

DEVELOPMENTAL DISABILITIES PROVIDER INTEGRITY MANUAL



Issued by:

Developmental Disabilities Division
North Dakota Department of Human Services
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OVERVIEW

The intent of this manual is to provide the Department of Human Services (Department), Developmental Disabilities (DD) Division and others information regarding the policies and procedures of auditing DD providers who receive payment for services from Medicaid.

AUTHORITY

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 Division 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.

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 DIVISION STAFF REPORTING RESPONSIBILITIES

All Department of Human Services Staff including the Medical Services Division staff, and the DD Division Staff, are required to report allegations of fraud and abuse immediately to the Fraud, Waste, and Abuse (FWA) Administrator. If a Division 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 Division 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 Fraud Abuse Manual May 2015.

PROVIDER OBLIGATIONS

A provider is required to release information to the DD Division 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 the Department.

DD STAFF REVIEWER RESPONSIBILITIES

Annually or as needed, the DD Division will determine audit topics relative to the services provided by the DD Division. The Fraud, Waste, and Abuse (FWA) Administrator serves as an advisor on the auditing activities to ensure consistency and integrity throughout the process.

DD Staff responsibilities for provider reviews consist of:

- Reviewing provider records/utilization reports to determine if services are being delivered according to accepted DD policy and procedures which includes:
 - Requesting, collecting and analyzing documentation from providers and recipients files for case reviews.
 - Documenting findings
 - Utilizing good verbal and written communication skills, accurate record keeping and organizational skills.
 - Advising the Director\supervisor of the need for specific reviews.
 - Coordinating and providing training for providers concerning billing/documentation
 - Recommending corrective action in cases where appropriate
- Advising the Surveillance Utilization Review Section (SURS) Division on new or revised policy and procedures needed to keep up with changing practices/trends.
- At the conclusion of the audit the DD Reviewer will submit a report to the DD Provider and a copy of that report will be maintained in the provider's file

PROVIDERS RESPONSIBILITIES

- Provide full disclosure of requested administrative, fiscal, and program information within the requested time frames.
- Respond to corrective actions as applicable within the requested time frame.

GUIDELINES TO CONDUCT REVIEWS

The audit is intended to provide assurance that services are being delivered in according to the individuals plan.

The reviewer will use the most current Review Guide and complete components for selected services including: Service Records and Payment Records.

Utilizing billing records, the provider's documentation\records, appropriate forms and information obtained from the provider, the reviewer will determine if services were delivered in according to the individual's authorization.

DETERMINING SAMPLE SIZE

Every audit will start by determining what the sample size is based on previous years utilization OR a 95% confidence level and a confidence interval of 5. Staffing resources will influence whether the confidence interval needs to be changed in order to establish a manageable volume to audit. The link used to establish the sample size is at: <http://www.raosoft.com/samplesize.html>

The sample sizes and confidence intervals associated with an audit are presented during the monthly SURS audit meetings and DD staff discusses which confidence interval is appropriate based on existing work load. The interval used is indicated in the "parameters used" field on the audit coversheet for future reference.

SELECTING CLAIMS TO SAMPLE

There may be instances where the sample size is such that every provider in the state would not necessarily be selected randomly for an audit. In those instances, five claims for each provider are randomly selected to ensure that each provider has at least one claim included in the audit. Then, the amount of claims needed to meet the sample size is randomly selected from the remaining claims in the data report.

DOCUMENTING AUDITS

All audits require an audit coversheet summarizing the type of review being conducted and the details involved. A sample review cover sheet can be found at the end of this manual. Review coversheets typically require updates following the conclusion of an review in order to properly reflect recoveries associated with the review as well as any policy changes that may occur as a result of the review.

EXPANDING AUDITS

If an error rate for an audit exceeds 5%, the audit will be expanded to determine if additional improper payments were made and the audit coversheets will reflect any changes or additions to the original audit sample size. 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 rate appears to apply to the entire DD provider population.

REPORTS AND DATA COMPARISON PROCESS

Providers will be informed that an audit is being conducted and they will be asked to send their documentation for the service period that is under audit.

The provider's service record must show the date of service, the service provided, the tasks authorized and performed during that time, the name of the provider, the direct staff that provided the task\service, the client's name and Medicaid ID number.

- Daily Rate Providers can meet the requirement by one itemized list of routine tasks and a single entry every day referring to the list with additions or deletions of tasks listed and completed. Only tasks listed on the authorization should be entered on the documentation.

The Audit is conducted in a three step process.

- 1) Payment histories are reviewed to assure the client had a plan authorizing the specific service. Payments on the entire history (time frame within the target for the audit) are reviewed to look for inaccurate coding, overbilling for a specific service, odd service combinations and other unusual issues.
- 2) Desk audits will be completed unless there is a specific concern that becomes evident during a review.
- 3) Over billing or over payments may be corrected by an adjustment or repayment and the provider is sent a letter outlining the process

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 providers 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 Division will meet with the Fraud & Abuse Unit and a representative from the Legal Advisor Unit to determine if termination is appropriate.

SAMPLE AUDIT SHEET

ND Department of Human Services - DD Division

Review Information	01/2016
Review Topic	
Amount Recouped	\$0.00
Referral Date	
Referral Source	
Reason for Review	
Parameters Used/Filters	
Provider Specialty/Type Audited	
Number of claims audited	
Number of providers audited	
File saved at:	Hyperlink to folder
Report Created By and Date Initial Report Ran	
Review Process/Timeline	
Analysis performed by:	
Findings of Review	
Error Percentage (recipients, claims, dollars):	
Refer to SURS for possible Fraud	
Provider put on suspension or terminated	
Follow up	