NORTH Dakota | Health & Human Services
Be Legendary.

Instructions for new Qualified Service Providers (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 save to refer to for future questions.

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MEDICAL SERVICES
600 East Boulevard Ave. Dept. 325 | Bismarck, ND 58505-0250 | hhs.nd.gov
701.328.7068 | Fax 701.328.1544 | 800.755.2604 | 711 (TTY) | Provider Relations 701.328.7098

Contact Information

❖ When will I get paid?

- Scheduled Payment Dates: https://www.hhs.nd.gov/healthcare-coverage/medicaid/checkwrite-dates
- Automated Payment Line: 1-866-768-2435

❖ Why didn't I get paid?

- MMIS Call Center: 1-877-328-7098
  (When asked for a PIN, select "0")

❖ How do I void or replace a claim?

- Claims billed in MMIS: 1-877-328-7098
  (When asked for a PIN, select "0")
- Claims billed in Therap: Submit a support request: https://help.therapservices.net/s/article/6939

❖ How do I reset my password and/or unlock my account?

- **MMIS** account access: 1-877-328-7098
  (When asked for a PIN, select "0")
- **Therap** account access:
  - **Individual** QSPs: Email: QSPresetpw@nd.gov

    Or use the self-password reset instructions: https://help.therapservices.net/s/article/2817
  - **Agency** QSPs: Agency Super Administrator(s) can reset/unlock user passwords. If the Super Admininstrator is locked out:
    1. Complete the online form: https://support.therapservices.net/super-administrator-password-reset-request-form/
    2. On agency letterhead, the QSP Executive Director (or equivalent position) must generate and sign a letter requesting a password reset.
    3. Upload a copy of the Executive Director's driver's license and the letter from Step 2.
    4. Click the "submit" button at the bottom of the webpage.

What is the QSP Hub?

The QSP Hub serves as the resource center for agency and individual QSPs throughout North Dakota.

What is the goal of the QSP Hub?

Our goal is to create a network that provides support, educational tools, and training opportunities to walk QSPs and QSP agencies through all stages of the QSP process.

What can the QSP Hub help me with?

One-on-one individualized support via email, phone, or video conferencing to assist with:

- Enrollment
- Service authorizations
- Electronic visit verification
- Documentation
- Billing processes
- Renewal
- Business operations and processes
- Education Tools
- Training Events
- One-on-one support

How to contact QSP Hub:

- Website https://www.NDQSPHub.org
- Email Info@NDQSPHub.org
- Call 701-777-3432
- Facebook https://www.facebook.com/NDQSPHub/

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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 Health & Human Services employees. QSPs are self-employed, independent contractors. QSPs provide a service and are paid for the authorized services that are rendered.

❖ Taxes

The Department does not withhold or pay social security, federal or state income tax, unemployment insurance, or workers' compensation insurance premiums from your QSP payments. It is your responsibility as a QSP (a self-employed individual) to withholding and pay taxes.

If you have questions about self-employment or tax withholding, 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 cannot help you with questions related to self-employment or taxes.

A federal tax form 1099 is mailed to QSPs who receive services payments that total more than $600.00 for the tax year. This form is mailed out by the end of January each year.

❖ Updating my address/phone/email

QSPs must tell the Department about changes to their contact information. If your mailing or physical address, phone number or email address changes, you must update the information within 14 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.

Update your information in the QSP Portal, visit: WWW.HHS.ND.GOV/QSP, then find the link to "Access the QSP Enrollment Portal". From the portal, you can update your contact information to stay up to date with the latest information.

What if my status closes? We still want you to update your address! We may still send an audit request, even after your enrollment closes. If you are sent a records request and don't respond, you will be required to pay back money to the Department for services you provided.

❖ Direct Deposit

Direct deposit payments to a checking or savings account are required for all QSPs.

- **Before you close an account** used to receive payment from the Department, log in to the QSP portal to update your account information.
- To login, visit: WWW.HHS.ND.GOV/QSP, then find the link to "Access the QSP Enrollment Portal".
- In the portal, update banking information and upload a copy of a voided check or bank letter showing proof of your account.
- Once direct deposit is set up, allow **UP TO TWO BILLING CYCLES before checks are deposited** into your account. You will receive a paper check until all account information is verified.
- The ND Medicaid payment schedule (check write) is online: https://www.hhs.nd.gov/healthcare-coverage/medicaid/checkwrite-dates

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Important Information

Frequently review the current QSP enrollment online handbooks for changes:
https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service

❖ 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 have their own unique number called a procedure or billing code. This code must be used when you submit a claim (bill) to the Department.

An explanation of QSP Billing Codes is available for each service:
https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service/billing-codes

You'll find helpful information about the billing code, instructions and examples for how to document the services you provide and templates to download. **Contact the HCBS Case Manager** for your member if you have questions**.**

Keeping Records

❖ Documentation Requirements and Options

When you enroll as a QSP, you agree to keep documentation of the services you provide to each of your members.

- These records are required to support your request for payment and **are in addition to EVV requirements** (if applicable).
- Individual QSPs must keep service records for 42 months from the date services are delivered.
- Agency QSPs must keep service records for 60 months from the date services are delivered.
- You may be required **to pay back funds** for services not properly documented and recorded in the EVV system (if required). **Criminal, legal and monetary penalties may also be required.**

Two options are available for you to record and store documentation:

- **Individual Support Plan** (ISP) Data
  - QSP scores task(s) for each visit and may provide comments to document the service.
  - The Therap system saves this documentation for QSPs for the required period.
  - QSP does not need to keep additional documentation if using this method.
  - For more information on ISP Data:
    - Mobile ISP Data Course: https://support.therapservices.net/course-mobile-isp-data/
    - Acknowledge ISP Data: https://help.therapservices.net/s/article/445
    - Submit ISP Data: https://help.therapservices.net/s/article/448
    - Learning How to Document ISP Data Directly in Therap: https://video.ndqsphub.org/w/8NMh1rxbUpbFkfV3dvdWYn

- **Form documentation** using available examples:
  - A downloadable PDF example and blank forms are available for QSPs to view and use to document services. Must be stored by QSP for required period, even if **your status as a QSP closes, you stop providing care to the individual or the individual you are caring for passes away**.
  - Records cannot be copied or cloned with times, dates or months changed.
  - Example documentation available on the QSP website: https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service/billing-codes
  - Records must include:
    - Name and ID # of the client
    - Name and ID # of the provider
    - Full date of the service MM/DD/YYYY
    - Location of the service
    - Start time and end time (including a.m. and p.m.)
    - Number of units of service, (use task name as listed on the SA).
    - Tasks performed (use task name as listed on the SA)

How to bill for services

❖ Electronic Visit Verification (EVV)

- EVV requires you to check in and out when providing services to clients.
- Many services require you to use EVV but not all services do; check the QSP handbook related to your service type for more information.
- The Department contracts with Therap to provide the EVV system, which includes billing and is available to QSPs free of charge.
    - If using Therap as your chosen EVV, you must also bill using Therap.
    - During the enrollment process, an Agency QSP can choose a different EVV provider, but is then responsible for setup and costs and must also use the alternate system for billing.
    - Starting in January 2024, you can also document the services you provide in Therap.
- You will receive a password and instructions by email or mail to log in and use Therap.
- Contact Therap to get started with their onboarding process https://help.therapservices.net/s/article/6945
    - More training is available: http://www.therapevv.net/nd
    - About the EVV system: https://youtu.be/SCUvxoZXAwY

❖ Timely Claims Filing Requirements

QSPs must follow ND Medicaid Timely Claims Filing Policy when submitting claims for reimbursement. ND Medicaid must receive an original claim within **one hundred eighty (180) days** from the date of service.

- For more information regarding this policy, visit the following link: https://www.hhs.nd.gov/healthcare/medicaid/provider/manuals-and-guidelines

❖ Service Authorizations & Prior Authorization

All HCBS services are prior authorized in the MMIS billing system, the ND Health Enterprise Web Portal. Prior authorization means the member's start and end dates, the type of service they are receiving and the number of authorized units are entered into the billing system. This information is sent to the billing system, based on the member's individual plan of care established by the HCBS Case Manager.

When a claim is submitted, EVV data is checked against the State aggregator, Sandata (if applicable). The system checks to see if the member is eligible for the service, the correct rate is being billed and units billed are authorized. If any problems are found, the claim may be denied, or the amount of payment reduced. The system will not pay if an authorization is not in the billing system or for more units than are authorized.

- You will provide authorized services and be paid for the services you deliver.
- Unless you provide Family Home Care (FHC) or Family Personal Care (FPC) services, once you are chosen as a QSP, the Case Manager will generate Service Authorization(s) in Therap, detailing the authorized service(s) and task(s) you are approved and expected to provide for the specific member.
- QSPs must have a current Service Authorization for each member before providing services and be eligible for payment by HHS.
- You must review and acknowledge Service Authorization(s) within Therap.
    - You may receive/acknowledge more than one authorization for each member (one for each service you are authorized to provide)
    - The tasks you are authorized to provide are listed on the authorization. Task descriptions are defined on the form beside the authorized task.

        - Directions to acknowledge Service Authorizations within Therap are online: https://help.therapservices.net/s/article/921
    - It is your responsibility to notify the Case Manager if you are approved for a service you are not enrolled to provide.
        - Contact QSP Enrollment if you need to update your enrolled services.
        - If you provide a service you are not enrolled in, payment cannot be guaranteed and you may be required to repay payments made in error.
    - Review your Authorization for the following information:
        - The tasks you are authorized and expected to provide.
        - Effective date of authorized services.
            - You may not begin providing services before the authorized date.
        - The maximum number of units you can provide/bill.
            - A unit can be equal to 15 minutes or one day, depending on the type of service you are providing.

❖ 15 Minute Unit Billing Requirements

QSPs who bill using a 15-minute unit rate are required to follow Centers for Medicare & Medicaid Services (CMS) Transmittal AB-00-14 unit rate standards.

If billing for services provided in 15-minute units, QSPs must deliver at least 8 minutes of service before they can bill for the first 15-minute unit. **QSPs 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, respite care, etc.

The amount of time QSPs must work to bill for a larger number of units, is as follows (The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours):

- 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

❖ Daily Unit Billing Requirements

Some daily rates require the QSP to provide and record at least 60 consecutive minutes of service through the Schedule Slot/EVV form to successfully generate EVV Billing for that day. If this criteria is not met, the following error message will be shown when generating EVV Billing:

"Duration must be at least 60 consecutive minutes."

❖ Billing Online in Therap

- **Therap Training:** Therap offers free, self-paced, on-demand training courses, in addition to North Dakota specific user guides and recorded webinars that can be utilized to help users learn to navigate their system.
    - Therap Overview for ND Aging Individual QSPs: https://www.therapevv.net/nd/aging-individual-qsps/
    - Therap Overview for ND Aging Agency QSPs: https://www.therapevv.net/nd/aging-agency/
    - Therap Training Academy: https://support.therapservices.net/training-courses/

- **Therap Support**:
    - https://help.therapservices.net/s/article/6939

- **Follow these steps to generate billing from EVV data:**
    - **Before you bill**
        - Acknowledge service authorizations and create a claim template for all members you provide care to; this will only need to be done once.

    - **Ensure all EVV data is complete**
        - Use the Scheduling Grid to ensure:
            - All slots are green
            - Marked as 'Billable - Yes' and
            - A service is selected
        - Or use the **EVV/Scheduling Dashboard** to make sure everything above is complete PLUS tell you:
            - If the slot has been billed
            - The amount of minutes the slot was
            - The status of the slots

    - **Generate Billing from EVV data**
        - Select a Service Description/Code and Dates of Service
            - Dates have to be within the same month
        - Therap will calculate units and dollar amounts based on the check in and check out times

    - **Utilization Report**
        - Create a report based on Program, Individual or Service Code to preview the units that will be attached to the claims.

    - **Generate Professional Claims** New (Using Templates)
        - Create Professional Claims by selecting
            - Service Description/Code
            - Service Date From and Service Date To (dates have to be within the same month)
            - The billing data will attach to the Professional claim
            - The claim will include your information, the member's information, the service code, and billed units

- **After Creating Claims**
  - A best practice is to run the Billing Summary Report. This report shows:
    - member name
    - service authorization information
    - service codes
    - units billed
    - amount billed
    - claim status
    - All billing data should be attached to a claim (unless the billing data shows 0 units)

- **Prior to Sending claims**
  - Check Sandata visits to ensure all have been accepted by Sandata

- **Send Claims**
  - Send claims together in batches up to 100 - Professional Claim - Send
  - Select the Payer ND MMIS - ND Medicaid Aging and dates of service

❖ Billing Online in MMIS

If billing for one of the following services, QSPs must submit claims using MMIS, the ND Health Enterprise Web Portal:

- Family Home Care (FHC)
- Family Personal Care (FPC)
- Home Delivered Meals (HDM)
- Emergency Response System (ERS)

MMIS is free and QSPs can make a claim template for each member you provide services to for faster and easier claim submission. Users can check claim status in real-time. Agency QSPs can also see member eligibility, view recipient liability and self-manage user security through the Organization Administrator function.

- **MMIS HCBS/DD Web Portal Claim Form Submission Instructions**
  https://www.hhs.nd.gov/sites/www/files/documents/ND%20MMIS%20Web%20Portal%20QSP%20Claim%20Form%20Submission%20Instructions.pdf

- **MMIS 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

- **MMIS Support:**
  - Email MMISinfo@nd.gov
  - Call 1-877-328-7098
    (When asked for a PIN, select "0")

- **QSP Hub Support:**
  - Email Info@NDQSPHub.org
  - Call 701-777-3432 (leave a voicemail with a good call back time)
  - Website NDQSPHub.org

❖ Billing Tips

- Read the material carefully and correct any errors before submitting.
- Call the correct phone numbers (referenced on page 2) with questions to route your call the fastest.
- Use the correct member ID number, found on the service authorization. The member's name and identification number can change, be sure to check each authorization carefully.
- Don't use the member's social security number as the member ID number.
- Don't bill for services that you haven't yet provided.
- Don't bill for more units than you actually provided.
- Don't bill for more units that you were authorized on the service authorization.
- 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.

❖ Automated Payment Line

Use to check on your payment status. The Interactive Voice Response System (AVRS) allows QSPs to ask about the status of their claims by calling a toll-free number or a local Bismarck number.

Toll free 1-866-PMT–CHEK (1-866-768-2435)
or
Local 701-328-2466

If you have called the interactive voice response system and you still have questions, press "0" 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.

Please note:

Payments are not grouped together in MMIS. Each payment inquiry plays the following payment information:

- Payment date
- Total Amount Paid
- Total number of claims paid
- Total number of claims suspended
- Total number of claims denied

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❖ Audits, Appeals, Denials and Exclusions

Audits

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

The Department is required to recover all funds paid for services not delivered in accordance with policies and procedures per NDAC (ND Administrative Code) 75-03-23-10. If a QSP does not keep service records, they may be subject legal and monetary penalties.

Example, if the QSP 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 (this list is not all-inclusive).

Appeals

Payment Denial

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 75 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 Health & Human Services - Appeals Supervisor
600 East Boulevard Ave
Bismarck, ND 58505

Enrollment Denial and State or Federal Exclusion

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 State Exclusion list 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

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 (FWA) requires diligence from everyone involved with the Medicaid program. Educating providers and the general public is an essential measure to the prevention of 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 members. 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 members
- Medicaid members are assured their out-of-pocket costs are as low as possible
- Tax dollars are properly spent
- Medicaid members receive necessary healthcare services (including HCBS)

The Department mandates Individual and Agency QSPs complete FWA training at initial enrollment and revalidation. Agency QSPs must designate a representative responsible for conducting employee training and maintain proof that each employee has completed the training, including the initial date of completion and subsequent trainings. The employee completion roster must be submitted upon initial enrollment and revalidation.

The online FWA training is available on the Department's QSP site and in the QSP Portal when you submit an application or revalidate your enrollment:
https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service
(look under the "QSP Training" tab)

➢ 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. This 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?

When provider practices are not consistent 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. 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 FWA. You can provide your name or remain anonymous. If you are reporting anonymously, be sure to report enough information so a proper investigation can be completed.

How do I report?

- Complete SFN 20 Surveillance and Utilization Review found at: https://www.nd.gov/eforms/Doc/sfn00020.pdf
- Call 1-800-755-2604 or 701-328-4024
- Email MedicaidFraud@ND.gov
- Fax 701-328-1544
- Send a letter to: Surveillance Utilization Review Administrator
  c/o Medical Services Division
  600 E Boulevard Ave Dept 325
  Bismarck, ND 58505-0250