PRE-ENROLLMENT/REVALIDATION SITE VISIT CHECKLIST

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 570 (9-2017)

Per 42.CFR 455.432, pre-enrollment site visits of providers who are designated as "moderate" or "high" categorical risk to the Medicaid program are required. The purpose is to verify that the information submitted to the Medicaid provider enrollment unit is accurate and to ensure compliance with federal and state enrollment requirements.

Section I. Provider Information

Instructions: ND Medicaid Provider Enrollment staff will complete this section based on the most recent provider data available. The type of services provided by the enrolling provider will determine necessary observations during the tour of the facility, such as for durable medical equipment providers.

Business Name	Owner(s) Identified in the Application		
Service Address	City	State	ZIP Code
Telephone Number	Fax Number	ATN or HE Number	
Site Visit ☐ Initial ☐ Follow up ☐ Revalidation	Provider Type ☐ NEMT ☐ DMEPOS ☐ Other	Provider Risk Category ☐ High ☐ Moderate	
Type of Services Provided (please describe)			

Section II. On Site Observations Prior to Attempting Entry

Instructions: The site visit should be unannounced, when possible. Upon arrival at the location, verify the service address. If the location is closed, determine if the business appears to be operational. If, after two reasonable attempts at a site visit, the site reviewer is unable to make contact and tour the facility, they should note that under the Site Visit area referenced above. Document your observations. Examples may include; location does not appear operational, facility not located at address provided, not allowed entry, etc.).

If the location gives the appearance of being oeprational, complete the following boxes under this section.

Is the provider/business entity available at service location identified above? ☐ Yes ☐ No	Is the business identified with visible signage? ☐ Yes ☐ No	Are the hours of operation posted? ☐ Yes ☐ No		Mon	Tue	Wed	Thu	Fri	Sat
			Open						
			Closed						
Does the facility have a number where they may be contacted after hours? ☐ Yes ☐ No ☐ N/A	If yes, provide the telephone number	Date of Site Visit	Time Entry Allowed						
Comments when unable to perform a site visit									

Section III. Business Identification

Instructions: Based on information from the contact person at the business location and through observation, check the following during the tour of the facility, as appropriate, and make applicable notes, such as condition of the facility and signage. Document whether or not you are able to tour the entire facility.
Upon entering the business, introduce yourself, explain that you are there to conduct a site visit for North Dakota Medicaid and ask to speak to the owner/ manager. Ask the contact to provide you with a tour of the facility.

Owner(s)/Manager Information

Instructions: If the contact person is not the owner, ask the contact who the owner(s) are. If the contact person does not know the owner(s), indicate "owners unknown" in the Owner(s)/Manager(s) Information section.

Contact Person Name	Title	
Contact Telephone Number	Contact Email Address	
Owner Name(s)		
Is the provider/facility representative able to provide sufficient information to complete the site visit? ☐ Yes ☐ No	Is it necessary to schedule another site visit? ☐ Yes ☐ No	If yes, why?

Durable Medical Equipment Provider

Instructions: Make observations during the course of the interview to determine if there is evidence of warehousing facilities, inventory tracking capability, ability to deliver equipment, etc.

Does the facility appear clean and well kept? ☐ Yes ☐ No
Observations

Non-Emergent Medical Transportation Provider (commercial)

Instructions: Make observations during the course of the interview to determine if there is a garage, maintenance logs, dispatch center, etc.

Observations

Request a copy of any brochures or other documents that include their rates. Request their "call in" number, a business card and a website address they use to advertise their business.

Does it appear that a transportation business is operating out of this location? ☐ Yes ☐ No	Is there a garage for storing vehicles? ☐ Yes ☐ No	If no, where are the vehicles stored? (parking lot, at home)

For any of the following areas checked yes by enrollment staff, confirm the type of vehicle present (Enrollment staff will indicate which vehicles the provider should have).

Wheelchair	☐ Yes	☐ No	Vehicle Present?	☐ Yes ☐ No
Taxi	☐ Yes	☐ No	Vehicle Present?	☐ Yes ☐ No
Minivan	☐ Yes	☐ No	Vehicle Present?	☐ Yes ☐ No
Stretcher	☐ Yes	☐ No	Vehicle Present?	☐ Yes ☐ No

For any vehicle types checked yes by enrollment staff but not present, obtain the justification from person conducting the tour.

Comments

Other Provider

Instructions: Enrollment staff will provide information in the following box specific to the provider type and what expectations the location should demonstrate.

Enrollment Staff
Observations

Section IV. Standard Operating Procedure/Policies

Instructions: Obtain and review the documents. It is not necessary to retain a copy.

Does the operation have an employee handbook? ☐ Yes ☐ No	Does the employee handbook contain information on the Federal False Claims Act and whistleblower protections? ☐ Yes ☐ No	Does the handbook include a quality assurance plan? ☐ Yes ☐ No
Does the operation have a HIPAA compliance officer? ☐ Yes ☐ No	If yes, provide the officer's name and credentials	Does the operation have HIPAA procedures defined? ☐ Yes ☐ No

Section V. Records and Documentation

Instructions: Ask to see where the medical records are stored. Answer the following questions through inquiry and observation related to records and documentation.

Does the operation maintain documentation of services provided?	☐ Yes	☐ No
Is the operation paperless?	☐ Yes	☐ No
Does the operation have plans to convert to electronic health record?	☐ Yes	☐ No
Is the documentation secure in the storage location?	☐ Yes	☐ No
If there are electronic health records, are they password protected?	☐ Yes	☐ No

Section VI. Billing Information

Instructions: Answer the following questions through inquiry and observation related to billing. Document your findings in the space provided.

Is this the billing location? ☐ Yes ☐ No - move to the signature section	Who submits claims to North Dakota Medicaid? ☐ Self ☐ Billing Service ☐ Other	Name of Billing Service (if applicable)
What type of certification/training/experience does biller have? Check all that apply. ☐ American Health Information Management Association (AHIMA) ☐ American Academy of Professional Coders (AAPC) ☐ Other		
If other, please specify:		
Does provider/biller have access to coding information/HCPSs books? ☐ Yes ☐ No	If no, where does provider/biller obtain coding information?	Are coding books current for the calendar year? ☐ Yes ☐ No
How will (does) the provider stay abreast of North Dakota Medicaid policies?		

Section VII. Site Visit Signatures

Name of Facility Contact Person	
Signature	Date
Name of North Dakota Medicaid Representative Conducting the Site Visit	
Signature	Date

Section VIII. Final Site Visit Notes and Comments

Instructions: Detail any pertinent observations below, including details on patient care and infrastructure conditions. i.e. leaky roof, damage, unsafe conditions.

Section IX. Recommendation for Approval or Denial (to be completed by ND Medicaid provider enrollment staff only)

Date	☐ Recommend to approve enrollment ☐ Recommend to deny enrollment

☐ Recommend to deny enrollment if during the first attempt at a site visit, there are obvious signs that the facility is no longer operational - no second attempt is required; (in the first attempt the facility is closed, but there are no obvious indications the facility is nonoperational, make a second attempt on a different day during posted hours). Document with a photograph.

☐ Recommend to deny enrollment if second attempt for a site visit is unsuccessful.

☐ Recommend to deny enrollment if the provider fails to permit access for the site visit.

☐ Recommend to deny enrollment for providers that (check all that apply):

- ☐ are not located at the service location listed on the provider application
- ☐ do not have adequate supplies or equipment to perform services
- ☐ demonstrate or provide ownership information that is not consistent with provider application

Comments	
Printed Name of Provider Enrollment Analyst (when signature is not electronic)	
Signature	Date
Printed Name of Provider Enrollment Supervisor (when signature is not electronic)	
Signature	Date