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POLICY

Nevada Developmental Services (DS) will maintain a comprehensive process of providing oversight, monitoring and review of provider direct services and claims.

PURPOSE

To establish a clear process to identify and correct provider claim errors on compliance with regulatory requirements of Nevada Division of Health Care Financing and Policy.

DEFINITIONS

Person Centered Plan: A document and working tool that identifies the individual's interests, personal goals; health and welfare needs; and agreed upon supports and services that are to be provided through a variety of programs to include Medicaid State Plan, Medicaid Waiver, natural and informal supports, generic community resources and contracted services.

Claim: An Invoice submitted by a contracted provider of service for reimbursement by DS.

Direct Service: A paid service provided by a DS contracted provider of service to an individual receiving DS services.

Service Authorization: Documentation recorded in the Harmony Information Management System that authorizes direct services, supports and state supplement for individuals receiving services through DS.

REFERENCES

Home and Community Based Services Waiver NV.0125.R06.00

NAC 435

NRS 435

MEDICAID WAIVER CHAPTER 2100, CHAPTER 2500, AND CHAPTER 100

PROCEDURE

A. PROVIDER RESPONSIBILITIES

1. Providers are responsible to submit accurate and timely claims utilizing the Harmony Information System.
2. All providers of 24 hour supported living will be required to upload all daily service logs to the 24 hour home's provider record in the Harmony Information System.
3. Providers who demonstrate accurate and timely billing for at least a 6 month period will be allowed to submit daily service records only when requested by DS auditing staff. Providers will be notified in writing of this allowance, with a copy of the letter to be filed in the providers' electronic record within the Harmony Information System.
4. All providers will be required to submit requested audit and service documentation, upon notification of an audit, within 1 to 3 business days.

B. SAMPLING METHODOLOGY

1. DS Quality Assurance (QA) Staff, or other staff designated by the Regional Center Agency Manager, will select two random samples, the first for individuals receiving services by DS contracted providers of Jobs and Day Training (JDT) and the second for individuals receiving services by DS contracted providers of Residential Support (RS) services.
    a. DS QA staff will draw a random sample with a confidence interval equal to a 95/5, using the total number of service recipients in each service category at least every six (6) months.
    b. Individuals who are selected for sample who receive both JDT and RS services will be placed on both the JDT and RS audit lists.
    c. DS QA staff will assign DS staff to complete audits monthly. Audit teams will include: Regional Center DSIII Service Coordinators, DSIV Service Coordinator Supervisors, Fiscal/Accounting Staff, and Quality Assurance Staff.
    d. DS QA staff will provide a schedule of audits at least every six (6) months to Regional Center staff.

C. **AUDIT PROCESS**

1. Audits of claims will be completed by Fiscal/Accounting Staff.
    a. Fiscal/Accounting staff who are assigned an audit will request the contracted provider to submit the following information within one (1) to three (3) business days, as requested, of the audit request:
        1) Approved service authorization(s) for the individual(s) and month of service selected for audit;
            i. For individuals receiving 24-hour residential support services, they will request copies of the service authorizations for all individuals living in the home;
        2) Daily Records, such Residential Support Service logs, JDT Attendance logs, etc.;
        3) Case management logs;
        4) Behavioral consultation logs;
        5) Nursing logs; Payroll records/timesheets for staff working with the individual that month;
        6) Other documentation of services for the individual(s) and month(s) of service they have been assigned to audit; and
        7) Paid claim for the services the individual(s) selected for audit for the month of service selected for audit.
    b. Fiscal/Accounting Staff who are assigned an audit will utilize the DS SLA Audit Worksheet or the DS JDT Audit Worksheet to complete the audit.
    c. The DS Regional Center may audit a provider’s service billing at anytime without cause.

2. Oversight of direct services will be completed by DSIII Service Coordinators, DSIV Supervisors, Quality Assurance Staff, and other program staff as assigned by the Program Manager. These staff are referred to as Program Staff.
    a. Program Staff assigned to oversight direct services will request the contract provider to submit the following information within one (1) to three (3) business days, as requested, of the audit request, as applicable:
        1) Habilitation data;
        2) Case management logs;
        3) Behavioral consultation logs;
        4) Nursing logs; and
        5) Other documentation of services for the individual(s) and month(s) of service they have been assigned to audit.
    b. Program Staff will review the Individual's Person Centered Plan, all related habilitation plans and supporting information to determine if the habilitation plan and direct services provided are in compliance with the PCP.
    c. Program Staff assigned will utilize the DS Direct Services Oversight Worksheet to document their review.
3. The DS Regional Center may provide oversight and review direct services provided at anytime without cause.

D. **FINDINGS**

1. Completed audits and direct service oversight reviews will be submitted to the Regional Center Quality Assurance Specialist Department, where designated staff will enter the findings and issue corrective action plans, as applicable, and enter them into a tracking spreadsheet.
2. The Quality Assurance unit will track the status of any corrective action plans the contracted provider has submitted.
3. All completed audits will be kept on file with the Regional Center Accounting Office.
4. The Regional Center Accounting Office will generate a "Financial Audit Findings" letter and submit to the provider for review and action as applicable. The ASO, QAIII and Agency Manager will be copied.
5. Provider will have thirty (30) days upon receipt of the "Financial Audit Findings" letter to resubmit a revised invoice or provide additional backup documentation to substantiate hours billed.
6. After review of any additional documentation submitted by the provider, any audits with findings of an overpayment to the provider will result in DS requiring that the provider reimburse the overpayment within thirty (30) days unless a specific reimbursement plan has been received and approved by the Regional Center.
7. Overpayments will be referred to the Surveillance and Utilization Review Unit within 30 days of a determination of overpayment.

8. Providers will be notified of all referrals to the SURs unit within 15 days of determination of overpayment.
9. The Regional Center Accounting Office will ensure billing to the Medicaid fiscal agency is/was accurate and make adjustments as needed.

ATTACHMENTS (CLICK BELOW)

ATTACHEMNT A - **DS-41-H** **SLA Audit Worksheet**
ATTACHEMNT B - **DS-41-I** **ISLA Audit Worksheet**
ATTACHEMNT C - **DS-41-J** **JDT Audit Worksheet**
ATTACHEMNT D - **DS-41-K** **Direct Services Oversight Worksheet**

Approved By		
Title	Signature	Date
Deputy Administrator		4/12/17
Division Administrator or Designee		4/12/17

Document History

Revision	Date	Change