“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
# Developmental Disabilities Provider Handbook

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Introduction to the Department of Health and Human Services

The Nebraska Department of Health and Human Services is also called DHHS. It includes five divisions: Behavioral Health, Children & Family Services, Developmental Disabilities, Medicaid & Long-Term Care, and Public Health.

Values and Core Competencies

DHHS values are constant commitment to excellence, high personal standard of integrity, positive and constructive attitude and actions, openness to new learning, and dedication to the success of others.

DHHS core competencies are demonstrating responsibility and accountability, professional composure, effective interpersonal relationships, productive communication, support of team, and self-improvement.

Division of Developmental Disabilities

The Division of Developmental Disabilities (DHHS-DD) is responsible for Medicaid Home and Community-Based Services (HCBS) developmental disabilities services in Nebraska for eligible people. There are specific eligibility requirements a person must meet to receive services through DHHS-DD. Eligibility is determined by DHHS-DD.

DHHS-DD supports the choices of people who have developmental disabilities and their families. We promote flexible, quality, participant-directed services and supports in Nebraska communities for people who meet institutional level of care in an intermediate care facility for people with developmental disabilities (ICF/DD).

“Participant” means the person receiving Medicaid HCBS Developmental Disabilities (DD) Waiver services and any person legally authorized to act on behalf of the participant.

Funding is determined and authorized by DHHS-DD after eligibility is determined. The funding amount is determined by the objective assessment process (OAP), which assesses the participant’s abilities and needs. A participant must be eligible for a Medicaid HCBS DD Waiver.

A participant must also apply for and accept any federal and state benefits for which he/she may be eligible, such as Social Security benefits and vocational rehabilitation services.

DHHS Regulations

Medicaid HCBS DD Waiver services are governed by state regulations, specifically Titles 403 and 404. Additional regulations may apply depending on which services you offer. All DHHS regulations are online.

All developmental disabilities providers must follow:
- Title 403 NAC – Medicaid Home and Community-Based Waiver Services for Individuals with Developmental Disabilities.
- Title 404 NAC – Community-Based Services for Individuals with Developmental Disabilities.

Providers who give medications, must follow the med aid regulations: Title 172 NAC 99.

Other pertinent regulations may include, but are not limited to:
- Title 175 - Health Care Facilities and Services Licensure
- Title 471 - Nebraska Medicaid Program Services
- Title 474 - Social Services for Families, Children, and Youth
Introduction to Developmental Disabilities Services

Developmental Disabilities Services

DHHS-DD provides funding and oversight of community-based providers for Medicaid HCBS DD Waiver services. Services can be provided by an independent or agency provider. Services help a participant live the most independent life possible. Goals are identified and habilitation programs are developed to teach skills. Goals focus on employment, independent living, and community access.

A list of Medicaid HCBS DD Waiver services, including definitions, limits, and provider requirements, can be found in the Developmental Disabilities Service Directory. Services are chosen by the participant except when provided under an applicable law or court order.

Developmental Disabilities Providers

There are two types of providers for developmental disabilities community-based services: agency providers and independent providers. Neither type of provider is employed by DHHS. All providers must meet requirements and have an authorization to provide a service.

Agency Providers

An agency provider is a company which is an enrolled Medicaid provider and certified by DHHS – Public Health (DHHS-PH) to provide developmental disabilities services. The agency provider is responsible for hiring (or contracting) and supervising employees and contractors who work with the participant, and other administrative functions.

The following services may be offered by an agency provider:

- Adult Day
- Assistive Technology
- Behavioral In-Home Habilitation
- Consultative Assessment
- Enclave
- Environmental Modification Assessment
- Habilitative Community Inclusion
- Habilitative Workshop
- Home Modifications
- Homemaker
- Independent Living
- Medical In-Home Habilitation
- Prevocational
- Residential Habilitation – Continuous Home
- Residential Habilitation – Host Home
- Residential Habilitation – Shared Living
- Respite
- Supported Employment – Follow Along
- Supported Employment – Individual
- Supported Family Living
- Transitional Services
- Transportation
- Vehicle Modification

Independent Providers

An independent provider is a person or vendor enrolled as a Medicaid provider and employed by a participant. The participant is responsible for hiring and supervising his/her provider. An independent provider is employed by the participant. A participant is responsible for locating, hiring, firing, scheduling, training, and supervising an independent provider. A participant may choose anyone not legally responsible for him/her. Once a participant chooses a person, DHHS has an approval process.

The following services may be offered by an independent provider:

- Assistive Technology
- Consultative Assessment*
- Environmental Modification Assessment
- Habilitative Community Inclusion*
- Home Modifications
- Homemaker
- Independent Living*
- Respite
- Supported Employment – Follow Along*
- Supported Employment – Individual*
- Supported Family Living*
- Transitional Services
- Transportation

Services with a star (*) are habilitative and include teaching. Additional provider requirements.
Provider Role and what is Expected

Working with a Participant

It is important to treat a participant with respect. Respect his/her choices and life experiences. Listen carefully, ask questions, and pay attention to body language. Take concerns seriously. A participant may have a different perspective than you. Your beliefs may not be the same as his/hers. Allow a participant his/her perspective. A participant has invited you into his/her life. When a participant asks you to do something you are uncomfortable with, talk with him/her about your feelings.

When a participant cannot directly tell you what he/she wants, explore other communication methods. Offer choices when appropriate. Never tell a participant what to do. Explain possible consequences of choices. Any advice must be given in an age appropriate manner, considering his/her perspective and life experience. Trust a participant to make decisions which are best for him/her. Build trust by being consistent and worthy of trust.

Respect a participant’s right to privacy. Always knock and wait for him/her to open the door. A participant needs time alone and time with friends. Medicaid HCBS DD Waiver services should increase opportunities, not limit the participant.

A participant should set his/her own schedule. You may need to be flexible. Do not expect a participant to change for you.

When you are an independent provider, ask how a participant wants you to let him/her know when you are unable to work due to illness or another unforeseen event, or are running late. Respect his/her time and communicate as the participant asks. A participant is counting on you to meet his/her needs.

Medicaid HCBS Developmental Disabilities Waiver services must be:

- Safe;
- Person-centered and according to the individual support plan (ISP);
- Focused on contributing to an increased quality-of-life;
- In compliance with regulations; and
- In compliance with waiver guidelines.

General Requirements

You must have knowledge and understanding of a participant’s needs. You will need training or experience in the service you are providing. DHHS-DD is committed to provide training to improve the lives of participants and many trainings are free. Training information is on the DHHS-DD website.

Medicaid HCBS DD Waiver services are person-centered and specific to a participant’s needs. You must attend a participant’s ISP team meetings. You must know the supports necessary to meet the personal and medical needs of a participant. You must be able to perform tasks to meet these needs, as specified in the participant’s ISP.

You will allow DHHS to monitor and evaluate services by observing service delivery, interviewing you, or similar methods. You must observe and report any change which affects a participant, or his/her plan, to his/her DHHS-DD Service Coordinator. You must assume responsibility, follow emergency procedures, maintain a schedule, and adapt to unpredicted situations. You are responsible for a participant’s safety and property. You must follow universal precautions and have the physical ability to provide services.

You will avoid all conflicts of interest and all appearances of conflicts of interest. You will immediately notify DHHS of any conflicts so other arrangements can be made for services to be provided.

You will follow Health Insurance Portability and Accountability Act (HIPAA) Rules. This refers to the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

- You will not use or disclose protected health information other than as allowed or required by DHHS.
• When you are an agency provider, you will develop, implement, and maintain reasonable security measures to protect health information. This will include appropriate administrative, physical, and technical safeguards.
• Any unauthorized use or disclosure of protected health information of which you become aware must be reported by you to DHHS within 15 calendar days with a written corrective action plan. You will take immediate steps to decrease any harmful effect of unauthorized disclosure. You will also report any breach to the participant affected and to the federal HHS Office of Civil Rights, as required by HIPAA regulations.

All Providers Must:
• Be authorized to work in the United States;
• Not be an employee of DHHS-DD, unless approved by DHHS;
• Enroll as a Medicaid provider;
• Work drug-free and maintain a drug-free workplace;
• Follow all statutes, regulations, and policies governing providers of Medicaid HCBS DD Waiver services;
• Follow HIPAA rules;
• Have access to and the ability to use the state-mandated web-based case management system;
• Comply with billing requirements, including submitting thorough and accurate claims through the state-mandated web-based case management system;
• Be able to meet the participant’s needs:
  o Follow and implement the participant’s ISP;
  o Be physically able to provide services to participants;
  o Know what to do in emergency situations;
  o Be responsible for a participant’s safety and property; and
  o Take steps to prevent incidents of abuse, neglect, and exploitation;
• Not be legally responsible for the participant when providing direct services;
• Avoid all conflicts of interest and any appearance of conflicts of interest; and
• When you stop working with a participant, return all records, funds, and personal property, including personal needs money, to the participant in a manner consistent with instructions provided by DHHS.

An Agency Provider Must:
• Have written policies to describe how their business runs and procedures giving direction to employees and contractors;
• Complete annual background checks on all employees and contractors working directly with participants;
• Make sure all employees and contractors meet requirements for education and experience, and other requirements;
• Make sure employees and contractors comply with all applicable laws, rules, regulations, policies, and procedures; and
• Maintain certification with DHHS-Public Health (PH) for all Medicaid HCBS DD Waiver services provided.

An independent provider must:
• Complete enrollment, including background checks, with Maximus;
• Be age 19 or older; and
• Not live with the participant when providing respite, homemaker, or home modification services.

Additional Requirements
In order to provide a habilitative service, an Independent Provider must:
• Have a Bachelor’s degree or equivalent coursework or training in: education, psychology, social work, sociology, human services, or a related field; OR
• Have four or more years of professional experience providing habilitative services for persons with developmental disabilities, or habilitative program writing and program data

Habilitation:
Assisting a person to improve and achieve a developmental skill, when an impairment has caused a delay in learning the skill.
collection/analysis, or four or more years of life experience in teaching and supporting a person with developmental disabilities; OR

- Have any combination of education and experience identified above equaling four years or more.

**When transportation is provided as part of any service, you must:**

- Maintain the minimum vehicle insurance coverage required by state law;
- Have a driver’s or chauffeur’s license which has not been revoked within the past three years; and
- Use your own personally registered vehicle to transport.

**When Abuse or Neglect is Suspected**

People with disabilities are protected under the law from abuse and neglect. Abuse and neglect are actions which may result in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services. Abuse or neglect can be intentional or the result of carelessness.

It is required by law you report any suspected abuse or neglect to proper authorities. Reports can be made to local law enforcement or to the Abuse and Neglect hotline.

**Examples of Abuse and Neglect include, but are not limited to:**

**Physical Abuse:** Hitting, pushing, hair pulling, kicking, biting, overuse or improper use of medications, use of restraints.

**Sexual Abuse:** Touching in ways which make a participant feel uncomfortable, talking sexually or showing sexual material or body parts the participant does not want to see, making a participant touch or talk in a way which makes him/her uncomfortable, taking nude pictures or asking to take pictures which make him/her uncomfortable.

**Emotional/Verbal:** Threats, name calling, denying the right to express wants and needs, cyber bullying, isolating from friends and family.

**Neglect:** Denial of food, clothing, shelter, or transportation; not providing supervision; not providing medical treatment.

**Exploitation:** Taking money or personal belongings, charging more hours than worked, not fulfilling job responsibilities.

**Whistleblower Protection – for Agency Providers**

You will comply with the provisions of 41 U.S.C. 4712, which states an employee of a contractor, grantee, or sub-recipient may not be discharged, demoted or otherwise discriminated against as a reprisal for “whistleblowing.” In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

- Your employees are encouraged to report fraud, waste, and abuse. You will inform your employees in writing he/she is subject to federal whistleblower rights and remedies. This notification must be in the predominant native language of the workforce.
- You will include this requirement in any agreement made with a contractor, grantee, or sub-recipient.

**Record Keeping (Documentation, Paperwork)**

“Records” means all paperwork and documentation related to providing Medicaid HCBS DD Waiver services. Records must be maintained according to generally accepted business practices. All your records, including data maintained in computer files or on other media, relating to work performed or money received from DHHS are subject to audit at any reasonable time with reasonable notice by DHHS.

All records are the property of DHHS. You will not copyright any of the copyrightable material produced in conjunction with the performance required without written consent from DHHS. DHHS reserves a royalty-free,
As a provider, you must complete and maintain records according to applicable regulations, your provider agreement with DHHS-DD, and a participant’s ISP. Documentation will include, but is not limited to:

- A Medicaid provider agreement with DHHS is signed on the Maximus web portal before you can begin providing services. It indicates you are approved to provide developmental disabilities services. This agreement is signed once for all participants you serve.
- A calendar of Medicaid HCBS DD Waiver services provided and/or record of participant’s attendance, depending on service(s) provided. Services must be differentiated within records so it is clear which service was provided to whom and when. Lack of appropriate documentation may result in funds being recouped for times when service delivery cannot be confirmed via documentation. This will support billing claims.
- Habilitation as outlined in the ISP when you are providing a habilitative service. This includes programs and data. Lack of appropriate documentation may result in funds being recouped for times when services specified in ISP cannot be confirmed via documentation.

All records are to be kept for five years from the date of final payment for services, unless records fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA). Records which fall under HIPAA must be kept for six years from the date of final payment for services. Records will be completed and maintained electronically in Therap, a computer program explained in the billing section.

For six years, you must keep, and be able to provide:

- Documentation which supports selection and delivery of services, including dates of service. You may use a calendar or written record of the hours worked, along with the provider authorization;
- Financial information necessary to allow for an independent audit, such as payment stubs;
- Documentation which supports requests for payment, such as copies of records submitted to DHHS; and
- Provider agreements signed with DHHS, including copies of provider checklists.

In addition to standard retention requirements, all records shall be maintained until any issues related to an audit, litigation, or other actions are resolved to the satisfaction of DHHS.

**Confidentiality**

All records will be held in the strictest confidence and not released to anyone other than DHHS without the prior written authorization of DHHS. Failure to maintain confidentiality of records will result in your provider agreement ending.

**Provider Billing**

**Getting Paid**

DHHS does not pay for room and board, the cost of facility maintenance, upkeep, or improvement. When applicable, room and board is the responsibility of the participant. When Medicaid HCBS DD Waiver services occur in a provider-owned and controlled setting, the provider is responsible for the cost of home and service location maintenance, upkeep, and improvement, including adaptations.

You are paid based on the service you provide. You may be authorized to provide more than one type of service. You must bill for each service separately. Most services are billed hourly. Some have a daily rate. The total hours or days of claim payment for any participant cannot exceed the maximum amount of the participant’s individual budget amount (IBA) in his/her service authorization(s).

Invoices for payments submitted must contain sufficient detail to support payment. No payment will be made for any deliverable or cost unless specifically authorized by DHHS.

When you fail to provide Medicaid HCBS DD Waiver services or perform duties, or are out of compliance with applicable laws or court orders, DHHS reserves the right to withhold payment. When payment has already been made, DHHS reserves the right to demand repayment, and any other available remedies.
DHHS may end your agreement when funding is no longer available. Should funds not be appropriated, DHHS may end your agreement for those payments during the fiscal years for which funds are not appropriated. DHHS will give you written notice 30 calendar days prior to the effective date of any termination. You are entitled to receive just and equitable compensation for any authorized services which have been satisfactorily completed as of the termination date. You will not be paid for a loss of anticipated profit.

Payment is made electronically unless otherwise specified by DHHS.

**Agency Provider Pay**

Each service has an assigned rate. There may be a rate increase most fiscal years (July-June). You will be informed of any rate increase before it occurs.

You can only bill for times when the participant is present and receiving habilitative services and supports, unless otherwise specified in service definition. There are no “leave days” or “therapeutic days.”

**Billable activities:**
- Running habilitation programs and direct support of needs as specified in the participant’s ISP, including documentation.
- Individualized job development and support on behalf of the participant as specified in his/her ISP.
- Attendance and participation at the participant’s team meetings.
- On days when a participant is hospitalized but also received Medicaid HCBS DD Waiver services before admission or after discharge, the services must be claimed at the hourly rate. Daily rates do not apply on days when a participant is either admitted to or discharged from the hospital and a maximum of 10 hours is allowable.

**Unbillable Activities:**
- Staff meetings, staff training, habilitation program training, habilitation program research and development, supervisory or administrative activities, staff paid leave time, ancillary support activities not involving the participant (such as shopping for supplies, building cleaning, or maintenance).
- Any time periods where other paid services are provided concurrently in a provider-owned and controlled location. Examples of other paid services include, but are not limited to: Consultative Assessment, Personal Assistance Services (PAS), speech therapy, physical therapy, or counseling sessions.
- For a participant under 21 years of age, time periods the participant is to be attending school – generally 8 am to 3 pm or the operational hours of the school.
- Paid staff time providing only general care and supervision not specified in the ISP.

**Independent Provider Pay**

Each service has a maximum rate of pay. A participant will decide your rate with you. The participant’s Service Coordinator will help him/her make the best use of his/her annual individual budget amount (IBA). The agreed-upon rate will be less than or equal to the maximum service rate. When you have more qualifications or are expected to meet more needs, you may agree on a rate closer to the maximum amount. There is no automatic rate increase.

**Billable activities:**
- Running habilitation programs and direct support of needs as specified in the participant’s ISP.
- Individualized job development and support on behalf of the participant as specified in his/her ISP.
- On days when a participant is hospitalized but also received Medicaid HCBS DD Waiver services before admission or after discharge, the services must be claimed at the hourly rate. Daily rates do not apply on days when a participant is either admitted to or discharged from the hospital and a maximum of 10 hours is allowable.

**Unbillable Activities:**
- Habilitation program research and development.
- Ancillary support activities not involving the participant, such as shopping for supplies or cleaning.
• For a participant under 21 years of age, time periods the participant is to be attending school – generally 8 am to 3 pm or the operational hours of the school.
• Paid staff time providing only general care and supervision (such as child or adult day care) not specified in the ISP.

Provider Service Authorization

You will sign a Medicaid provider agreement with DHHS on the Maximus web portal. Your provider service authorization explains the terms of your agreement and allows you to bill DHHS for services. No service should be provided until you are approved as a Medicaid provider and receive a service authorization for each service you are providing. You will be notified by DHHS-DD service coordination when you are authorized to provide a service.

DHHS-DD utilizes a web-based electronic case management system called Therap Services, LLC (Therap). Service authorizations are completed by the Service Coordinator in Therap, then entered into NFOCUS. The Service Coordinator electronically sends your approved service authorization to you. You are responsible for reviewing the service authorization for accuracy before acknowledging.
• When inaccurate, you should contact the Service Coordinator for revisions.
• When accurate, electronically acknowledge the service authorization for the authorization to be activated.

The service authorization is not complete and cannot be billed until you have acknowledged it.

Step-by-step instructions, including screen shots, for receiving and acknowledging a Service Authorization may be found on Therap’s webpage for Nebraska.

Billing Requirements

Please read the billing instructions carefully. Inaccurate or incomplete billing documents will cause a delay in payment as your billing document will be returned to you for revision.

As a developmental disabilities provider, you are not an employee of the state of Nebraska or DHHS-DD. Medicaid HCBS DD Waiver services must be provided according to DHHS values, competencies, and developmental disabilities service definitions. You may not assign or transfer duties, responsibilities, or payment.

Services billed must be provided according to all statutory, regulatory, and contract requirements and according to the approved Home and Community Based Services (HCBS) Medicaid Waivers.

You may not provide a service without an authorization.
• Authorizations are service-specific and participant-specific.
• You can only bill for services provided during the period on your authorization.
• Double check claims for accuracy.
• Inaccuracies or discrepancies will delay your payment.
• Your electronic signature certifies truth and completeness of the claim.

You can only bill for the time you are with a participant.
• Talk with service coordination when you are working with more than one participant at a time. He/she will explain expectations and billing guidelines.
• Two providers cannot bill for the same time frame. When claims are submitted and there is an overlap, the claims could be rejected. When this is a routine problem, your claims may be reviewed for Medicaid fraud.

Services and supports must be delivered as documented in each participant’s person-centered ISP.
• The type and amount of service, the location and schedule for delivery of the service, and the provider responsible for the delivery of the service must be documented in the ISP.
• You can only bill for services assigned to you in the ISP.

In-home services are services provided in a participant’s home, and may include teaching tasks such as hygiene, meals, or laundry.
Out-of-home services are services and supports provided in the community, away from a participant’s home.

You must submit a claim after a service is provided and within 180 calendar days. The state of Nebraska cannot pay for claims which are older than 180 calendar days. Additional information about the six month (180 day) timely filing requirements is available from Medicaid. No claims will be processed after the 181st day after the service was provided. When you dispute payment for a claim which is more than calendar 180 calendar days old, you may file a request for a fair hearing.

Once DHHS-DD receives a claim, there are 60 calendar days to pay unless the documents are not complete or are inaccurate. It usually takes about 14 business days for payment to be made once a complete and accurate claim is received by DHHS-DD. Additional documentation may be requested in order to process a claim. Questions about payments which have not been received within 14 business days may be directed to DHHS-DD Central Office.

You will accept Medicaid reimbursement as payment in full for authorized services. As a Medicaid waiver provider, you cannot suggest, endorse, or agree to private payment arrangements. For example, you cannot request additional or higher mileage payment. Payment from Medicaid may have a participant’s obligation deducted, when applicable. You will accept a rate agreed upon with a participant.

Agency Provider Billing
You have an agreement with DHHS and must provide Medicaid HCBS DD Waiver services only as authorized. When you are experiencing problems with payment, you can contact the DHHS employee who processes your claims.

Independent Provider Billing
Your employer is the participant for whom you provide services. You must provide Medicaid HCBS DD Waiver services only as authorized by DHHS-DD.

You may bill twice a month, on the first of the month and the fifteenth. Do not overlap dates or put more than one month on your claim; this will cause your claim to be returned to you and cause a delay in payment. You will permit DHHS to recover funds paid erroneously. You will retain financial and statistical records for six years to support all claims. You will supply any and all financial records at the request of DHHS. You can only claim for services provided during the period shown on the Service Authorization.

When you are experiencing problems with payment, you can contact the assigned Service Coordinator. You may be directed to speak directly to a DHHS employee who processes claims.

Claims Processing
Billing for Medicaid HCBS DD Waiver services is completed in Therap, which is an internet-based program you can access anywhere you have internet. You can complete billing on a computer, laptop, tablet, or smartphone. You have quick and immediate access to service authorizations sent electronically.

You will record Medicaid HCBS DD Waiver services delivered using the attendance module. Therap will automatically calculate billing and you will submit claims electronically. Once a claim has been paid, you can view payment information in Therap. An explanation of payments is available and you can view the status of all online billing claims. There is a webinar on how to complete attendance and submit billing claims.

A participant or guardian may request a copy of attendance information prior to you submitting the billing claim. It is your responsibility to provide this information.

When there are inadequate units in a participant’s budget or there is not an active service authorization, the claim will be returned and you will need to contact DHHS-DD service coordination for resolution.

In the event DHHS-DD makes overpayments for any reason, you agree to repay such overpayments.

Agency Provider Billing
As an agency provider you receive Therap login information from DHHS-DD upon signing your agreement.
Independent Provider Billing

As an independent provider you receive Therap login information from the Service Coordinator. Quick Guides for billing are available on the Therap page for Nebraska independent providers.

Medicaid Fraud

Fraud is an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit. Fraud may include billing for Medicaid HCBS DD Waiver services not provided or billing for non-covered services.

Persons who knowingly make a false claim may be criminally prosecuted. Punishment may include fines up to $250,000 and/or up to 5 years imprisonment.

States are required to suspend Medicaid payments when there is a credible allegation of fraud and a pending investigation. This means your payment for submitted claims during a credible allegation of fraud or a pending investigation could be suspended or not paid.

Share of Cost

A participant may have a share of cost to be eligible for Medicaid. The share of cost is assigned to a provider, and the amount is deducted from the DHHS payment. A participant or his/her Service Coordinator will tell you when you are assigned a share of cost. When this happens, you are paid the amount of your claim minus the share of cost. The participant is responsible to pay the share of cost amount to you.

Tax Withholding

Nebraska law requires DHHS to withhold Nebraska income tax when payments for personal services are made in excess of $600 to a provider who has not maintained a permanent place of business or residence in Nebraska for a period of at least six months.

This applies to independent providers, to agency providers when 80% or more of the voting stock is held by the shareholders who are performing personal services, and agency providers who are a partnership or limited liability company when 80% or more of the capital interest or profits is held by the partners or members who are performing personal services. The Nebraska Department of Revenue Nebraska Withholding Certificate for Nonresident Individuals must be completed. The form is available from the Department of Revenue.

When you have tax-related questions, you can email DHHS.TaxData@nebraska.gov

Taxes for Agency Providers

As an agency provider, you are an employer and responsible for tax withholding and reporting for your employees.

Taxes for Independent Providers

DHHS may withhold taxes from your payments. The employer’s share of Social Security Tax is withheld from your payments for in-home services, since you are not affiliated with an agency. For tax purposes, a participant or his/her legal representative authorizes DHHS to act as his/her agent. As the agent, DHHS withholds, deposits, and reports all FICA taxes to the Social Security Administration. DHHS does not withhold federal or state income tax. It is recommended you consult with your income tax advisor or the IRS regarding the possibility you may owe taxes at the end of the year. A participant or his/her guardian signs form FA-65 explaining this.

False Claims Act

The False Claims Act establishes a civil liability for knowingly presenting a false or fraudulent claim to the government for payment. No specific intent to violate the Act is required for conviction.

Consequences may include:
- Civil penalties of up to $11,000 per claim
- Treble damages
- Exclusion
Tax forms will be sent to you after February 1st following the end of the calendar year:

- You will receive a Form W-2 Wage and Tax Statement for each participant you worked with when FICA tax was withheld from your wages and submitted to the Social Security Administration. You may receive more than one Form W-2 when you work for more than one participant.
- You will also receive a Form 1099 Miscellaneous Income for income from participants you worked with when no FICA tax was withheld or when it was refunded to you. The total wages you earned for the year as a service provider are figured by adding the amounts shown on each of the forms. You should not get more than one Form 1099.

**Social Security – Independent Providers ONLY**

At the end of each calendar quarter, bills submitted are totaled for each participant you worked with during the quarter. Your wages from working with a participant must amount to $50.00 in order for FICA tax to be withheld. When your earnings for a participant are at least $50.00, DHHS will pay the employer’s share of FICA and deposit it, along with the FICA tax withheld from your State warrants, with the Social Security Administration.

There may be times when you do not earn at least $50.00 in a calendar quarter for Medicaid HCBS DD Waiver services you provided for a particular participant. In this case, the FICA tax previously withheld will be refunded to you at the end of the calendar year.

When you have questions about FICA withholding or other tax-related questions, you can email DHHS.TaxData@nebraska.gov.

**General Provider Finances – Agency Providers ONLY**

DHHS will end the Medicaid Provider Agreement with you in cases of bankruptcy proceedings or trusteeship. This includes:

- An involuntary proceeding has been commenced by any party against you under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) you have consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) you have been decreed or adjudged a debtor; or
- A voluntary petition has been filed under any of the chapters of Title 11 of the United States Code; or
- A trustee or receiver of your assets or of any substantial part of your assets has been appointed by a court.

When your agreement with DHHS is for more than $150,000, you will make sure you are in compliance with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).

You will comply with all applicable provisions of 45 C.F.R. §§ 87.1-87.2. You will not use direct federal financial assistance to engage in inherently religious activities, such as worship, religious instruction, and/or proselytization.

**Failure to Preform Services**

DHHS may terminate your Agreement to provide services, in whole or in part, when you fail to perform your obligations in a timely and proper manner. DHHS may give you a written notice of default to allow you to fix a failure within 30 calendar days or longer, at DHHS’s discretion, considering the gravity and nature of the default. This notice will be delivered by Certified Mail with Return Receipt Requested or in-person with proof of delivery.

Allowing you time to fix a failure does not waive DHHS’s right to immediately terminate your contract for the same or a different default occurring at a different time.

DHHS may hold you liable for any excess cost caused by your default. This does not preclude the pursuit of other remedies for default as allowed by law.
Links for Resources

DHHS-DD makes the information you need easily accessible in a way you can easily understand. When you do not have access to the internet, please ask about having specific items printed.

The following links are included in this document and available for your use:

- DHHS Regulations: http://dhhs.ne.gov/Pages/DHHS-Regulations.aspx
- DHHS website: www.dhhs.ne.gov
- DHHS-DD Agency Provider page: http://dhhs.ne.gov/Pages/DD-Agency-Providers.aspx
- DHHS-DD Independent Provider page: http://dhhs.ne.gov/Pages/DD-Independent-Providers.aspx
- DHHS-DD Resource page: http://dhhs.ne.gov/Pages/DD-Resources.aspx
- DHHS-DD Training page: http://dhhs.ne.gov/Pages/DD-Training.aspx
- Email for tax-related questions: DHHS.TaxData@nebraska.gov
- Request for a fair hearing: http://dhhs.ne.gov/DD%20Documents/DA-6%20Request%20for%20Fair%20Hearing.pdf
- Therap: http://www.therapservices.com/
- Therap Nebraska independent provider page: https://www.therapservices.net/nebraska/nebraska-independent-providers/
- Therap Nebraska page: http://www.therapservices.net/nebraska
- Title 175 - Health Care Facilities and Services Licensure http://dhhs.ne.gov/Pages/Title-175.aspx
- Title 403 NAC – Medicaid Home and Community-Based Waiver Services for Individuals with Developmental Disabilities: http://dhhs.ne.gov/Pages/Title-403.aspx
- Title 404 NAC – Community-Based Services for Individuals with Developmental Disabilities: http://dhhs.ne.gov/Pages/Title-404.aspx
- Title 471 - Nebraska Medicaid Program Services http://dhhs.ne.gov/Pages/Title-471.aspx
- Title 474 - Social Services for Families, Children, and Youth http://dhhs.ne.gov/Pages/Title-474.aspx