click “SUBMIT CLAIM” at bottom right

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Bill Type List

- 1 Admit through Discharge Claim This code is to be used when a member is admitted and discharged in the same month. Member CANNOT be in the "Still a Patient" status.
- 2 Interim – First Claim This code is used for the first claim and the Discharge Status (fld17) as "Still a Patient."
- 3 Interim – Continuing Claim This code is used for the second and any ongoing months that have a Discharge Status (fld17) as "Still a Patient."
- 4 Interim – Last Claim This code is used for the Final claim billed for the member.

Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 7 Replacement of Prior Claim A claim replacement may be submitted to modify a previously processed claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:
 - Field 4: Use 7 as the last digit in the Type of Bill Code
 - Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN)

If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

Example:

Legacy ICN: 101515320010

Replaced Legacy ICN: 102015015320010

Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 8 Void/Cancel of Prior Claim
Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:
Field 4: Use 8 as the last digit in the Type of Bill Code
Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN)

If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

Example:
Legacy ICN: 101515320010
Replaced Legacy ICN: 102015015320010

SECTION XVI – LICENSING HANDBOOK & FORMS – APPENDIX D

LICENSING FORMS

The following is a brief explanation of each of the forms used in the licensing review process. In general, these guidelines apply to all the forms utilized:

- All requests for single signature/title dates refer to the individual completing the form, generally the agency's chief executive officer.
- Additional sheets may be attached to provide additional information.
- Photocopies of forms may be made, as necessary.

All forms can be found at <https://www.nd.gov/eforms>.

Criminal Offense Conviction Statement (SFN 235)

A two-part form which certifies that either no staff or board member has been convicted of an offense or lists those, that has a conviction record. Applicant completes only the appropriate section.

Financial Disclosure Statement (SFN 236)

A two-part form, which certifies the board member, does not have any financial relationship with the agency or delineates that relationship. Each board member must complete only that appropriate section when they begin their term on the board, or as changes develop (does not have to be submitted annually).

Fire Inspection Certification (SFN 223)

Completed by the appropriate fire authority following the required National Fire Protection Association Life Safety Code chapter (as specified in NDAC 75-04-01-23). If deficiencies are cited, confirmation of completion and date of corrections must be shown by the agency Chief Executive Officer (under agency confirmation column).

Governance Statement (SFN 1549)

Lists the presiding official and other governing board officers/directors. Term dates refer to dates, which that individual has agreed to serve. Consumer or consumer representative refers to their relationship to individual served (either is developmentally disabled or is related to the third degree of kinship to someone with developmental disabilities). May be used to report Advisory Board members, if applicable.

Insurance Coverage Statement (SFN 234)

Requests all information pertinent to the agency's operation (as specified in NDAC 75-04-01-38).

License Application Checklist (Day/Residential) (SFN 1552)

Lists all requirements for licensure and dates, which they have been submitted. Intended for licensing review use and serves as the guideline for the service provider to determine compliance.

License Termination Request (SFN 1550)

Required for termination of any day or residential service(s). List each service being discontinued with

the address of the facility involved and the number of individuals in that service, as well as the effective date of termination. Include in the rationale the reasons for which the agency wishes to discontinue the service(s).

Medicaid Program Provider Agreement (SFN 615)

To be completed by the service provider prior to rendering any service to Medicaid individuals.

North Dakota Developmental Disability Provider Application (SFN 1794)

Must be submitted for all renewal, changes, or new services. Signatures required are either governing board head or chief executive officer for the agency. Accreditation/certification refers to The CQL accreditation or Department of Health and Human Services – Health Facilities Unit (for Title XIX) certification. Individual numbers refers to the occupancy of that location whether day/work or residential setting.

North Dakota Developmental Disabilities Provider Letter of Intent Application (SFN 1793)

Must be submitted for all renewal, changes, or new services. Signatures required are either governing board head or chief executive officer for the agency. Accreditation/certification refers to CQL and for ICF/IID the Centers for Medicare and Medicaid (CMS). Individual numbers are requested for each site whether day or residential. The Regional Developmental Disabilities Program Administrator must approve applications for changes in licensure status.

Ownership/Controlling Interest and Conviction Information (SFN 1168)

To be completed by the service provider outlining key management positions, i.e. CEO, CFO, COO, Business Managers, etc. If the service provider is a corporation, the Board of Directors section must also be completed.

Physical Standards Checklist (SFN 1555)

Delineates those requirements for group homes as mandated in the Implementation Order of March 6, 1984 and is conducted by licensing review during an initial survey.

Plan of Correction (SFN 1556)

To be completed by the service provider within ten (10) days of notice of noncompliance (during review process).

Policies and Procedures Checklist (SFN 1544)

Provides assurance that the agency has approved and is implementing those policies as described in NDAC 75-04-01-20.

Provider Assurance to the Federal Home and Community Based Services (HCBS Regulations) (SFN 1010)

To be completed by the service provider to certify the provider has read and understands their responsibilities as a provider to comply with the Home and Community Based Services (HCBS) regulations.

Sanitation Inspection Certification (SFN 1545)

Completed by appropriate health/sanitation inspector. The Chief Executive Officer must confirm deficiencies cited and corrected.

All completed forms should be forwarded to:

Licensing Program Administrator
ND Dept of Health and Human Services
Developmental Disabilities Section
1237 W Divide Ave Ste 1A
Bismarck, ND 58501-1208
dhsddreq@nd.gov

TIMELINES FOR THE SUBMISSION OF FORMS

<u>Licensure Forms</u>	<u>Submitted</u>
Criminal Offense Conviction Statement	Initial licensure & annually for license renewal
Financial Disclosure Statement	Initial licensure & annually for license renewal
Fire Inspection Certification	Initial licensure & annually for license renewal
Governance Statement	Initial licensure & annually for license renewal
Insurance Coverage Statement	Initial licensure & annually for license renewal
License Application Checklist	Initial licensure
Medicaid Program Provider Agreement	Initial licensure & annually for license renewal
ND DD Provider Letter of Intent	Initial licensure
ND DD Provider Application	Initial licensure, license renewal & bed changes
Ownership/Controlling Interest & Conviction	Initial licensure & as any changes occur
Physical Standards Checklist	Initial licensure
Plan of Correction	Initial licensure & as needed
Policies and Procedures Checklist	Initial licensure & as any changes occur
Provider Assurance to the Federal Home and Community Based Services (HCBS Regulations)	Initial licensure & annually for license renewal
Sanitation Inspection Certification	Initial licensure & annually for license renewal