

To: Newly Enrolled Qualified Service Providers (QSP)

From: Medical Services / HCBS

Re: Instructions for new QSPs

Thank you for enrolling as a QSP. The information in this packet is very important, it explains how you bill for the services you provide, who to call for help and what your responsibilities are as a provider. PLEASE read the entire packet and keep with your records to refer to when you have questions.

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MEDICAL SERVICES

Who do I call if I have questions?

When will I get paid?

1-866-768-2435

Why didn't I get paid?

1-877-328-7098

(When asked for a PIN, select "0")

How to void or replace a claim?

1-877-328-7098

(When asked for a PIN, select "0")



If you need your online billing password reset or you're locked out of your online billing account, call either number listed below.

1-877-328-7098

For help with the following, call **701-328-4602**

- Add or change something on your enrollment
- Update contact information
- Get more billing forms
- Set up a new online billing account

HCBS Fax – **701-328-4875**

HCBS Email – **DSHCBS@ND.GOV**

QSP Enrollment staff are located at 3541 N 14th Street in Bismarck. If you need to meet with enrollment staff for any reason, please call 701-328-4602 to schedule an appointment. Staff is only available to meet during the following schedule:

- Tuesday afternoon: 12 p.m. – 4 p.m.
- Wednesday morning: 8 a.m. – 12 p.m.
- Thursday morning: 8 a.m. – 12 p.m.

What are my responsibilities as a QSP?

Self-Employment - You're not an employee, you're a self-employed contractor.

When you enrolled as a QSP, you were made aware that Qualified Service Providers' (QSPs) are not employees of the Department of Human Services. QSP's are self-employed, independent contractors. QSP's provide a service and are paid for the authorized services that are rendered.

Taxes

The Department does not withhold or pay any social security, federal or state income tax, unemployment insurance, or workers' compensation insurance premiums from the payments you receive as a QSP. Withholding and paying taxes on QSP payments is the responsibility of the self-employed individual.

If you have questions about self-employment or the withholding of taxes, please contact the Social Security Administration, the Internal Revenue Service or a qualified tax professional. Information on the tax responsibilities of independent contractors can also be found at WWW.IRS.GOV. The Department of Human Services will not be able to assist you with questions related to self-employment.

Federal tax form 1099 will be mailed to QSP's if they received services payments that total more than \$600.00 for the tax year.

Updating your Address/Phone

You are required to notify the Department of any phone number or address changes within 10 days. Failure to notify the Department could lead to an automatic closure of your status as a QSP. If your status is closed, you will not be paid for services provided after the stop date. Even if your status closes, you should update your address. The Department can audit records even if you've been closed. If you don't respond to an audit request, you could be required to pay back money to the Department.

Forms you need

Explanation of Procedure (Billing) Codes

- When you enrolled as a QSP, you chose the type of services you wanted to provide; for example, personal care (PC) or homemaker (HMKR) services. All services, like PC & HMKR, have their own unique number called a procedure/billing code. This code must be used when you submit a claim (bill) to the Department.
- **Attached to this packet is an explanation of the billing codes you are approved to provide. The information includes the billing code and other important information about the service. If you have questions, contact the Case Manager for your client.**

Authorization to Provide Services Forms are documents that authorize you to provide services to an HCBS client.

- **Do not** provide HCBS services until the Case Manager gives you one of these forms.
- If you provide services before you receive this form, you may not be paid.
- You may receive more than one authorization for each client. The authorization identifies the billing code and tells you what tasks can be completed for a specific client.
- Only provide the tasks that are checked on the form. Tasks are defined on the back of the form.
- The form will show the date that you can begin providing the service, the date the authorization ends, the total number of units you can provide and the dollar limits.
- Instructions are included at the back of this packet for how to read these forms.
- Contact the Case Manager if the client's needs change.
- For questions about these forms, please contact the Case Manager at the County.

Keeping Records

Always keep a copy of the current QSP enrollment handbook.

Documentation Requirements & Examples

When you enrolled as a QSP, you agreed to keep written records documenting the services you provide to each of your clients. These records are necessary and required to support your request for payment. Records must be kept for 42 months from September 30th of the year in which the service / care was provided - **EVEN IF YOUR STATUS AS A QSP IS STOPPED.**

- For 15-minute, Unit rate, your records must include:
 - ✓ Name of the client/member
 - ✓ Name of the provider (you)
 - ✓ Date of the service
 - ✓ Start time and end time (including a.m. and p.m.) in the client home,
 - ✓ Units of service, by procedure code, or if T1019, by task category
 - ✓ Tasks performed (use task name as listed on the authorization)
- For daily rate, your records must include:
 - ✓ Name of the client/member
 - ✓ Name of the provider (you)
 - ✓ Date of the service
 - ✓ Tasks performed (use task name as listed on the authorization)

The Department will request a refund or void or replace a claim to take back payments made to a provider if the provider does not keep appropriate records.

QSP Audits, State Exclusion & OIG Referrals

The Department is required to complete provider reviews of QSPs to ensure that clients are receiving the services they need and to ensure the services provided meet standards set by the Department. When you enrolled as a QSP, you agreed to assist the Department in completing these reviews and you agreed to submit documentation upon request.

The Department is required to recover all funds paid for services that were not delivered in accordance with policies and procedures per NDAC (ND Administrative Code) 75-03-23-10. Example, if the provider does not keep appropriate records, does not provide the service, bills over authorized amount, uses the wrong billing codes or makes any other type of billing errors.

Provider Appeals

A QSP may request a review of denial of payment in accordance with ND Century Code 50-24.1-24, by filing a written request for review with the department within thirty days of the date of the department's denial of payment. The written request for review must include the notice of recoupment or adjustment and a statement of each disputed item with the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service or for a full or partial denial, recoupment, or adjustment of a claim due to required federal or state changes, payment system defects, or improper claims submission.

Within 30 days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits and other written information that support the providers request for review, together with a computation and the dollar amount that reflects the providers claim as to the correct computation and dollar amount for each disputed item.

The Department shall make and issue a decision within seventy-five days, or as soon thereafter as possible, of receipt of the notice of request for review.

Requests for formal reviews must be sent to:

ND Department of Human Services - Appeals Supervisor
600 East Boulevard Ave
Bismarck, ND 58505

If you are denied enrollment or terminated as a QSP, you may be placed on the State Exclusion list. If you are on the state exclusion list, any businesses that receive Medicaid funding are prohibited from employing you.

You may also be referred to the OIG (Office of Inspector General) for possible exclusion in any capacity in Medicare, Medicaid and all federal health programs as defined in Section 1128(b)(5) of the Social Security Act. If you are placed on the OIG exclusion list, you could not work for any business that receives Medicaid or Medicare funding.

Any of the following Audit findings could result in being placed on the State Exclusion list and/or referral to the OIG for possible exclusions. This list is not all-inclusive.

- Inappropriate records.
- Billing and being paid for services not provided.
- Billing over the authorized amount or billing the wrong code.
- Photocopied records, indicating records were not completed at the time of service.
- Billing for an authorized task that is utilized in an unreasonable time frame.

- Failure to comply with a request to send records or information.
- Failure to set up payment arrangements or pay back funds paid in error.
- Professional incompetence or poor performance.
- Financial integrity issues.
- Certain criminal convictions.

Fraud, Waste & Abuse

The Department's mission is to provide quality, efficient, and effective human services, which improve the lives of people. Healthcare fraud is one of the most common fraud areas in the US. While an individual is wasting and/or abusing the Medicaid services and supports, the funding for another individual will be unavailable. Detecting fraud, waste, and abuse requires diligence from everyone involved with the Medicaid program. Educating both providers and the general public is an essential measure to the prevention of Fraud, Waste, and Abuse (FWA).

Medicaid provides healthcare coverage to qualifying low-income and/or disabled individuals, children, and families. HCBS services are part of those services. Fraud can be committed by Medicaid providers (including QSPs) or clients. The Department does not tolerate misspent or wasted resources.

By enforcing fraud and abuse efforts:

Medicaid providers receive the best possible rates for the services they provide to Medicaid recipients.

Medicaid recipients are assured that their out-of-pocket costs are as low as possible.

Tax dollars are properly spent.

Medicaid recipients receive necessary healthcare services (including HCBS).

The Department mandates that fraud, waste and abuse training be completed at initial enrollment and upon renewal. The AFHA Agency must designate a representative that is responsible for conducting the training, printing and maintaining a copy of the certificate of completion. The representative is also responsible for maintaining a list of all employees that have completed the training, to include the completion date. That roster is required to be submitted upon initial enrollment and renewal. The online training is available at DHS QSP site <https://www.nd.gov/dhs/services/adultsaging/providers.html>.

What is Fraud?

A knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment. Includes any intentional or deliberate act to deprive another of property or money by guile, deception, or other unfair means.

Example: Knowingly submitting claims for services that were not rendered.

What is Waste?

Overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act.

Example: Costs incurred when an individual is receiving more units or hours of service than needed, e.g., when an individual's health improves but their intensity of supports remains the same.

What is Abuse?

Abuse is when provider practices are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or services that fail to meet professional recognized standards for healthcare.

Abuse may also include recipient practices that result in unnecessary costs to the Medicaid programs.

- Example: A QSP bills for services during an individual's institutional stay. This is abuse because the QSP should have been aware of the rules, which specify that services cannot be billed during an institutional stay.

Biggest difference between Fraud vs. Waste and Abuse: Intent to deceive.

What is my role in helping prevent Medicaid fraud and abuse?

REPORT any instance of suspected fraud or abuse. Anyone can and should report suspected fraud, waste, and abuse. You can identify yourself or report FWA anonymously. If you are reporting anonymously, be sure to report enough information so that a proper investigation can be completed.

How do you report:

- Complete SFN 20 Surveillance and Utilization Review <https://www.nd.gov/eforms/Doc/sfn00020.pdf>
- Call 1.800.755.2604 or 701.328.4024
- Email medicaidfraud@nd.gov
- Fax 701.325.1544

Send a letter to:

Surveillance Utilization Review Administrator
c/o Medical Services Division
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250

How do I bill for services?

Service Authorizations & Prior Authorization

- All HCBS services are prior authorized in the Enterprise billing system. Prior authorization means that the client's authorization start date and end date, the type of service they are receiving, and the number of authorized units are entered into the billing system. This information is submitted on the client's individual care plan by the HCBS Case Manager.
- When a claim is submitted, the billing system will check to make sure that the client is eligible for this service, you are billing the correct rate, and are billing within the authorized amount of units.
- If a problem is found in any of these areas, the claim may be denied or the amount of payment reduced. The system will not pay for more units than are authorized and HCBS claims will not pay if a client's service authorization has not been entered into the new billing system.

QSPs should bill once per month for the previous months services after you have finished providing the services.

15 Minute Unit Billing Requirements

The Department requires providers who bill using a 15-minute unit rate based on Centers for Medicare & Medicaid Services (CMS) Transmittal AB-00-14. These requirements were put into effect on June 1, 2008 and apply to all Home and Community Based Service programs.

If you or your agency bill for services provided in 15-minute units, you must deliver at least 8 minutes of service before you can bill for the first 15-minute unit. **Providers cannot bill for services performed for less than 8 minutes.** This applies to all services billed using a 15-minute unit rate including homemaker, personal care and respite care, etc.

The amount of time you must work to bill for a larger number of units is as follows:

- 2 units: work at least 23 minutes
- 3 units: work at least 38 minutes
- 4 units: work at least 53 minutes
- 5 units: work at least 68 minutes
- 6 units: work at least 83 minutes
- 7 units: work at least 98 minutes
- 8 units: work at least 113 minutes

The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

Billing Online using the ND Health Enterprise Web Portal:

QSPs are encouraged to use the ND Health Enterprise Web Portal to submit their QSP claims. There are many advantages to using the web claim submission process including:

- Available at no cost to providers.
- Claim templates are available to increase efficiency during claims submission.
 - Customizable by member or service
- View all submitted claims (Paper or Web submitted).
- View real-time claim status before weekly check-write cycle (To-Be Paid, Suspended, To-Be Denied).
- Search for historical claims with specific date ranges.
- Check member eligibility and view recipient liability. **(Agency QSPs Only)**
- Self-manage user security through the designated Organization Administrator function. **(Agency QSPs Only)**

Billing by Paper with HCBS/DD billing forms – SFN 1730

If you choose to bill using paper billing forms, you must use the SFN 1730 HCBS/DD billing form. The form is available at the County Social Service office or online at: <http://www.nd.gov/eforms/>. The online version is a fillable, printable form. Instructions are included with this packet.

Tips for filling out the HCBS/DD billing forms:

Web Based Tutorial - <https://www.cnd.nd.gov/STLPCatalog/325/SFN1730G/story.html>

1. Use only black and blue ink.
2. Stay within the box, don't write on or over the lines, as this will cause our scanner to not be able to correctly read the form.
3. Type or print all letters and numbers within the boxes. Enter only one letter or number in each box.
4. Print letters and numbers like this:

0	1	2	3	4	5	6	7	8	9	T
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Please note the following “Don'ts” –

- Claims cannot be faxed or email. If billing by paper, you must send the original form, no copies can be accepted.
- Don't use pencil.
- Don't enter a dollar sign (\$), comma (,), decimal point (.), or any other punctuation mark or symbol.
- Don't use a “whiteout” correction fluid.
- If you make a mistake, don't cross off a line, scribble out the mistake or write above the box – get a new billing form and start over.
- Don't place a slash or dash mark over the number 0 or 7. Our scanner will not be able to read the correct number. Examples:



Void or Replace a Claim

Instructions are included with this packet on how to void or replace a claim. Please contact the Call Center for further instruction.

Computer Training

Computer-based training is available online at

<http://NDMMIS.learnercommunity.com>.

- In the upper, right hand corner, click the Log In / Register link
- Sign up for a new account
- Navigate the website using the menu tabs



Billing Tips

- Read the material carefully and correct any errors before submitting.
- Call the correct phone numbers (Page 2) with questions to route your call the fastest.
- Mail the HCBS/DD billing form directly to Medical Services using the provided yellow Billing Stickers.

- Use the correct client ID number, found on the authorization to provide services that you received from the Case Manager at the county. The client's name and identification number can change, be sure to check each authorization carefully.
- Don't use the client's social security number as their recipient ID number.
- Don't bill for services that you haven't yet provided.
- Don't bill before the end of the month in which the service was delivered.
- Don't bill for more units than you actually provided.
- Don't bill for more units that you were authorized on the Authorization to provide services form.
- If a claim is denied, it means that a payment wasn't issued. Claims that are denied because of an error must be rebilled. Please correct the billing error before you resubmit the claim.

Direct Deposit

The Department of Human Services offers automatic deposit of payments to either a QSPs checking or savings account. This option allows providers to have access to their payments faster than waiting for mail delivery of a payment.

If you don't have automatic deposit and would like to start, call 701-328-4602. A form will be mailed for you to fill out and return with a voided check or deposit slip. Accounts other than checking or savings cannot be setup, including pre-paid cards.

Contact Medical Services **before** closing a bank account that is used to receive automatic deposits from the Department of Human Services.

****Once Direct Deposit is set up, please allow UP TO TWO BILLING CYCLES before checks will be deposited into your account. You will receive a paper check until all account information is verified by our Finance Department.**

Instructions for using the Automated Payment Line

The Medical Services Interactive Voice Response System allows Qualified Service Providers (QSPs) to inquire about the status of their claims by calling a toll-free number or a Bismarck local number.

The HCBS Office cannot assist QSPs in checking on the status of provider checks or claims that are suspended because of an error. QSPs must use the telephone response system OR contact the Call Center.

**Toll free 1-866-PMT-CHEK (1-866-768-2435) or
Locally at 701-328-2466**

If you have called the interactive voice response system and you still have questions, press Zero to reach the ND Health Enterprise MMIS call center. **If asked for a PIN, press "0".

What is required to use this service?

- A push button telephone
- Your provider number (received when you enrolled as a QSP)

Instructions for Use:

- Dial the toll-free number or local number;
- When asked, enter your 7-digit provider number followed by the pound (#) sign, then verify the number entered by pressing the "1" key when asked.
- The system automatically plays the last payment information
 - If only one payment is found, you will be prompted to press "1" to repeat, "0" for the service desk or hang up.
 - If more payments are found, you are prompted to press "1" to repeat, "2" for the next payment, "0" for the service desk or hang up.

NOTE: There is no consolidation of payments in Enterprise. Each payment inquiry plays the following payment information:

1. Payment date
2. Total Amount Paid
3. Total number of claims paid
4. Total number of claims suspended
5. Total number of claims denied

If you have questions, please press "0" to reach Call Center or call toll free 1-877-328-7098.

****If asked for a PIN, press "0".**