FAQs for Overtime

The Purpose

The North Dakota Department of Health and Human Services must pay individual Qualified Service Providers (QSP) overtime per the Fair Labor Standards Act (FLSA).

Overtime Definition

The Fair Labor Standards Act established that overtime is to be paid at a rate of 1.5 times the regular pay rate for work in excess of 40 hours in an established seven consecutive day period. Aging Services defines a work week as seven days starting on Saturday at 12:00 a.m. and ending the following Sunday at 11:59 p.m.

Overtime payments are not required for work completed on weekends or holidays; overtime payments are not automatically paid for care provided on these days unless the time worked on these days otherwise falls within the requirements of overtime.

The following time may be counted toward weekly hours even though you are not paid for the time spent completing these activities.

- Drive time: an individual QSP may use Therap to track driving time between consumers' homes. You may not count the time you drive to your first consumer's home or after your last consumer of the day. Drive time must be tracked in the EVV system.
- Time spent in training or assisting with developing an individual's care plan

Who is eligible to receive overtime payments?

Any person enrolled as an Individual QSP who provides care in excess of 40 hours in a work week, Saturday through Sunday, may be eligible for an overtime payment.

QSPs must deliver care within the specified scope and duration outlined in their service authorization to maintain eligibility for overtime payments.

Overtime Applies to individual QsPs only. Agency QSPs are required to follow overtime laws for their employees.

How is the overtime rate calculated for individual QSPS?

The overtime rate is paid at 1.5 times the regular unit rate. This means that for every hour of authorized care provided beyond the standard 40 hours in a week, the caregiver receives 1.5 times their usual pay rate.

What is the regular unit rate payment?

Regular unit rate: Individual QSps are still responsible for billing all authorized hours worked in Therap or directly to MMIS. Therefore, the caregiver is already compensated for all units at the regular rate for all units of authorized care. This regular rate is applicable for the first 40 hours of authorized work in a week.

How will I receive any overtime owed?

Since the caregiver has already been paid at the regular rate for all units, any additional compensation for hours worked beyond 40 is provided as a separate payment. This payment is calculated at 0.5 times the regular unit rate. In other words, it is half of the caregiver's usual pay rate for each unit worked beyond the standard 40 hours.

To illustrate, let's consider an example:

- If the regular unit rate is $10 per hour, and the caregiver works 50 hours a week:
    - The first 40 hours are paid at the regular rate ($10 per hour).
    - The additional 10 hours (units) are considered overtime and paid at 1.5 times the regular rate.
    - However, the supplemental payment comes into play since the caregiver has already been paid the full regular rate for all units.
    - The supplemental payment for these 10 overtime hours is calculated at 0.5 times the regular rate.
    - This approach ensures the caregiver is appropriately compensated for the extra effort beyond 40 hours per week.

When should I expect my overtime payment?

Overtime payments will always be two months behind. The claims have to be verified against the billable claims. All overtime claims must have records to support the release of payment.

How will I know if I am receiving overtime?

Not everyone is guaranteed overtime. Overtime will be based on the number of units that are authorized or the number of hours authorized in the provider service agreement.

What are service agreements?

The Fair Labor Standards Act (FLSA) recognizes the unique nature of programs where the care provider and the eligible individual live together and have pre-existing family ties or a shared household. There is both a familial or household relationship and an employment relationship. Under these programs, the services to be provided and the number of hours of paid services are described in the plan of care, which is based on an assessment of the services the eligible individual requires and the individual's existing circumstances, such as unpaid assistance provided by family or household members ("natural supports"). The person-centered care plan covers the scope of employment relationships and the services paid under the Home and Community Based Services or Medicaid program. Additional services provided because of familial or household relationships are unpaid natural supports.

Exclusions from Overtime Payments:

Complaints of Fraud:

- If a Qualified Service Provider (QSP) is subject to an open complaint involving a credible allegation of fraud, overtime payments may be withheld. Overtime payments will only be released if the complaint is not substantiated.

Outstanding Balances:

- Providers with outstanding balances owed to the Department may have overtime payments garnished to settle the balance unless a pre-established payment plan is in effect.

Claims Not Supported by an Authorization:

- Overtime will be denied if submitted claims exceed the scope and duration of services outlined in the pre-authorization. Claims must align with the authorized service parameters to be considered for overtime payment.

Safety Considerations:

- Overtime will be denied if a provider exceeds a safe working duration for the consumer. According to Aging Services, care exceeding 12 hours per day is considered unsafe.

Failure to Submit Documentation:

- Overtime will be denied if a provider fails to submit the requested service documentation.

Inadequate Documentation:

- Overtime requests will be denied if a provider fails to maintain service documentation that meets the Department's outlined requirements. Denial continues until the provider can demonstrate compliance with the documentation requirements.

Service Documentation

Qualified Service Providers (QSPs) must thoroughly document services provided to eligible individuals. The purpose of this documentation is to verify payment requests and support the quality and integrity of services provided. The specific elements required in these records are detailed in the provider handbook and must include:

- Consumer's name
- Consumer's ND# (North Dakota ID number)
- Provider name
- Provider number
- Service location
- Date of service
- Time services started
- Time services ended
- Authorized tasks completed

Documentation Format: Written or electronic documentation of daily services is mandatory and must be completed when services are provided to ensure accuracy.

Providers are encouraged to refer to the provider handbook for comprehensive documentation guidelines and to ensure compliance with these requirements.

Providers are encouraged to use ISP in Therap for documentation.

Timely Submission of Overtime Claims:

To facilitate the prompt processing of overtime payments, Aging Services requires that claims for overtime must be submitted within 3 months after the delivery of services.

While the Department of Health and Human Services allows claims within 6 months after service delivery, it is important to note that such claims will only be compensated at the customary unit rate.

- **Aging Services Requirement:** Claims for overtime must be submitted within 3 months after the service date.
- **Department of Health and Human Services Allowance:** While the Department allows a 6-month window for claim submission, overtime claims within this timeframe will only be paid at the customary unit rate.

Audits

Aging Services may complete an audit of any individual who submits claims for overtime. All QSPs who submit claims for more than 80 hours of care in a week will be subject to an audit of their records. This is to ensure clients are receiving the services they need and that the services provided meet standards set by the Department.

Sanctions

Suppose the Department finds that payments made to the QSP were inappropriate due to audit findings, Inappropriate services, services not provided, provider self-disclosure of inappropriate payments received, inappropriate billing, billing over authorization or wrong procedure code, inappropriate documentation/records, or any other situation deemed inappropriate by the Department. In that case, the Department will request a refund or file adjustments to recoup funds.

The QSP will receive an email and a letter stating the circumstances around the adjustment and providing the opportunity to set up a payment plan for the balance owed to the Department. If a payment plan is not set up within 30 days of the notice, the Department will proceed with the adjustment.

If it is found that QSP is not in compliance with the Department due to the following examples, all money paid to QSP may be recoupled:

- Failure to keep appropriate records
- If you did not provide the service
- Billing over the authorized amount or billing the wrong code
- Billing for an authorized task that is utilized in an unreasonable time frame
- Failure to comply with a request to send records or information
- Photocopied records indicating service records were not completed at the time of service

Formal Review

If a provider is denied overtime, they will receive a denial letter outlining the dates of service and why overtime was denied.

The provider may request a formal review of the denial of overtime payments.

A Formal Review may be requested if you disagree with any action regarding provider reimbursement. Per ND Admin Code 75-03-23-12, to request a formal review:

Submit a formal written request within 30 days of notification of the adjustment or request for a refund. The adjustment notification may be contained in the remittance advice or included in a document sent to you by the Department. Within 30 days of requesting a review, provide to the Department all documents, written statements, exhibits, and other written information supporting your request for review. A provider may not request a formal review of the rate paid for each disputed item. The Department has 75 days from the date we received the notice of a request for review to make a decision.