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SECTION I - INTRODUCTION

This manual functions as a primary reference document for DD licensed providers delivering services covered by North Dakota’s Department of Human Services’ (“Department”) Developmental Disabilities Division (“DD Division”). The DD Division provides support and training to clients and families in order to maximize community and family inclusion, independence, and self-sufficiency. The DD Division 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.

A. 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 clients 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 client’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 client’s personal goals, support needs, and preferences.

You can view the waiver at the Developmental Disabilities website http://www.nd.gov/dhs/services/disabilities/docs/traditional-iid-dd-hcbs-waiver.pdf.

B. Medicaid State Plan Services

Clients 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 County Social Services office. In addition, Developmental Disabilities Program Managers (DDPMs) can assist eligible clients 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 client eligibility, covered services, and service limitations, refer to the County Social Services office at http://www.nd.gov/dhs/locations/countrysocialserv/index.html and document available at http://www.nd.gov/dhs/services/medicalserv/medicaid.

C. 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 a client does not qualify for the ICF/IID level of care. For licensing, enrollment and service authorization procedures, contact the local Regional Human Service Center.
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 Human Services. They are located 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.

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 client 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.

A. 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.

B. 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.

C. Notification of Client Eligibility

If an applicant is found to be eligible for IID/DD services, the DDPM contacts the client to assist in selecting appropriate services and DD providers. Upon selection of services and providers, the DDPM
refers the client 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 client’s eligibility for services by:

1) *Contacting a DDPM at the appropriate Regional Human Service Center.*

2) *Referencing the client’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 client’s Medicaid eligibility status.* It is recommended that the DD provider check the Medicaid eligibility at least once a month to ensure the client remains eligible.

D. Traditional IID/DD HCBS Waiver

The number of clients 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 client must meet all of 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 client meets the criteria for ICF/IID level of care to access federal Medicaid funding under the Traditional IID/DD HCBS Waiver. The client’s PAR level (“the HCBS indicator”) will determine if the client is eligible for the ICF/IID level of care to access the Traditional IID/DD HCBS Waiver. If the client is not already receiving Medicaid, the DDPM will assist the client in the application process.

Eligible clients 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 Division will keep a waiting list based on the date of application.

E. Medicaid State Plan Services

The County Social Services office determines financial eligibility for Medicaid Health Care Coverage. Depending on a client’s amount of income (or for children, on their parent(s) or legal decision maker’s

\(^1\) 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.
income), clients 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 DHS website:

F. 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

A. 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 clients.

For detailed information on covered services, service limitations, client 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
- Infant Development (ID)

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

- Adult Foster Care (AFC)
- Homemaker

Self-Directed Services

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

B. Medicaid State Plan Services

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

C. 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.

A. Procedures Pertaining to DD Licensed Providers Voluntary Discharge by Client

Clients 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 a client 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 client 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 client;
2) Reasons for the discharge;
3) Potential impact the discharge may have on the client;
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 client and/or legal decision maker and DDPM within 10 business days following the meeting.

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

B. Procedures Pertaining to DD Licensed Providers Involuntary Discharge by Client

Involuntary discharge occurs when a DD licensed provider has made a decision to discontinue services and terminate supports even though the client 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 client services. Clients 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 client, unless the client chooses to discontinue the services earlier. The
written discharge notice must include the reason for the discharge, why the provider cannot continue to serve the client, the provider’s grievance policy, and the client’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).

Prior to issuing a discharge notice, the DD licensed provider must take the following steps:

1) Formally request consultative and technical assistance with the Regional Behavioral Analyst (RBA) and the Clinical Assistance Respite and Evaluation Services Team (CARES team) – a team of behavioral consultants, whose goal is to ensure that clients remain in the home and are not institutionalized or transferred to a hospital. The request should be made early and as soon as the provider and team members are aware that the placement may be compromised and additional assistance is needed to support that client. Seeking services from the CARES team when concerns have been ongoing and discharge is imminent is not acceptable.

2) Following the consultation with the RBA and the CARES team, the provider must schedule an in-person meeting with the client, DDPM, and other Individual Program Planning Team members to discuss the reason for discharge and possibilities of reconciliation. This meeting must occur prior to the provider issuing a thirty (30) day written discharge notice.

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 client;
   b. Reasons for the discharge;
   c. Potential impact the discharge may have on the client; and
   d. Opportunities to prevent discharge, specific recommendations and arrangements for alternative services.

3) The provider is responsible for documenting all discussions and decisions made during the discharge planning meeting in the client’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 client and/or the legal decision maker and the DDPM within ten (10) business days following the discharge meeting.

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

D. 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 Division:

- 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)
- Infant Development (ID)

A. Agency Licensing Process

New Providers

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

1) Letter of Interest  
2) DD Provider Orientation  
3) Council on Quality and Leadership (CQL) Systems Accreditation (provider is responsible for cost)

Upon completion of the above items, providers must submit the licensure packet (i.e. application, required inspections, etc.) to the DD Division before any services can be provided.

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.

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.
Existing DD Providers/Annual Renewal/New Services

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

1) Submit the licensure packet (i.e. application, required inspections, etc.) to the DD Division 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 Division 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 clients.

2) Once the application is returned to the DD Division, 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.

3) 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:
   
   a. Unrestricted
   b. Restricted

4) 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.

B. Accreditation

All DD licensed providers are required to obtain and maintain accreditation as identified in NDAC 75-04-01-15. CQL offers a variety of accreditation options however the Department has determined that the following 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. The costs associated with this accreditation are the responsibility of the potential provider.

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.

The Department contracts with CQL to provide Level 2 & 3 accreditation, therefore the expense of these levels are paid for by the Department. It is expected that all DD licensed providers achieve and maintain the level 3 accreditation. If a provider is unable to maintain this level of accreditation, a restricted license may be issued until the provider is in compliance with level 3 accreditation.

CQL also offers a “Person-Centered Excellence / With Distinction Accreditation. If a provider wishes to obtain this level of accreditation, they will be required to pay the difference between this and the Person-Centered Excellence Accreditation.

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

C. 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 to the DHS website at: http://www.nd.gov/dhs/providers/docs/licensing-review-handbook.pdf

D. 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 Division 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 DHS website: http://www.nd.gov/dhs/services/adultsaging/providers.html.
As part of its quality improvement strategy, the DD Division is responsible for monitoring service implementation, client 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.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Rule Title and Reference</th>
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<tr>
<td>CFR Titles 34, 42, 45</td>
<td>Code of Federal Regulations most commonly referenced relating to Developmental Disabilities and Home and Community-Based Services. Found at: <a href="https://www.ecfr.gov">https://www.ecfr.gov</a></td>
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<td>Individuals with Disabilities Education Act (IDEA)</td>
<td>Found at: <a href="http://idea.ed.gov">http://idea.ed.gov</a></td>
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<td>NDCC 25-01.2</td>
<td>Developmental Disability Found at: <a href="http://www.legis.nd.gov/general-information/north-dakota-century-code">http://www.legis.nd.gov/general-information/north-dakota-century-code</a></td>
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<td>NDCC 50-06</td>
<td>Department of Human Services Found at: <a href="http://www.legis.nd.gov/cencode/t50c06.pdf">http://www.legis.nd.gov/cencode/t50c06.pdf</a></td>
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<td>NDCC 50-06.2</td>
<td>Comprehensive Human Services Programs Found at: <a href="http://www.legis.nd.gov/cencode/t50c06-2.pdf">http://www.legis.nd.gov/cencode/t50c06-2.pdf</a></td>
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<td>Foster Care Homes for Children and Adults Found at: <a href="http://www.legis.nd.gov/cencode/t50c11.pdf">http://www.legis.nd.gov/cencode/t50c11.pdf</a></td>
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<tr>
<td>Rule</td>
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<tr>
<td>NDAC 75-03-23-07</td>
<td>Policy, rules and regulations for Qualified Service Providers (QSPs) Found at: <a href="http://www.legis.nd.gov/information/acdata/pdf/75-03-23.pdf">http://www.legis.nd.gov/information/acdata/pdf/75-03-23.pdf</a></td>
</tr>
<tr>
<td>DD Division Policy</td>
<td>For detailed information on DD Division Policy, refer to the DD Bookshelf: <a href="http://www.nd.gov/dhs/policymanuals/816/816.htm">http://www.nd.gov/dhs/policymanuals/816/816.htm</a>, select “PI’s/Outstanding PI’s” on the left hand side.</td>
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A. Informing Clients of Their Rights

Every DD licensed provider shall post conspicuously in public areas a summary of the rights defined in NDCC 25-01.2. Client rights, such as the DD Bill of Rights, should be reviewed initially and 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 client’s condition permits, every client eighteen (18) years of age or older, the parents or the custodian of all clients under eighteen (18) years of age, and the guardian must be given written notice of the rights guaranteed by the aforementioned chapter.

B. 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 Division of any change in the policy of confidentiality.

C. 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, Division of Health Facilities.

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 DHS website:  

D. 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 Division for each client whom service is being provided;
   b. Attendance sheets and other records documenting the days and times that the clients 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.

E. 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 Division will determine audit topics relative to the services provided by the DD Division.

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

F. 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](http://www.nd.gov/eforms/Doc/sfn01555.pdf). Group homes must allow for all bedrooms to have lockable doors, except where clients 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.

**G. Client Documentation and Reporting for DD Licensed Providers**

The DD Division 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).

**H. Therap Software**

Therap, the Department’s official source of client 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)
- Client Referral
- Individual Data Form (IDF)
- Individual Plan of Protective Oversight (IPOP)
- Residential Information and General Information
- Risk Management Assessment and Plan (RMAP)

Required Therap modules for Department staff include:
- Client Eligibility
- Progress Assessment Review (PAR)
- Overall Service Plan (OSP)
- Individual Support Plan (ISP)
- Case Action
- Progress Notes
- Quality Enhancement Review (QER)
- Client Referral
- Individual Authorizations
- Risk Management Assessment and Plan (RMAP)

Reference the Therap Website for how to tutorials [http://www.therapservices.net/northdakota/?p=106](http://www.therapservices.net/northdakota/?p=106). 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.
I. Abuse and Neglect Reporting

The Department is committed to ensuring that all clients 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 Division policy and NDAC, DD licensed providers are required to report Serious Events or Reportable Incidents.

If a DD licensed provider fails to report any suspected incidents of abuse, neglect or exploitation; the DD Division 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 Health Facilities 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.

J. 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 client 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 clients, regardless of payer source. These records must include:
1. Identification of the client;
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 client.

K. 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 is 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 Division will notify the provider of the status of their submitted POC within 20 business days. All deficiencies must be corrected within 45 calendar days from the POC approval date. The DD Division will verify correction of all deficiencies.

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

The Centers for Medicare and Medicaid Services (CMS), which is a part of the federal government that oversees the federal funding, used to pay for Home and Community Based waiver services, issued requirements in March 2014. The requirements impact where people work, live, and attend day services.

Require that all home and community based settings meet certain qualifications, including:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual’s rights of privacy, dignity and respect, and freedom from restraint;
- Optimizes individual initiative, autonomy, and independence in making life choices;
- Facilitates choice regarding services and who provides them.

Identify settings that are not home and community based and where they should not occur, including:

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

Defines person-centered planning requirements, including:

- 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;
- Will assist the individual in achieving their personal outcomes in the most integrated setting;
- Ensure delivery of services in a manner that reflects personal preferences and choices; and
- Assurance of health and welfare.

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

This initial review is the first step in determining a waiver setting’s compliance with the HCBS Final Rule. 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.

The second step in compliance with the HCBS Final Rule 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.
Refer to the Overall Service Plan (OSP) instructions for directions on the planning process and documentation needed within the plan.

For detailed information on this section, refer to the DHS website: 
http://www.nd.gov/dhs/services/disabilities/docs/2015-cms-requirements-for-hcbs.pdf and 
SECTION VIII - SERVICE PLANNING

The North Dakota DD Division is committed to ensuring that all clients 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 client 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 client needs and goals, settings are appropriately integrated in the community and meet all federal requirements, backup plans are effective, clients 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 clients 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 client satisfaction and the appropriateness of the amount and frequency of service provision, discuss progress towards the client’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 client’s team must meet initially, annually, and as needed to discuss the client’s needs and identify which services are most appropriate to meet the client’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 DHS website:
SECTION IX – STANDARIZED ASSESSMENTS FOR RESOURCE ALLOCATION

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

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

Clients who qualify for the above services are required to have a Support Intensity Scale (SIS) assessment if 16 or older or an Inventory for Client and Agency Planning (ICAP) assessment for clients 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 client beginning a qualified service. A reassessment of client needs using the standardized assessment tool must be completed every thirty-six (36) months for a client aged sixteen (16) or older, or every twelve (12) months for a client under age sixteen (16).

If a major life-changing event occurs prior to the reassessment date, a client 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 client 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.

Clients who are private paying for authorized services will not be required to participate in the assessment process. The client’s team will determine the number of staffing hours wanted to meet the client’s needs. The provider will use the rates identified in the rate matrix to determine the rate that the client will be responsible to pay the provider.
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 a client receives a service prior to the completion of the initial standardized assessment, the assessment score hours authorized for the client shall apply from the first date the client was authorized for that service.

A. 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 regional DD program administrator will review the outlier request and forward to the DD Division for final review.
   - The DD Division 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 http://www.nd.gov/dhs/services/disabilities/dd-rate-methodology.html

B. 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 client’s behavioral status, stress upon the family, and type and frequency of service required.

C. Self-Directed Supports
   - Clients 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. Clients 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 client is assigned a Fiscal Agent.

D. Adult Foster Care (AFC) & Homemaker
   - The authorized units for these services will be based on 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 client-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 http://www.nd.gov/eforms/Doc/sfn01810.pdf.

E. 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, home visit, consultations, and IFSP development. The DDPM will complete the service authorization based on the frequency identified by the team.

F. Personal Care

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

G. Section 11 Services

- The Day & Residential Services Administrator works with the DD regional human service center program administrator biennially to identify clients eligible for the service. The DD Division contracts with Section 11 providers, based on client need. No standard service authorization forms exist for Section 11 residential and employment services.

H. Appeals

1) A client or client 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 client or client 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) A client or client 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.
### Table 3: Authorization Period

<table>
<thead>
<tr>
<th>Service</th>
<th>Individual Service Authorization Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFC, Homemaker, Personal Care</td>
<td>Up to 6 months</td>
</tr>
<tr>
<td>Residential Habilitation, Independent Habilitation, Day Habilitation,</td>
<td>Up to 12 months</td>
</tr>
<tr>
<td>Prevocational Services, Individual Employment, Small Group Employment</td>
<td></td>
</tr>
<tr>
<td>and Intermediate Care Facilities</td>
<td></td>
</tr>
<tr>
<td>In-Home Supports, Parenting Supports, EHHC</td>
<td>Up to 3 months*</td>
</tr>
<tr>
<td>Infant Development</td>
<td>Up to 6 months</td>
</tr>
<tr>
<td>Self-Directed Services</td>
<td>Up to 3 months*</td>
</tr>
</tbody>
</table>

*Authorization period must end on March 31, June 30, September 30 and December 31. These cannot exceed 3 months.*
SECTION XI - RATES & BILLING GUIDANCE

A. Rates

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

At the completion of the state fiscal year (June 30), the DD Division will send notification to provider agencies with ICF/IID services. ICF/IID 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.

1. Residential Habilitation

   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 and administrative costs. An “absence factor” is added to the service rate for Residential Habilitation to account for temporary consumer absences.

   b. Night staff - The assessment score hours indicates 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.

   c. Room and board costs that the participant pays to the DD licensed provider are subject to the following limitations:
      1) Charges to clients must not be greater than the client’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 client. Personal incidental expenses are valued at one hundred dollars for group-home clients.
      2) For residential units or clients receiving rental assistance, the governmental unit providing the subsidy must establish the room charges.
      3) Room and board rates must reflect the average dollar value of any energy assistance program benefits, if offered.

2. 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, and room and board costs. Providers may bill for 30 therapeutic absence days in a calendar year and up to 15 absence days for hospitalization per occurrence.
b. Personal incidental expenses are valued at one hundred dollars for ICF clients.

c. 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 Division 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 clients to the qualifying location.

d. 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 clients to the qualifying location.

3. Independent Habilitation, 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.

4. Adult Foster Care (AFC)

   a. AFC is paid on a daily rate basis, and includes a relief care component based on the intensity of support needs.
   b. AFC rates are preauthorized by Department staff through an individual authorization.
5. **In-Home Supports**
   
a. These services are paid on a 1 hour 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 client, family and DDPM will complete the In-Home Supports Application annually which may include information on the client’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 client will receive an individualized authorization.

6. **Family Care Option, Parenting Supports, and Extended Home Health Care**
   
a. The client, family and DDPM meet annually to discuss information on the client’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 client will receive an individualized authorization.

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

8. **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.

9. **Self-Directed Supports**
   
a. Equipment & Supplies, Environmental Modification, Behavioral Consultation, and Self-Directed In-Home Supports 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 client, family and DDPM meet annually to discuss information on the client’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 client authorization.

10. Additional considerations for Residential Habitation and ICF/IID services

   **Base Staffing Rate**

   a. 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.

   **Vacancy Add-on**

   a. Residential habilitation or ICF/IID provider agency may receive an add-on payment in the event of a vacancy due to a client move or death. If the vacancy is a result of a client move, proper notification and discharge timelines must be followed per the OSP instructions.
   
   b. The vacancy rate add-on is calculated using the service rate of the client who vacated the setting, and is applied to the service rates of all clients in that setting.
   
   c. The add-on must be requested by the provider agency within fifteen (15) days of such a vacancy on the form (SFN 1801) prescribed by the Department.
   
   d. The vacancy shall be offered until the vacancy is filled but no more than three (3) months. Refer to the NDAC 75-04-05-09(4) for further details.

   **Non-school Days for 16-21 Add-on**

   a. When a client 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 client 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.
B. Billing Guidance

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

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

A provider must enroll in HE MMIS and comply with the requirement in Table 4 in order 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 – DIVISION INFORMATION

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

ND Department of Human Services  
Developmental Disabilities Division  
1237 W Divide Ave Ste 1A  
Bismarck ND 58501-1208  
Phone: (701)328-8930  
Toll Free: 1-800-755-8529  
Website: http://www.nd.gov/dhs/services/disabilities/dd.html
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 35 |
| II. | Traditional IID/DD HCBS Waiver Services | Page 36 |
| III. | Medicaid State Plan Services | Page 54 |
| IV.  | General Fund Services | Page 56 |

### 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 Human Services. They are located 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 Division 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)
15. Infant Development (ID)
16. Parenting Support
1. **Day Habilitation**

<table>
<thead>
<tr>
<th>Provider Managed: Yes</th>
<th>Self-Directed: No</th>
</tr>
</thead>
</table>

**Service Description**

Day Habilitation 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 an individual’s sensory motor, 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.

Day Habilitation is furnished 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.

Participants may receive Day Habilitation outside the facility as long as the outcomes are consistent with the habilitation described in the participant’s plan and the service originates from the licensed day program.

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.

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

- An individual may be enrolled concurrently in Day Habilitation per DD Division policy.
- Day Habilitation and hours of employment in Individual Employment Support, Small Group Employment Support and Prevocational Services combined cannot exceed 40 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.
- This service will not be authorized, nor payment made, for individuals who are eligible for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition.
- 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).
- The maximum utilization by a participant for Day Habilitation services shall not exceed eight (8) hours per day.

**Service Unit**

- 15 minute

**Provider Category**

- 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.

**Verification of Provider Qualifications**

- Entity Responsible: The Developmental Disabilities Division 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

<table>
<thead>
<tr>
<th>Service Description</th>
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</thead>
<tbody>
<tr>
<td>In ND the alternate service name is <strong>Independent Habilitation</strong> services. Independent Habilitation services are formalized training and staff supports provided to participants on a regular, but not on a daily basis for fewer than 24-hours per day. 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.</td>
</tr>
<tr>
<td>Independent habilitation may be provided in community residential settings leased, owned or controlled by the provider agency, or in a private residence owned or leased by a participant.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Independent Habilitation is to provide support for conditions specifically related to IID/DD.</td>
</tr>
<tr>
<td>Multiple participants living in a single or a shared private residence are eligible for this service.</td>
</tr>
</tbody>
</table>

**Limits on the amount, frequency, or duration of this service**
- Independent Habilitation shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
- Independent Habilitation service may not be authorized for participants who are receiving In-Home Supports, Residential Habilitation, Adult Foster Care, Homemaker, Family Care Option, Parenting Support, 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.
- 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 minute

**Service Delivery Method**
- Provider Managed

**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.

**Verification of Provider Qualifications**
- Entity Responsible: The Developmental Disabilities Division is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.
3. Supported Employment | Provider Managed: Yes | Self-Directed: No

Service Description

In ND the alternate service name is **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 for work performed in accordance with State and Federal laws, at or above minimum wage.

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

Transportation costs for individuals from their residence to their workplace may be allowed in the service rate when an individual needs it as a support intervention necessary for the individual to maintain employment. It is not allowed as a substitute for personal, public or generic transportation. If transportation is to be allowed in the rate, the Regional Developmental Disabilities Program Administrator must certify the number of individuals for whom transportation is necessary as part of intervention to successfully support continued employment.

**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 Division 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 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.
- 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.

**Service Unit**

- 15 minute

**Service Delivery Method**

- Provider Managed

**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.

**Verification of Provider Qualifications**

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

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In ND the alternate service name is <strong>Prevocational Services</strong>. The service is 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.</td>
</tr>
</tbody>
</table>

Prevocational Services are to provide support for conditions specifically related to IID/DD.

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.

Individuals participating in this service may be compensated in accordance with applicable federal laws and regulations.

Rates for Prevocational Services may allow transportation costs to access program related activities in the community.

Participation in Prevocational Services is not a required prerequisite for Individual Employment or Small Group Employment services.

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

- Prevocational Services are available to those receiving Day Habilitation, Individual Employment Support and Small Group Employment Support are subject to limitations stipulated in DD Division 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 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.
- 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 Division.
- 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.
- Prevocational Service may not duplicate services provided under any other service in the waiver.

### Service Unit

- 15 minute

### Provider Type Title

- Agency: 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.

### Verification of Provider Qualifications

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

<table>
<thead>
<tr>
<th>Service Description</th>
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</thead>
<tbody>
<tr>
<td>In ND the alternate service name is Small Group Employment Support. The service is for long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting. Service include 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. Participants are paid by the employer for work performed in accordance with State and Federal laws.</td>
</tr>
</tbody>
</table>

Small Group Employment Support is to provide support for conditions specifically related to IID/DD.

Transportation for individuals from their residence to their workplace may be allowed in the service rate when an individual needs it as a support intervention necessary for the individual to maintain employment. It is not allowed as a substitute for personal, public or generic transportation. If transportation is to be allowed in the rate, the Regional Developmental Disabilities Program Administrator must certify the number of individuals for whom transportation is necessary as part of intervention to successfully support continued employment.

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

- 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 Division 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 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.
- 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.

Service Unit

- 15 minute

Service Delivery Method

- Provider Managed

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.

Verification of Provider Qualifications

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

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6. Homemaker

<table>
<thead>
<tr>
<th>Service Description</th>
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<tbody>
<tr>
<td>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. Homemaker services are offered to participants living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks.</td>
</tr>
</tbody>
</table>

Provider Managed: Yes  
Self-Directed: No
If the participant lives with a capable person or provider, prior approval from the State Office is required.

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

Limits on the amount, frequency, or duration of this service
- If shopping is the only identified task for homemaker services, homemaker services cannot be authorized.
- Transportation or escorting the client 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. Providers may choose to use a rate that is less than the service cap.
- Homemaker services cannot be provided to an individual living with a legally responsible caregiver (such as a parent or spouse).
- Homemaker services cannot be provided along 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.
- Homemaker services may not duplicate services provided under any other service in the waiver.

Service Unit
- 15 minute

Service Delivery Method
- Provider Managed

Provider Category
- 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; http://www.legis.nd.gov/information/acdata/html/pdf/75-03-23pdf?20140505085618

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

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, and adaptive skills that improve the participant’s ability to independently reside and participate in an integrated community.

Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

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

- Residential Habilitation shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.
- 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 will not be authorized for participants who are receiving In-Home Supports, Independent Habilitation, Adult Foster care, Homemaker, Parenting Support, Extended Home Health Care, Family Care Option, 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, 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 Division is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

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8. Extended Home Health Care

<table>
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<tr>
<th>Service Description</th>
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</thead>
</table>

Extended Home Health Care is an Extended Medicaid State Plan service and is available when an eligible participant has exceeded the amount of service available under the Medicaid State Plan. This service provides skilled nursing tasks that cannot be delegated to unlicensed personnel. Nursing assessment and care plan are required. The participant’s person-centered plan must address medical necessity.

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.

Extended Home Health Care service is to provide support for conditions specifically related to IID/DD.

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

- Extended Home Health Care service is not available for individuals who are eligible for services under EPSDT.
- Extended Home Health Care service is not available to participants receiving 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.
- Extended Home Health Care service cannot duplicate any other service in the waiver.

Service Unit
- Hourly

Service Delivery Method
- Provider Managed

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.
- Certified as a Home Health Care provider under Medicare or licensed according to NDAC 75-04-01.

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

### 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 may not be provided in conjunction 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 participant pays for room and board costs which are not included in the AFC payment.
- The cost of AFC is limited to a maximum monthly cap set by the Department or through legislative action.
- AFC rates are established to be comparable with the rates that providers charged their private pay clients for the same service. 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.
- AFC cannot duplicate any other service in the waiver.

### Service Unit

- Daily rate

### 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 a Family Foster Home for Adults as stated in NDCC 50-11; [http://www.legis.nd.gov/cencode/t50c11.pdf?20140616141522](http://www.legis.nd.gov/cencode/t50c11.pdf?20140616141522) and NDAC 75-03-21;
- Individual must be enrolled as a QSP, meeting requirements as stated in NDAC 75-03-23-07;

### Verification of Provider Qualifications

- Entity Responsible: State Medicaid Agency, Aging Services, 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.
### Service Description

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.

#### Allowable Activities covered are:
- 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.

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.

Behavioral Consultation services are to provide support for conditions specifically related to IID/DD.

#### 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 Medicaid State Plan or 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 DHS/DDD 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.
- Behavioral Consultation service cannot be provided in the Family Care Option setting, foster care setting, Adult Foster Care Service, or Infant Development service.
- 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.
- Behavioral Consultation service may not duplicate any other service in the waiver.

#### Service Unit
- Hourly

#### 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 through a licensed DD Provider within the participant’s plan of care.

#### Verification of Provider Qualifications
- Entity Responsible: State Medicaid Agency, DD Division, DDPM.
- Frequency of Verification: Annually
### 11. Environmental Modifications

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Provider Managed: No</th>
<th>Self-Directed: Yes</th>
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</thead>
</table>

Environmental Modifications service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State 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 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:
- Ramps and Portable Ramps
- Lifts, elevators, manual, or other electronic lifts,
- Modifications and/or additions to bathroom facilities
  - Roll in shower
  - 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 adaptations, including alarms
  - Shatterproof windows
  - 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.

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 or lease itself. 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
- Safety/security modification

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 $20,000 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 other 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:
- The base product and one repair of the home modification which is cost efficient and 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).
- 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, central air conditioning, 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, renting, or leasing 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 one repair of the vehicle modification which is cost efficient and 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
- Agency

Provider Type Title
- Individual
- Agency

Provider Qualifications
- Individual
  - 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.
  - The Consumer and/or legal decision maker, along with the Team members will identify the appropriate Environmental Modifications within the participant’s Plan. Once identified, the Team will determine 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 consumer and/or legal decision maker will obtain the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

- 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 American’s 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.

- Agency:
  - This service may be provided by an agency staff member who is a relative of the participant but cannot be provided by an agency staff member who is legally responsible for the participant or a legal guardian of the participant.
  - 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. American's 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: participant or primary caregiver
- Frequency of Verification: Prior to Modifications

---

### Table: 12. Equipment and Supplies

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Provider Managed: No</th>
<th>Self-Directed: Yes</th>
</tr>
</thead>
</table>

**Equipment and Supplies**

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.

The participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participants plan.

Equipment and Supplies service covers purchases of the following which are not covered under the Medicaid State Plan:

- 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);
- 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:
  - 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;
• coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
• training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
• training or 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 Response System – is an electronic device that enables waiver participants to secure help in an emergency. 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.

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 $20,000 per participant per approved waiver period. 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) 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 may be provided by an agency staff member who is a relative of the participant but cannot be provided by an agency staff member who is legally responsible for the participant or a legal guardian of the participant.
• 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

Service Description

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.

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.

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.

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.

Participants may receive Day Habilitation outside the facility as long as the outcomes are consistent with the habilitation described in the participants plan and the service originates from the licensed day program.

Participants receiving services in Family Care Option must have an active IEP (Individual Education Plan).

Family Care Option service is to provide for conditions specifically related to IID/DD.

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

- Family Care Option is not provided in group residential settings.
- Family Care Option is not available when the participant receives Adult Foster Care, Residential Habilitation or Independent Habilitation service.
- In-Home Supports and Extended Home Health Care are not available in the Family Care Option setting.
- Family Care Option service is not available to children under the custody of county social service.
- 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.
- Family Care Option service cannot duplicate any other service in the waiver.

Service Unit

- 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 Division is responsible for licensing verification.
- Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

<table>
<thead>
<tr>
<th>Provider Managed</th>
<th>Self-Directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Service Description**

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.

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.

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.

In-Home Supports service is to provide for conditions specifically related to IID/DD.

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

- In-Home Support service is limited to 300 hours per month per participant unless an exception is approved by the DD Division.
- Individuals providing IHS may not live in the same home as the participant.
- IHS is not authorized during the same time of the day that Part B services of IDEA are offered through the North Dakota Department of Public Instruction, Day Habilitation is available to the participant.
- IHS cannot be provided for the purposes of administering a specialized curriculum or service that is not specifically identified on the participant’s service plan (ISP section of the plan).
- An IHS participant cannot be authorized to receive both provider managed and self-directed at the same time.
- 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 provided to participants receiving Residential Habilitation or Independent Habilitation.
- In-Home Supports may not be provided at the same time as Day Habilitation and Medicaid State Plan Personal Care services.
- In-Home Support cannot be provided in a Family Care Option setting.
- 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.
- In-Home Support service cannot duplicate services provided under any other service in the waiver.

**Service Unit**

- Hourly rate

**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 may be provided by a relative, not living in the participant’s home but cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.
- Agency
- Individual
  - Must be 18 years or older and cannot live in the participant’s home; and
  - Must meet qualifications as listed in the participant’s plan.

**Verification of Provider Qualifications**

- **Entity Responsible:**
  - Agency: The Developmental Disabilities Division is responsible for licensing verification.
  - Individual: Fiscal Agent verifies initial proof of age, address, background check 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

<table>
<thead>
<tr>
<th>Provider Managed: Yes</th>
<th>Self-Directed: No</th>
</tr>
</thead>
</table>

**Service Description**

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.

- **Home visit:** Home visitors coach the primary caregiver(s) on how to address the identified needs for their child.
  - 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.
• Infant Development service cannot duplicate any other service in the waiver.

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 Division is responsible for licensing verification.
• Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.

<table>
<thead>
<tr>
<th>16. Parenting Support</th>
<th>Provider Managed: Yes</th>
<th>Self-Directed: No</th>
</tr>
</thead>
</table>

Service Description
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.

Parenting Support service is to provide for conditions specifically related to IID/DD.

Limits on the amount, frequency, or duration of this service
• Support is available from the first trimester, until the eligible participant’s child is 18 years of age.
• Parenting Support service is not available if Residential Habilitation or Independent Habilitation is authorized.
• Parenting Support is limited to an average of four 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.
• Parenting Support service cannot duplicate any other service in the waiver.

Service Unit
• Hourly rate

Service Delivery Method
• Provider Managed

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 Division is responsible for licensing verification.
• Frequency of Verification: At the time of initial application, annually and/or upon notification of provider status change.
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 county level.

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 client 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 client 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/IID 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

**Targeted Case Management (TCM) Eligibility Requirements:**

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

- Medicaid recipient.
- Be over 65 years of age, or be less than 65 years of age and meet Social Security disability criteria.
- Not currently be covered under any other case management/targeted case management system.
- 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.
- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs. The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.
- An assessment must be completed and a care plan be developed. The TCM client’s case file must contain documentation of eligibility for TCM. This should be accomplished by the Application for Service and completion of a comprehensive 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 client must be informed of that fact by noting Case Management Service and cost on the Personal Care Service Plan. Clients 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.
IV. General Fund Services

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

General Fund Services under the DD division are:

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

1. **Section 11 Funds**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

2. **Corporate Guardianship**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 Division of Developmental Disabilities.</td>
</tr>
</tbody>
</table>
2017/2018 Salary Reimbursement Levels

Direct Care Staffing for 2017/2018

<table>
<thead>
<tr>
<th>Provider Managed In-Home Support &amp; Parenting Supports</th>
<th>Salary Allowance</th>
<th>Salary &amp; Fringe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7.46/hour Administration</td>
<td>$17.70</td>
<td>$23.62</td>
</tr>
<tr>
<td>$3.74/hour Program Coordination</td>
<td>$36,935</td>
<td>$49,124</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self Directed In-Home Supports</th>
<th>Salary Allowance</th>
<th>Salary &amp; Fringe</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHS/FOCO III (Level II)</td>
<td>$17.76</td>
<td>$23.62</td>
</tr>
<tr>
<td>Annual</td>
<td>$36,935</td>
<td>$49,124</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Care Option</th>
<th>Salary Allowance</th>
<th>Salary &amp; Fringe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$9.81/day Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4.43/day Program Coordination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Infant Development Fee For Service Rates for 2017 2018 | Activity         |                  |
|--------------------------------------------------------|------------------|
| Evaluation                                             | $476             |
| Individual Family Service Plan                         | $461             |
| Home Vists                                             | $139             |
| Consultation                                           | $289             |

<table>
<thead>
<tr>
<th>DD Provider Extended Home Health Care Rate for 2017-2018</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$37.71 Per Hour</td>
</tr>
</tbody>
</table>
### State of North Dakota
#### Rate Matrix

**Fully Loaded Hour Value: "The Brick"**

<table>
<thead>
<tr>
<th>Component Driven</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>Notes:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>D X E</td>
<td>D + F</td>
<td>Relief</td>
<td>G X H</td>
<td>G + I</td>
<td>D X K</td>
<td>J + L</td>
<td>Gross</td>
<td>With</td>
<td>F</td>
<td>A Factor</td>
<td></td>
</tr>
<tr>
<td>ICF-ID Medically Intensive</td>
<td>$17.07</td>
<td>35.1%</td>
<td>$5.99</td>
<td>$22.06</td>
<td>14.0%</td>
<td>$3.22</td>
<td>$20.28</td>
<td>113.1%</td>
<td>$19.31</td>
<td>$25.59</td>
<td>$50.66</td>
<td>$50.66</td>
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<tr>
<td>ICF-ID</td>
<td>d</td>
<td>$17.07</td>
<td>35.1%</td>
<td>$5.99</td>
<td>$22.06</td>
<td>14.0%</td>
<td>$3.22</td>
<td>$20.28</td>
<td>113.1%</td>
<td>$19.31</td>
<td>$25.59</td>
<td>$50.66</td>
</tr>
<tr>
<td>Day Habilitation</td>
<td>h</td>
<td>$17.13</td>
<td>35.1%</td>
<td>$6.01</td>
<td>$23.14</td>
<td>14.0%</td>
<td>$3.24</td>
<td>$20.38</td>
<td>56.7%</td>
<td>$9.71</td>
<td>$36.09</td>
<td>$40.10</td>
</tr>
<tr>
<td>Prevocational Services</td>
<td>h</td>
<td>$17.13</td>
<td>35.1%</td>
<td>$6.01</td>
<td>$23.14</td>
<td>14.0%</td>
<td>$3.24</td>
<td>$20.38</td>
<td>56.7%</td>
<td>$9.71</td>
<td>$36.09</td>
<td>$40.10</td>
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<tr>
<td>Small Group Employment Supports</td>
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<td>35.1%</td>
<td>$6.01</td>
<td>$23.14</td>
<td>14.0%</td>
<td>$3.24</td>
<td>$20.38</td>
<td>56.7%</td>
<td>$9.71</td>
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<td>$20.41</td>
<td>56.6%</td>
<td>$6.79</td>
<td>$33.20</td>
<td>$39.99</td>
</tr>
</tbody>
</table>

**Notes:**

- **<>** ICF Property Costs are 9.5% of DCS ($1.40 - approximately 3.4% of the overall rate)
- **<>** The wage is calculated using a CM approach and a case load assumption of 1 to 30
- **<>** Component Cost history for Attendant Care / Homemaker have not been discreetly studied.
How to enroll as a DD provider in Enterprise:

1. Become licensed by the DHS-DD Division.
2. Complete a SFN 615 & DD Provider Addendum with DHS (contact the DD Division).
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 complete 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 Developmental Disabilities.
   b. Select “Add Licensure/Certification”
i. Select “License”
ii. License number is “00000”
iii. Licensing Agency is “Developmental Disabilities”
iv. Effective Date is the date the license issued by DD is effective
v. Expiration date is coincides with your license issued by the DD Division
vi. State is North Dakota
vii. Select “Save” in the small box
i. Select “Add Specialty”
ii. Choose correct Specialty from drop down box.
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. If specialty type is an ICF/ID select “Add Taxonomy”, if not ICF/ID select overall “Save”, then “Continue”.
   a. Add Taxonomy number, if ICF/ID, which is 315P00000X.
   b. Begin Date is the date the ICF/ID 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. If completing an application for an ICF/ID you’ll need to add an NPI number. If not completing an application for an ICF/ID you can select “Continue” at the bottom of the page.
   a. For ICF/ID, 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.
   a. Choose “North Dakota MMIS Web Portal” if you are anything but an ICF/ID
   b. If you are submitting an ICF/ID application, select “Vendor Software” if you use Noridian or have your own software you use to submit ICF/ID claims. Select “Billing Agent/Clearinghouse” if you use any company besides Noridian to submit your ICF/ID claims. If you will submit your ICF/ID claims through MMIS web portal, you will choose “North Dakota MMIS Web Portal”
      i. Fill out information as best to your knowledge. This information will be used to create a Trading Partner.
   c. 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 Facilities Rates Administrator with the DD Division.
   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.
   b. Select “Save” overall, then “Continue”
16. Complete “Exclusions/Sanctions” section of the application as it relates to your agency.

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

![Image of the North Dakota MMIS Web Portal]
• 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
• 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.
• 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.

• 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

- 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.

DD Provider – New Medicaid Numbers, NPI Numbers, & Taxonomy

- All current provider Medicaid numbers will be retired. New provider Medicaid numbers have been generated as a result of approved applications.
- ICFs/IID will need to include a NPI number and Taxonomy number when submitting a claim.
  - ICF/IID Taxonomy number is 315P00000X.
  - NPI numbers are registered for by the provider and unique to each provider.
DD Provider – Service Codes (Atypical)

- **00010** Homemaker Services
- **00012** Adult Family Foster Care – Respite
- **00026** Adult Family Foster Care – Nonrespite
- **W0275** Extended Home Care
- **W0280** Parenting Support
- **W0300** In-Home Support
- **W0310** Family Care Option
- **W0500** Home Visits
- **W0510** Consultations
- **W0520** Evaluation and Assessment
- **W0530** Individual Family Support Plan
- **W0540** Environmental Supports/Modification
- **W0540** Environmental Supports/Modification
- **W0550** Equipment and Supplies
- **W0560** In-Home Supports – Self-Directed
- **W0570** Behavioral Consultation
- **W0580** Transportation Out-of-State
- **W0585** Transportation In-State
- **W0590** Extended Services – Self-Directed
- **W0700** Prevocational Services
- **W0705** Individual Employment Supports
- **W0710** Small Group Employment Supports
- **W0715** Day Habilitation
- **W0720** Independent Habilitation
- **W0725** Residential Habilitation

DD Provider – Creating an Atypical Claim

- To Submit a DD Atypical claim (non-ICF/IID claim) select “Claims”, “Create Claims”, “HCBS/DD Claim”.

North Dakota DD Provider Manual  Page 81
DD Provider – Creating an Atypical Claim

- Enter the “Provider Organization Name”, “Member ID Number”, “Member’s Last Name”, “Member’s First Name”, “Begin Date”, “End Date”, “Service Begin Date”, “Service End Date”, “Procedure Code”, “Units”, “Billed Amount”, then click on the plus sign to add the claim. Once all claims are ready to be submitted click on “Submit Claim”. The option to save the claim instead of submit is available by clicking on “Save Claim”.

North Dakota DD Provider Manual
DD Provider – Creating an Atypical Claim

- After clicking on “Submit Claim” this screen will appear stating if the claim is “To Be Paid”, “To Be Denied”, or “Suspended”.
- Print this page or record your TCN for future tracking use.

DD Provider – Adjustment or rebill an Atypical Claim

- To adjust or rebill a claim search for the claim using the TCN number.
- Once viewing the claim select “Yes” to the question “Is this a void/replacement?”
- Make necessary adjustments and click on “Submit Claim”.

DD Provider – Creating a Claims Template

To create a claims template select “Claims”, “Create Templates”, “Create HCBS/DD Template”.

A claims template can be set up in a combination of ways. It can remember provider, client, and service information.

Note only 100 claims templates can be set up for each user ID.

DD Provider – Creating a Claims Template

Enter in a “Template Name” and “Long Description”, then click on “Continue”.
• Enter the information you want to be saved in the template in this screen and click on “Save Template”.

• Note you will get a message confirming the template has been completed.
To manage a claims template go to “Claims”, “Manage Templates”, and “View/Edit/Delete Template”.

To view an already created claims template you can search by “Starts with” or “Contains” and selecting “HCBS/DD”, then click on “Search”.
• Returned two items that began with “TEST”, select the item you want to view, edit, or delete by clicking on the blue hyperlink.

• To edit simply change the items that need updating and click on “Save Template”.
• To delete simply click on “Delete”.
DD Provider – Creating a Claims from a Claims Template

- To manage a claims template go to “Claims”, “Create Claims”, and “Create Claim from Template”.

DD Provider – Creating a Claims from a Claims Template

- To view an already created claims template you can search by “Starts with” or “Contains” and selecting “HCBS/DD”, then clicking on “Search”. 
DD Provider – Creating a Claims from a Claims Template

- Returned two items that began with “TEST”, select the item that you want to submit a claim for by clicking on the blue hyperlink.

- Update the necessary information to submit a claim and click on “Submit Claim”.
- If not ready to submit claim, you can save the updated claim by clicking on “Save Claim”.

DD Provider – Creating a Claims from a Claims Template
DD Provider – View Submitted Claims

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

- 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”.

North Dakota DD Provider Manual
Page 90
- 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.

- 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.
Some Common Remark Codes

- 62
  - Payment denied/reduced for absence of, or exceeded, precertification/authorization
  - There is no authorized hours for the service being billed, or the amount being billed is more than the amount authorized.

- 140
  - Patient/insure health ID number and name do not match

- N29
  - Missing documents
  - The ISP is pending or there is no ISP for service billed.

- N56
  - Procedure code billed is not correct/valid for the services being billed or the date of service billed
  - Billing with an R, should be K or vice versa

- N61
  - Rebill services on separate claim

There may be more than one Remark Code assigned to a claim on the Remittance Advice
• To check for client eligibility for Medicaid and the amount of Recipient Liability (RL) select “Member” and “Check Eligibility”
• Enter the member ID, date of birth, last name, first name, and dates of service to view eligibility and click on “Search”.

• 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

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

○ Enter your User ID and Password

○ Select “Login”
Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 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

- Under the heading “Create Claims” select “Institutional Claim”
Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 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

Billing Provider

*Note: Healthcare providers are required to submit institutional provider ID.

<table>
<thead>
<tr>
<th>National Provider ID</th>
<th>Taxonomy Code</th>
<th>NPI ID</th>
<th>Location Code</th>
</tr>
</thead>
</table>

Additional Billing Provider Information

Currency Code

Physician Name

Address 1

City

State

Zip Code

Country

Subdivision Code

Contact Information

Is the Billing Provider Address also the Payee Address?

- Yes
- No

Addressing Provider

Residency Provider
Intermediate Care Facility (ICF) Web Portal Billing Instructions

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

- REQUIRED
- Enter your facility name, address, city, state, and zip code
Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 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

- 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

- 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

- REQUIRED
  - Enter the member’s address, city, state, and zip code
Intermediate Care Facility (ICF) Web Portal Billing Instructions

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

- Statement From Date
- Statement To Date
- Total Claim Charge Amount
- Claim Frequency Code
- Admission Date / Hour:Minute
- Discharge Hour:Minute
- Medicare Assignment Code
- Benefits Assignment Certification
- Release of Information Code
Intermediate Care Facility (ICF) Web Portal Billing Instructions

- 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 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

- 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

- 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

- **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

- **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
- **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 (Adult Licensed Facility)
      - 0180 Therapeutic Leave Days (Adult Licensed Facility)
      - 0182 Hospital Leave Days (Adult Licensed Facility)
      - 0120 In-House Medicaid Days (Children’s Licensed Facility)
      - 0183 Therapeutic Leave Days (Children’s Licensed Facility)
      - 0185 Hospital Leave Days (Children’s Licensed Facility)
Intermediate Care Facility (ICF) Web Portal Billing Instructions

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

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: 10201515320010