NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

"This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document."

Pursuant to
Neb. Rev. Stat. § 84-901.03

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Pete Ricketts, Governor

PROVIDER BULLETIN

No. 17-09

DATE: March 27, 2017

TO: Medicaid Personal Assistance Providers (PAS)

FROM: Calder Lynch, Director
Division of Medicaid & Long-Term Care

BY: Debbie Flower, Program Specialist

RE: Personal Assistance Service – Signature Requirements/Billing Guidance

Please share this information with administrative and billing staff.

The purpose of this bulletin is to inform Personal Assistance Service (PAS) providers about appropriate signatures for billing documentation and to provide guidance regarding the Service Need Assessment/Plan Notification. Please retain this provider bulletin for future reference.

Signature Requirements:
A paid provider cannot sign his/her own Provider Record of Services form (MC-37-ES-A) on behalf of the client. The signature of the client or another competent representative with knowledge of the service delivery is required. As of April 15, 2017 **any future billing document(s) signed by the provider, as both the provider and client's authorized representative/designee, will be returned.** For individuals who need an authorized representative, a Designation of Authorized Representative form (MLTC-35) is attached. The completed form can be returned to your local DHHS office or assigned case worker.

Billing Guidance:
Effective immediately, the Provider Record of Services (MC-37-ES-A) is available on-line at http://local.hhss.local/FORMS/Home.aspx. You can make copies for your own use or pick them up at your local DHHS office.

this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document

Information on the Service Need Assessment/Plan Notification and provider authorization process for PAS is in regulation at 471 NAC 15-004.02B and 471 NAC 15-004.03D. A sample of a Service Need Assessment/Plan Notification and page one of a Provider Authorization are attached. Both forms are mailed to the client and the provider.

The Service Need Assessment/Plan Notification lists the specific tasks and times per week authorized for EACH task. The sample Provider Authorization shows an example of an authorization period and units authorized for the provider. The Provider Authorization includes the authorization time period, authorized units, client information and provider information**.** The Provider Record of Services (MC-37-ES-A) must match each frequency/unit/task authorized on the Service Need Assessment/Plan Notification and Provider Authorization.

Per 471 NAC 2.001.03(6), providers are to submit claims which are true, accurate and complete. Any deviation from the Service Need Assessment/Plan Notification may cause delay in the processing of, return of and/or required refund of your claim(s).

The following are examples of items, which would cause rejection of a Provider Record of Services (MC-37-ES-A) or claim (DHHS-5N):

- Submitting claims for services that were **NOT authorized** on the Service Need Assessment/Plan Notification. For example: washing dishes is included on the Provider Record of Service form (MC-37-ES-A). However, it is not listed as an authorized service on the Service Need Assessment/Plan Notification. Payment would not be made for this service.
- Submitting claims for the maximum quarter hours authorized, but not documenting all of the services provided in the plan to receive payment for the maximum hours. This would be considered overbilling.
- Submitting claims for services exceeding the authorized frequency (how often something is completed per week) for any task. For example: billing escort to the physician's office two times per week when only one time per week is authorized. Payment would not be made for the second weekly appointment.
- Submitting claims for the incorrect time/units. For example: billing four hours of laundry when only two hours of laundry are authorized.
- Submitting incorrect totals on the claim (DHHS-5N) that are to be submitted with the Provider Record of Service (MC-37-ES-A). A sample of each is attached, demonstrating a correctly completed Provider Record of Service form/claim.
- Submitted claims must use the correct billing work week, Sunday through Saturday. When a Sunday through Saturday work week spans two months, the week must be split into two lines on the claim (DHHS-5N).

Regulations for Provider Participation:
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-02.pdf

Regulations for Personal Assistance Services:
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-15.pdf

If you have general questions about this Provider Bulletin, please contact DHHS.PAS@nebraska.gov or 402-471-9462.

Medicaid Provider Bulletins, such as this one, are posted on the DHHS website at http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx. The "Recent Web Updates" page will help you monitor changes to the Medicaid pages.

Enclosures (5)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 85801
LINCOLN NE 68501-9884

CONTACT - ACCESSNebraska
Toll Free Number - (402)323-3900
Fax Number - (402)471-9209
Date of Notice - 06-27-2016
Mail Date - 06-27-2016

[redacted]

SERVICE NEED ASSESSMENT/PLAN Notification

The request for services for [redacted] has been reviewed. The information provided indicates you are eligible for the following services listed below for the period beginning **06-16-2016 to 06-30-2017**. The total time approved is **41 hours 35 minutes/week.**

Eligibility Criteria

Does not have needs that require more intensive services due to an acute health care level.
Needs Personal Assistance or Chore services to live in the community.
Is not receiving or eligible for similar staff support based on residence or place of employment.
Lives in a residence (not a hospital, nursing facility, intermediate care facility, prison or other institution).
Is a current Medicaid client.
Meets income eligibility guidelines for SSAD.

NEEDS	FREQUENCY/WEEK	TIME/OCCURRENCE
Bath/shower	7	20
Dressing	14	15
Shampoo	7	5
Oral care	14	5
Nail Care	1	10
Assist with administration of medications	14	5
Remind to refill prescriptions	1	5
Wheelchair Maneuvering - Complete assistance	28	10
Transfer - Heavy support lifting	28	10
Needs meals prepared	15	20
Needs assistance with eating such as cutting meat	7	5
Needs to be fed	15	20
Laundry	1	120
Clean bathroom	1	30
Clean other living areas used by client	1	15
Make bed and/or change linens	7	10
Wash dishes	7	10
Remove trash	1	5
Shopping for personal items, medications and other	1	30
Assist on/off toilet	21	10
Cleansing on toilet	21	10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 98933
LINCOLN NE 68509-8933

Case Name	-	[redacted]
CONTACT	-	
Phone Number	-	
Toll Free Number	-	(877)213-4754
Fax Number	-	(402)471-9209
Date of Notice	-	06-27-2016
Mail Date	-	06-27-2016

[redacted]

AUTHORIZATION NOTICE UPDATE
Personal Assistance Services
UPDATED ON 06-27-2016 AT 2:03pm

This is to notify you that we have authorized the provider you selected as detailed below.

[redacted]
Provider Telephone - [redacted]

Authorized Service: PERSONAL ASSISTANCE SERVICE

Authorized Clients	Client ID#	Authorization #
[redacted]	[redacted]	[redacted]

Authorized Period: 06-01-2015 through 06-30-2016

Authorized Units:
10152.00 Quarter Hours

Authorized Rate:
2.490 per Quarter Hour effective 06-01-2015
2.540 per Quarter Hour effective 07-01-2015

Authorized Period: 07-01-2016 through 06-30-2017

Authorized Units:
8851.00 Hours

Authorized Rate:
2.540 per Hour effective 07-01-2016

APPROVED FOR 41 HOURS PER WEEK (167UNITS). SEE SNA FOR DETAILS. THANK YOU.

THERE CAN BE NO BILLING FOR DD AND PAS AT THE SAME TIME AS THIS COULD BE A DUPLICATION. THE GROUNDS FOR THE DEPARTMENT TO IMPOSE SANCTIONS UPON A PROVIDER INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: SUBMITTING DUPLICATE BILLS, INCLUDING BILLING NMAP TWICE FOR THE SAME SERVICE, OR BILLING WITH NMAP AND ANOTHER INSURER OR GOVERNMENT PROGRAM (471 NAC 2-002.03#24.

Nebraska Medicaid Eligibility	Go online:	Federal Health Insurance Marketplace
Toll Free: (855)632-7633	ACCESSNebraska.ne.gov	Go online: Healthcare.gov
Lincoln: (402)473-7000		Customer Service Center: (800)318-2596
Omaha: (402)595-1178		

DHHS
NEBRASKA

N-FOCUS BILLING DOCUMENT

All billings must be received within ninety (90) days of service provision

Claim Number: 34567891

Date: FOR BILLING	DHHS Provider ID: 123456789
Office No: 444 Office Name: LINCOLN	Phone Number: 402-000-0000
Provider Name: PROVIDER, IMA 0000 HUSKER DR LINCOLN, NE 68500	By signing this form, the claimant certifies that the information contained in this claim is accurate and all services provided were in compliance with Department of Health and Human Services Nebraska Administrative Codes Titles 465, 471, 473, 474, and 480, whichever are applicable. The claimant is aware that a false claim may result in prosecution for fraud. Under penalty of applicable Federal and State Laws, I certify that representation herein are true and complete, and that no additional payment will be claimed.

Ln	Client Name	Client ID Number	Authorlz. Number	Service Code	Service From Date	Service Thru Date	Freq	Units	Rate	Total Charge	Cust Oblig	DHHS Charge
1	CLIENT, IMA	22222222	99999999	4475	7/17/2016	7/23/2016	QR	166.98	2.59	432.48	0	432.48
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Provider/Preparer Signature	Signature Date	Service Approval Signature	Approval Date	Total DHHS Charge
Ima Provider	7/24/2016			

For information about the status of your claim, call ACCESSNebraska at 1-800-383-4278. For information regarding where to submit your claim see the reverse of this form.

DHHS-SN Rev. 10/11

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Designation of Authorized Representative

Client Name: _____ Client Date of Birth: _____ Client Social Security Number: _____

I hereby designate _____ ☐ Individual ☐ Organization, to act responsibly on my behalf in assisting with my application and renewal of eligibility and other ongoing communications with Nebraska Department of Health and Human Services; Division of Medicaid and Long-Term Care.

Authorized Representative (Name, Address, City, State, Zip, phone, email): _____

_____

_____

Scope of this authorization:

☐ Sign an application on the applicant's behalf

☐ Complete and submit a renewal form

☐ Receive copies of the applicant or beneficiary's notices and other communications from the agency

☐ Act on behalf of the applicant or beneficiary in all other matters with the agency

I understand that this designation is valid until I modify the authorization or notify the agency in writing that the Authorized Representative is no longer authorized to act on my behalf. By signing this designation, I acknowledge that the information to be released pursuant to this designation may include material that is protected by federal or state law and may relate to Drug/Alcohol treatment, mental health, and HIV information. I understand that the Nebraska Department of Health and Human Services cannot control what the Authorized Representative does with the released information and that such information might be re-disclosed to a third party. Any released information might no longer be protected by federal or state law. I specifically authorize the Nebraska Department of Health and Human Services to discuss information released pursuant to this designation with the Authorized Representative. Failure to sign this form will not affect treatment, payment, enrollment in a health plan, or eligibility for benefits except in limited circumstances. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Client Signature: _____ Date: _____

Personal Representative: ☐ Parent ☐ Guardian ☐ Power of Attorney Date: _____

Authorized Representative Declarations

As an Authorized Representative I understand (Initial Below):

_____ I am responsible for fulfilling all responsibilities encompassed within the scope of this authorized representation.

_____ I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

_____ I will adhere to the regulations in Title 42, subpart F, part 431 of the Code of Federal Regulations (CFR) and 45 CFR 155.260(f).

_____ I will adhere to the regulations in Title 42 CFR 447.10, relating to the prohibition against reassignment of provider claims. Please note, this only applies to facilities or organizations acting on a facility's behalf.

_____ I will adhere to all other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative Signature: _____ Date: _____

If signing on behalf of an organization or entity, the signatory above must be authorized to bind the organization or entity to the terms of this authorization.

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

DHHS

Division of Medicaid and Long-Term Care / División de Medicaid y Cuidado de Largo Plazo

Provider Record of Services / Registro del Proveedor de Servicios

This Record of Services is a legal document completed by you to record the dates and units of service provided. Both the provider and the client must sign and date this record verifying the accuracy of this information. A description of services provided must be recorded.* This Record of Services with the billing document must be submitted within 90 days of service and can be submitted semi-monthly or monthly. Return this Record of Services with the billing document to your specified worker. The Provider is responsible for keeping records for six years. *Please print clearly and legibly.*

Este registro de servicios es un documento legal completado por usted para registrar las fechas y unidades de servicio provistos. Tanto el proveedor como el cliente deben firmar y fechar este registro verificando la exactitud de esta información. Una descripción de los servicios prestados debe ser registrada. El Registro de Servicios con el documento de facturación debe ser enviado dentro del plazo de 90 días del servicio, y pueden ser enviads quincenalmente o mensualmente. Regrese este Registro de Servicios con el documento de facturación a su trabajador asignado. El Proveedor es responsable de mantener los registros por seis años. *Por favor escriba en letra imprenta clara y legible.*

Client's Name / Nombre del Cliente	Client's ID Number / # de Identificación del Cliente	Provider Name / Nombre del Proveedor
Ima Client	12345678	Ima Provider

Service Provided: Servicio Prestado: Child Care / Cuidado Infantil (9704) In-Home Child Care / Cuidado Infantil en el Hogar (2500) Chore / Quehaceres (1691)	Home Again (8234) Independence Skills Building / Desarollo de Destrezas para la Independencia (8382) In-Home Independence Skills Building / Desarollo de Destrezas para la Independencia en el Hogar (9233)	Respite / Relevo para el descanso del cuidador (7395) In-Home Respite / Relevo para el descanso del cuidador en el hogar (1113) Personal Assistance Services (4475) Servicio de Asistencia Personal (4475)

Month/Mes July Year/Año 2016

Day of the Week / Día de la Semana	Date / Fecha	Service Code / Código del Servicio	Time in and out / Tiempo de Inicio y de Fin		Description of Authorized Services Provided / Descripción de los Servicios Provistos	Quarterly Units / Unidades trimestrales	Hourly Units / Unidades por Hora	Daily Units / Unidades diarias	Occurrence Units / Unidades de frecuencia
			IN	OUT					
Sunday / Domingo	17	4475	8:00 am	11:30 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	22			
			7:00 pm	9:00 pm	meats, bed, dishes, toileting, cleansing, meals, feeding, nails				
Monday / Lunes	18	4475	8:00 am	11:25 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	21.66			
			7:00 pm	9:00 pm	meat, bed, dishes, toileting, cleansing, meals, feeding, remind				
Tuesday / Martes	19	4475	8:00 am	11:20 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	21.33			
			7:00 pm	9:00 pm	meat, bed, dishes, toileting, cleansing, meals, feeding				
Wednesday / Miércoles	20	4475	8:00 am	11:20 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	21.33			
			7:00 pm	9:00 pm	meat, bed, dishes, toileting, cleansing, meals, feeding				
Thursday / Jueves	21	4475	8:00 am	11:20 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	21.33			
			7:00 pm	9:00 pm	meat, bed, dishes, toileting, cleansing, meals, feeding				
Friday / Viernes	22	4475	8:00 am	11:20 am	Bath, shampoo, dressing, oral care, meds, wheelchair, transfrs,	21.33			
			7:00 pm	9:00 pm	meat, bed, dishes, toileting, cleansing, meals, feeding				
Saturday / Sábado	23	4475	8:00 am	3:20 pm	Bath, shampoo, dressing, oral care, meds, whlchr, trnsfrs, meat	38			
			7:00 pm	9:00 pm	bed, dishes, tleting, clnsng, meals, feeding, lndry, shpping, cln				

I verify that the above hours/days are correct and accurate and understand that fraudulent claims may result in prosecution. / Por medio de la presente doy fe de que las horas/días anotados son correctos y exactos, y entiendo que las reclamaciones fraudulentas pueden resultar en una acción penal.

Signature of Individual Providing Services / Firma del Proveedor	Date / Fecha	Provider Number / Número del Proveedo	Client/Guardian/Authorized Representative Signature / Firma del Cliente/Tutor/Representante Autorizado	Date / Fecha
Ima Provider	7/23/2016	123456789	Ima Client	7/26/16

MC-37-ES-A (52037) 10/18