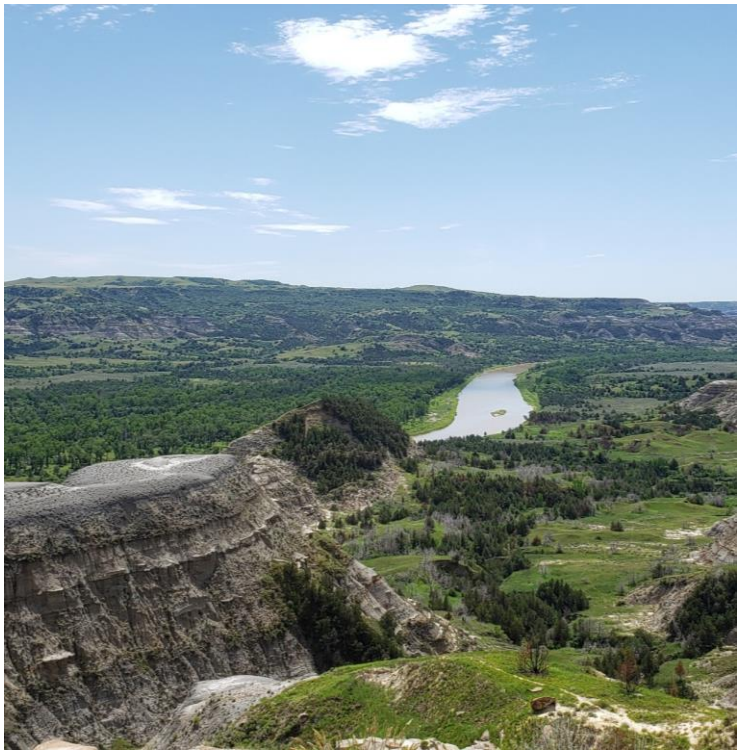

DEVELOPMENTAL DISABILITIES PROVIDER INTEGRITY MANUAL

EFFECTIVE OCTOBER 2025

NORTH Dakota | Health & Human Services
Be Legendary.

DEVELOPMENTAL DISABILITIES SECTION

1237 W. Divide Ave, Suite 1A
Bismarck ND 58501-1208

Table of Contents

OVERVIEW

The intent of this manual is to provide North Dakota Health & Human Services (HHS), Developmental Disabilities (DD) Section and others information regarding the policies and procedures of auditing DD providers who receive payment for services from Medicaid through the State Plan, the Traditional IID/DD waiver and IDEA Part C.

AUTHORITY

Federal regulations (42 CFR 456) stipulate that each State Medicaid Agency utilize surveillance and review processes 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 DD Section is required to follow federal requirements in conducting reviews and investigations. General requirements are found in 42 CFR, Chapter IV, Part 455 - Program Integrity: Medicaid. Program Integrity is governed by North Dakota Administrative Code Chapter 75-02-05. 34 CFR 303 must monitor the implementation of Part C of IDEA, including monitoring appropriate use of funds.

The 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.

DD SECTION STAFF REPORTING RESPONSIBLITIES

All HHS Staff, including the Medical Services staff, and the DD Section Staff, are required to report allegations of fraud and abuse immediately to the Fraud, Waste, and Abuse (FWA) Administrator. If a DD Section staff member receives any type of fraud or abuse complaint, regardless of the communication mode, it will be forwarded to the FWA Administrator with all data that can be gathered from the complainant. If the DD Section representative is unable to speak with the complainant directly, the FWA Administrator will follow up with the complainant and gather the necessary information per the policies and procedures of the current Fraud Abuse Manual.

PROVIDER OBLIGATIONS

A provider is required to release information to the DD Section as part of the Medicaid Provider Agreement form. The Provider Agreement form can be found at http://www.nd.gov/eforms/Doc/sfn00615.pdf. The form specifies that as part of the provider agreement to participate in the Medicaid Program, the provider agrees to, upon reasonable request, release information needed to support the services billed to HHS.

DD STAFF REVIEWER RESPONSIBILITIES

DD Staff responsibilities for provider reviews consist of:

- Reviewing provider records and/or utilization reports to determine if services are being delivered according to accepted DD policy and procedures which include:
    - Requesting, collecting and analyzing documentation from providers and recipients' files for case reviews.
    - Documenting findings.
    - Coordinating and providing training for providers concerning billing and required documentation.
    - Recommending corrective action in cases where appropriate.
- Determine whether new or revised policy and procedures are needed to keep up with changing practices or trends.

PROVIDER RESPONSIBILITIES

- A provider will be informed that an audit is being conducted, and they will be required to send their documentation for the service period that is under audit.

- Full disclosure of requested administrative, fiscal, and program information within the requested time frames must be provided.
    - All DD licensed providers are responsible for day-to-day monitoring and service plan implementation, and hence, must maintain the following client documentation to facilitate census data auditing and periodic quality reviews. Per State Medicaid Manual, Publication 45, §2500.2, documentation should support the service billed and include:
        - Date of service
        - Name of 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 services can meet the requirement by one note summarizing each shift)
        - The record should be written in clear language and without alterations

    - Per NDAC 75-04-05-08.2(a) Adequate census records for all clients, regardless of payer source, must be prepared and maintained on a daily basis by the provider agency to allow for proper audit of the census data. The daily census records must include:

        1. Identification of the client.
        2. Entries for all days that services are offered, including the duration

of service, and not just by exception.
3. Identification of type of day, i.e., hospital, personal assistance retainer, or in-house day.

- Respond to corrective actions as applicable within the requested time frame.

- Adjust claims for any audit findings (identified in the Provider Integrity Audit Report) within the requested time frame. If the provider fails to make the adjustments within the requested time frame, adjustments will be made by HHS and provider will be notified.

GUIDELINES TO CONDUCT REVIEWS

Annually or as needed, the DD Section and/or staff from the Program Integrity Unit will determine audit topics relative to the services provided by the DD Section. The Program Integrity Unit (PIU) can provide guidance as needed related to auditing activities to ensure consistency and integrity throughout the process.

The audit is intended to provide assurance that services are being delivered according to the individuals plan, authorization, and service requirements per Medicaid State Plan, the Traditional IID/DD HCBS waiver or IDEA Part C.

The DD reviewer will send a letter to the provider requesting documentation for identified claims to be sent within a specific timeline. The DD reviewer will verify the documentation received from the provider, or additional documentation in case management system and MMIS claims data, includes all of the required components and services were provided in accordance with all State and Federal policies and regulations.

At the conclusion of the audit, the DD Section will complete a DD Provider Integrity Audit Report. This report summarizes the services and timeframe reviewed. It also identifies any findings and corrective actions the provider may need to complete to close the audit. The DD reviewer will submit this report to the provider and a copy will be maintained in the provider's file.

DETERMINING SAMPLE SIZE

Sample size varies depending on the type of audit. It may be based on previous years' utilization OR a 95% confidence level and a confidence interval of 5 based on the number of claims billed. Staffing resources will influence whether the confidence interval needs to be changed in order to establish a manageable volume to audit. When utilizing a 95% confidence level and a confidence interval of 5, Raosoft is used to establish the sample size at: http://www.raosoft.com/samplesize.html

EXPANDING AUDITS

An audit may be expanded if documentation shows consistent billing errors that are not following policy. Additional documentation may be requested and reviewed to determine if additional improper payments were made. The DD Provider Integrity Audit Report will reflect if an additional review is needed. An audit expansion may be provider specific or include additional providers; depending on whether the errors are associated with a particular provider or if the error appears to apply to the entire provider population.

Staffing resources will influence the number of claims that will be reviewed as part of the expanded audit.

CORRECTIVE ACTION PLAN

Corrective action plans may be required if a provider is determined to be non-compliant. Corrective action plans may require providers to update policies, procedures, submit additional documentation, or rectify billing practices.

Upon receipt of an acceptable corrective action plan, a copy will be maintained in the provider's file at the State DD office.

If termination is applicable based on overbilling, inappropriate billing, poor records, repeated errors, failure to respond to corrective action plan, etc., the DD Section will meet with the Fraud & Abuse Unit and a representative from the Legal Advisory Unit to determine if termination is appropriate.

Appendix A

DD Provider Integrity Audit Report - Sample

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
DEVELOPMENTAL DISABILITIES (DD)

DD Provider Integrity Audit Report

The information contained in this report is the result of the review of your service records and payments made. Findings are based on federal and state law, North Dakota Administrative Code, and the policies and procedures established by the Department of Health & Human Services.

Within 30 days of receiving this report, provide documents responding to the findings listed at the end of this report. If no findings are identified at the end of the report, there is no need to respond.

If there is disagreement with any findings or corrective action, an informal conference regarding the decisions made may be requested by contacting the individual who conducted the review. An informal request for a review must be made in writing within 5 working days upon receipt of the review.

If there is still a disagreement after an informal conference, the provider may submit a formal written request for a review. Formal requests for a review must be made in writing within 10 working days following the informal conference and must include all additional documents, written statements, exhibits, and other information supporting the request for formal review. The Department will make a final decision within 30 working days of receiving the request.

A provider may not request a formal review of the rate paid for each disputed item.

Send all written requests or information to:

North Dakota Health & Human Services
Developmental Disabilities
1237 West Divide Avenue Suite 1A
Bismarck, ND 58501

Thank you for your participation in this review.

Provider Name	
Provider Number	
Region	
Date(s) of Review	
Service Records Reviewed	
Claim Period Reviewed	
Funding Source(s)	DD Traditional HCBS Waiver
DD Reviewers' Name	

Responses with an X in the appropriate column reflecting these codes: Y (Yes) = Totally Addresses Criteria; P (Partial) = Partially Addresses Criteria; N (No) = Does Not address Criteria; NA (Not Applicable) = Not Applicable or Evaluated.

Additional information may be indicated in the appropriate "comments" section.

SERVICES AND PAYMENT RECORDS

Criteria	Y	P	N	NA	Comments
1. Did the provider maintain accurate records of service delivery that contained all required information?	☐	☐	☐	☐	
2. Did the providers written documentation for dates and units of service delivered correlate with the payment history of Department of Health & Human Services?	☐	☐	☐	☐	
3. Did the provider bill within the amount authorized and per policy and/or DD Section Policy?	☐	☐	☐	☐	
4. Did the provider use the correct procedure code for tasks authorized?	☐	☐	☐	☐	
5. Did the provider use the correct client ID number?	☐	☐	☐	☐	

1. Findings: Corrective Action:
2. Findings: Corrective Action:
Narrative: