

AGING AND DISABILITY SERVICES DIVISION

Community Based Care Services Service Provider Manual

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COMMUNITY BASED CARE SERVICE PROVIDER MANUAL

The billing procedures addressed in this manual refer to the following Community Based Care (CBC) programs: Community Options Program for the Elderly (COPE), the Homemaker Program and the Personal Assistance Services (PAS) program. Providers must be contracted as providers through Medicaid before they can provide services for CBC programs.

1.0 **Service Authorization**

- 1.1 Case managers will authorize all Home and Community Based Services (HCBS) to be provided for each program recipient. Aging and Disability Services Division (ADSD) will only reimburse providers for services authorized by ADSD case managers.
- 1.2 Once approved for one of the HCBS programs, the case manager will complete a service plan. The completed service plan will be faxed to the provider. The recipient cannot receive program services until the provider is in receipt of the approval.
- 1.3 The service provider will inform the case manager of any changes in the provision of services for each recipient. The case manager must approve any changes in the delivery of services to the recipient before the provider is eligible to be paid for the services. Any changes to the recipient's assessed needs will require a new service plan.
- 1.4 All service plans have a start and end date. Service providers must be aware of the end date and be prepared to adjust services when case managers conduct reassessments. This typically occurs annually or sooner if a recipient's condition warrants a change.

2.0 **Transportation**

- 2.1 Providers are prohibited from transporting recipients. ADSD will not reimburse any provider for the transportation of a recipient for any reason.
- 2.2 Providers may only accompany a recipient to medical appointments or shopping via public transportation.

3.0 **Medical Services**

- 3.1 HCBS programs provide non-medical services. ADSD will not reimburse a provider for any services not listed on the service plan; this includes medical services. The case manager should be contacted if there are any questions regarding the authorized tasks.

4.0 **Cancellation of Services**

Whenever possible, the recipient or case manager will cancel services by notifying the provider 24 hours in advance.

5.0 **Recipient Not at Home/No Services**

The provider will not be reimbursed for a visit if the recipient is not present in the home at the time of services.

6.0 **Billing Procedures**

6.1 **Billing Format**

- A. Claims must include a summary listing all individual invoices that comprise the total.
- B. There must be an invoice for each recipient.
- C. A copy of each recipient's verification log must be included with the original provider invoice for that recipient.

- D. The billing summary and invoice must contain an original signature of the billing preparer and/or person authorized to represent the provider agency.

6.2 **Provider Invoices**

- A. A provider invoice must be completed monthly for each recipient.
- B. Providers are required to submit claims by the 15th day of the month following the month of service to be considered timely.
- C. Providers may computerize the form for their own convenience as long as the format remains intact.
- D. Invoices must be limited to a one-month period. Portions of prior or subsequent months must be submitted on a separate invoice.
- E. Recipient verification logs (e.g., timesheets or attendance records) must be included with the original provider invoice for each recipient.
- F. ADSD will not reimburse providers for service(s) without recipient verification of the dates, amount, and types of service provided.
- G. The providers name and address must be the same as listed with the State Controller's Office. ADSD must be notified in writing of any changes. The provider is also responsible for reporting any name and address changes or deletions to the Nevada Medicaid office.

6.3 **Recipient Verification Logs**

- A. Providers are responsible for obtaining recipient verification of dates, times, amounts and types of services provided. Each document must contain original signatures that are entered on the date of service. Submitted timesheets may be copies.
- B. If a recipient has difficulty signing the service verification form, they may use his/her initials.
- C. If a recipient is unable to sign the service verification form, a designated representative may sign the form.
- D. The case manager shall approve the use of an "X" if the recipient cannot sign his/her name or initials or no designated representative is available.

6.4 **Secure Submission Procedures**

Chapter 7 of the Department of Health and Human Services (DHHS) Aging and Disability Services (ADSD) HIPAA Policies and Procedures Manual requires business associates (including Community Based Care providers) to use appropriate safeguards to prevent unauthorized use or disclosure of Protected Health Information (PHI). All service providers sign a Business Associate Addendum acknowledging HIPAA requirements before they are authorized to serve ADSD recipients. Service providers **must** utilize one of the following methods of submitting invoices and recipient verification logs.

- A. File Transfer Protocol (FTP) Site
 - i. Providers who wish to upload invoices, recipient verification logs and other back-up documentation to ADSD's secure FTP site should submit a request to their ADSD assigned billing contact for help in obtaining log-in credentials and instructions.
- B. Email
 - i. Providers who submit billing via email are required to use a software application that will encrypt the sender's email. Such an application requires the recipient to log into the application to access messages and attachments.
- C. Thumb / Flash Drives / Memory Stick
 - i. Invoices, recipient verification logs and other back-up documentation may be submitted on a thumb drive, flash drive or memory stick only if the device is encrypted or password-protected.
 1. Decryption instructions or the password must be provided in a separate communication to the billing staff at ADSD.
 2. If the device is sent to ADSD via the U.S. Postal Service or another delivery service, the provider must follow the mailing instructions in Section 6.4(D).
- D. Standard Mail / United Parcel Service / Federal Express
 - i. PHI must be mailed via traceable means (i.e., certified mail, Federal Express, USPS delivery confirmation).

- ii. Mail containing PHI must be accompanied by a cover sheet or other notification that contains the following message:

This information contains PHI that is intended for disclosure only to the authorized recipient. Unauthorized interception and/or disclosure are violations of the Health Insurance Portability and Accountability Act. Violations may result in administrative, civil, or criminal penalties. If this mail is received in error, please notify the sender and/or return the mail immediately in a properly sealed envelope. Destroy any copies made in error.

E. Fax Machine

- i. The accuracy of the fax number must be verified before transmission.
- ii. Every fax transmission containing PHI must be accompanied by a confidential cover sheet or stamped with the following privacy warning:

This information contains PHI that is intended for disclosure only to the authorized recipient. Unauthorized interception and/or disclosure are violations of both the Electronic Communications Privacy Act and the Health Insurance Portability and Accountability Act. Violations may result in administrative, civil, or criminal penalties. If this document is received in error, please notify the sender immediately and destroy the document and any copies made.

- iii. No PHI may be included on the fax cover sheet.
- iv. Before transmitting PHI via fax, the sender must alert the billing staff at ADSD of the impending transmission.

7.0 **Reimbursement**

The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

1. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records, and personnel consultant;
2. The cost of criminal background checks and TB testing;
3. Travel time to and between recipient's homes;
4. The cost of basic training, in service requirements, and the CPR and first aid requirements; and/or
5. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

8.0 **Payment of Claims**

- 8.1 Invoices, recipient verification logs and other back-up documentation will be reviewed for accuracy and compliance as to type and amount of services authorized.
- 8.2 Invoices reviewed and approved by the billing staff are then submitted to the ADSD fiscal unit for payment.
- 8.3 All invoices received will be reviewed within 10 working days of receipt.
- 8.4 Payment is issued by the Controller's Office only via electronic funds transfer. (Paper checks are no longer issued.) The payment process may take up to 4 weeks after ADSD has received the complete and accurate bill.

9.0 **Incorrect Claims**

- 9.1 ADSD staff are not authorized to modify, change or correct billing submitted by a provider.
 - A. If billing errors occur, ADSD staff will notify the provider of the issue(s) at which time ADSD will send back the incorrect billing for any necessary corrections.
- 9.2 Providers should be aware that any errors will delay payment. If asked by ADSD billing staff to make corrections, providers must respond within 5 working days. If corrections are not received within that timeframe, ADSD billing staff may disallow questioned costs in order to process the balance of the invoice in a timely manner. Any corrections received after such action is taken must be submitted as a new invoice and processed separately.

10.0 **Stale-Dated Claims**

- 10.1 Claims that are submitted more than 180 calendar days (6 months) after services are provided are considered “stale-dated” claims.
- 10.2 ADSD will not reimburse providers for stale-dated claims unless documented good cause is shown why the bill was not submitted in a timely manner. An example of good cause would be an event or disaster that disrupts normal services.
- 10.3 ADSD operates on a fiscal year that begins July 1st and ends the following June 30th. Providers are required to submit claims by the 15th day of the month following the month of service to be considered timely (see Provision 6.2B). At the end of the fiscal year, timely submission is critical. Claims not submitted and processed by the Controller’s Office prior to the close of the fiscal year become stale claims regardless of the service date and may delay reimbursement. Providers are cautioned to follow Provision 6.2B of this document to avoid stale claims.

11.0 **Reconciliation of Past Claims**

- 11.1 Either a provider or ADSD may initiate a reconciliation of past claims to verify that certain service units were submitted, processed, and paid accurately.
- 11.2 Reconciliations are limited to specific claims that may be in question; not for all claims in a given date range. Copies of all documents in question must be submitted for all reconciliations.
- 11.3 Reconciliation requests must comply with the provisions of Section 10.0 regarding “Stale-Dated Claims.” Specifically, reconciliations will not be considered for service dates that exceed the 180-day window unless the provider can show good cause for the delay.
- 11.4 ADSD will issue an initial response to provider requests within 10 working days of submission. Likewise, providers will issue an initial response to ADSD requests within 10 working days of submission. Extensions of up to 10 working days are allowable if either party makes such a request before the initial 10 working day timeline has ended.
- 11.5 The length of time required to complete relevant research and issue a final response will be determined by ADSD and the provider, and will depend upon the volume of work required.
- 11.6 If a reconciliation requires payment from ADSD for services delivered in a prior fiscal year (July 1st through June 30th), the claims must be considered “stale-dated” regardless of the party responsible for any errors. This is because additional approvals are necessary to pay prior year claims from current funding.

12.0 **Questions about Payment**

Providers should direct all billing questions to their assigned ADSD billing contact.

13.0 **Charges to the Recipient**

The service provider must not bill any HCBS recipient directly for services delivered that were authorized under the HCBS program. Donations may not be solicited, nor additional fees levied against the recipient for services reimbursed by HCBS. Providers should not discuss payment or charges with the recipient.

14.0 **Tips/Gifts**

Providers must not accept tips or gifts from recipients.

15.0 **Record Retention**

Providers are required to retain a recipient’s records for six (6) years.

Each provider agency must have a file for each recipient. In the recipient file, the agency must document the actual time spent providing services and the services provided. These records must be maintained by the provider for at least six years after the date the claim is paid.

16.0 Provider Accountability

Providers are expected to exercise their fiscal responsibilities as ADSD business associates with integrity and fidelity. Suspicion of fraud, waste, and abuse will be investigated and acted upon in accordance with applicable sections of the Nevada State Administrative Manual (SAM), Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC) and other relevant regulations, policies and procedures.

17.0 **Home and Community Based Services (HCBS) Service Provider Manual Acknowledgement**

Please sign below indicating that you have received and read this Service Provider Manual and agree to abide by the guidelines described therein.

The owner, administrator and primary billing staff (if different) should each sign on the lines provided. This page must be returned to your assigned ADSD billing contact by mail, fax or a scan attached to an email.

New providers must return this page with their initial application.

I have read and agree to the guidelines described in the Service Provider Manual.

Name of Agency: _____

Address: _____

Telephone: _____ Fax: _____

Owner's Name (Printed): _____

Owner's Signature: _____

Owner's Email: _____ Date: _____

Administrator's Name (Printed): _____

Administrator's Signature: _____

Administrator's Email: _____ Date: _____

Primary Billing Staff's Name (Printed): _____

Primary Billing Staff's Signature: _____

Primary Billing Staff's Email: _____ Date: _____