

# DD Provider Integrity

November 2016

# DD Provider Integrity

Purpose of training:

- ▶ Discuss policies and procedures for auditing DD providers who receive Medicaid funding
  - This includes all DD funded services (e.g. day supports, infant development, ISLA, etc.)

# DD Provider Integrity

## Authority:

- ▶ The Division is required to follow federal requirements in conducting reviews and investigations
- ▶ Requirements are found in 42 CFR, Chapter IV, Part 455 – Program Integrity: Medicaid
- ▶ Provider Integrity is governed by NDAC Chapter 75–02–05

# DD Provider Integrity

## Importance of Provider Integrity:

- Avoid unnecessary costs to the program due to fraud or abuse
- Assure that eligible recipients receive quality and cost effective care

## Importance of Fiscal Integrity Protections:

- Essential to prevent improper payments
- Vital to the continuation of services and programs
- Reduces and prevents fraud, waste, and abuse
- Allows States to continue to support services/programs

# DD Provider Integrity

- ▶ **DD Division Staff Reporting Responsibilities**
  - All DHS staff are required to report allegations of fraud and abuse immediately to the Fraud, Waste, and Abuse (FWA) Administrator
- ▶ **Provider Obligations**
  - Required to release information to the DD Division as part of the Medicaid Provider Agreement form. The form specifies that as a part of the provider agreement to participate in the Medicaid Program, the provider agrees to, upon reasonable request, release information needed to support the services billed to the Department.

# DD Provider Integrity

## DD Staff Reviewer Responsibilities:

- Annually, or as needed, the DD Division will determine audit topics relative to the services authorized
- Review provider records/utilization reports to determine if services are being delivered according to accepted DD policy and procedures which includes:
  - Requesting, collecting and analyzing documentation from providers and recipients files for case reviews
  - Documenting findings
  - Coordinate and provide training for providers concerning billing/documentation
  - Determine corrective action in cases where appropriate
- At the conclusion of the audit, submit a report to the DD provider and maintain a copy of the report in the provider's file

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## Provider Responsibilities:

- ▶ Provide full disclosure of requested administrative, fiscal and program information within the requested timeframes. Documentation should support the service billed and include:
  - Date of service
  - Name of provider
  - Individual's name/Medicaid ID number
  - Staff who provided service (if using staff initials a legend of staff names must be provided)
  - Summary of tasks and activities performed during that time (daily rate providers can meet the requirement by one itemized list of routine tasks and a single entry every day)
  - The record should be written in clear language and without alterations
  
- ▶ Respond to corrective actions as applicable within the requested timeframes

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## Guidelines to Conduct Reviews:

- Review is intended to provide assurance that services are being delivered in according to the individuals plan
- The reviewer will use the most current review guide and complete components for selected services including service and payment records

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## Determining Sample Size and Selecting Claims:

- Every audit will start by determining what the sample size is based on previous years utilization OR a 95% confidence level and a confidence interval of 5. Staffing resources will influence whether the confidence interval needs to be changed.
- There may be instances where the sample size is such that every provider in the state would not necessarily be selected randomly for an audit
  - In those instances, five claims for each provider are randomly selected to ensure that each provider has at least one claim included in the audit.

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## Audit:

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

**DD LICENSED PROVIDER REVIEW**

**PURPOSE:** Determine that the DD Licensed Providers are delivering services in accordance with the Department of Human Services rules and regulations.

Provider Name		
Provider Number		
Region		
Date(s) of Review		
Date of Previous Financial Record Review		
Date of Provider Enrollment		
Service Records Reviewed	(such as ISLA, Day Hab, infant development, ect)	
Funding Source(s)	DD Traditional HCBS	
	Waiver	
DD Reviewers' Name	Marella A. Krein	

## SERVICES AND PAYMENT RECORDS

Criteria	Y	P	N	NA	Comments
Did the provider maintain accurate records of service delivery that contained all required information?					
Did the providers written documentation for dates and units of service delivered correlate with the payment history of the Department of Human Services?					
Did the provider bill within the amount authorized by the DDPM?					
Did the provider use the correct procedure code for tasks authorized?					
Did the provider use the correct client ID number?					

1. Findings:

Corrective Action:

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- ▶ DD Provider Integrity Manual can be found at:  
Will be added to DD Division website
- ▶ Introduce Medicaid Provider Integrity Unit  
(Fraud & Abuse Unit)

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## Questions

