Important Information for Qualified Service Providers (QSPs)

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. For more in depth information, refer to the online QSP handbooks.

Contact Information

What are my responsibilities as a QSP?

Important Information

Keeping Records

How to bill for services

♦ Contact Information

○ When will I get paid?

- Scheduled Payment 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: 203-596-7553
  Email: NDSupport@TherapServices.net

○ 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.
  - **Agency** QSPs: Agency Super Administrator(s) can reset/unlock user passwords. If the Super Admininstrator is locked out:
    1. Complete the online 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.

North Dakota QSP HUB

North Dakota's centralized source of support and information for Qualifed Service Providers

What is the QSP Hub?

The QSP Hub is a central source for support and information QSPs.

Services provided by the QSP Hub

Support, educational tools and training opportunities to walk QSPs through all stages of the QSP process.

What can the QSP Hub help me with?

One-on-one support by email, phone or video conferencing to help with:

- **Enrollment:** Assistance with application process
- **Revalidation:** Support for maintaining your provider status
- **QSP Web Portal:** Help navigating and using the portal effectively

Guidance and referrals on where to go for help with:

- Electronic visit verification (EVV) (Therap)
- Documentation best practices
- Billing processes
- Business operations and processes

Other QSP Hub resources:

- Library of easy-to-understand educational materials and guides
- Training events/opportunities for both individual and agency QSPs
- Create a mentoring network for QSPs and QSP agencies
- Create awareness of HCBS policy changes and updates

Questions

Please contact the North Dakota QSP Hub at info@ndqsphub.org or (701) 777-3432.

NORTH Dakota Be Legendary. | Health & Human Services

North Dakota QSP Hub
Center for Rural Health, University of North Dakota, 1301 N Columbia Rd, Stop 9037, Grand Forks, ND 58202-9037
ndqsphub.org (701) 777-3432 info@ndqsphub.org North Dakota QSP Hub

♦ What are my responsibilities as a QSP?

○ Self-Employment: You're not an employee, you're a self-employed contractor.

QSPs are independent contractors, not Health & Human Services (HHS) employees. QSPs provide a service and are paid for the authorized services that are rendered.

○ Taxes

HHS 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. HHS 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 HHS 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 HHS 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.

Log in to your account in the QSP Portal within 14 days of any change. Once logged in, update your contact information to stay up to date with the latest information and any tasks assigned to you.

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 HHS 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 HHS, log in to your account in the QSP portal to update your account information.
- In the portal, update banking information and upload a copy of a voided check or signed 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 new account. You will receive a paper check until all account information is verified.
- The ND Medicaid payment schedule (check write) is online.

♦ Important Information

○ Review the QSP enrollment handbooks online for frequent updates.

○ 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 HHS.

An explanation of QSP Billing Codes is available online for each service. 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 for your service).
- 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 some QSPs 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.
  - This is not an option for all QSPs. Consult your CM for more information.
  - 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.

- **Form documentation** using available examples:
  - A downloadable PDF example and blank forms are available online to view and use to document services. Must be stored by QSP for required period, even if **your QSP status 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.
  - 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.
- HHS 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.
  - You may also document the services you provide in Therap.
- See more information and Therap training links on Page 8 of this document.

- **Individual QSPs – Therap process once enrolled**
  - After you receive a notice that you are approved as a new QSP, the QSP Enrollment team will send you an email notifying you that a Therap account has been created for you. Please allow 5-7 business days to receive this information.
    - If you do not have log in information, email QSPresetpw@nd.gov for assistance.
  - **After you have a client/individual assigned to you**, a CM will quick refer at least one individual to your newly created Therap account. **This must be done before you can move to the next step.**
  - Once you receive a quick refer, complete the onboarding form to start training with Therap.
  - Therap offers a weekly webinar for QSP Therap 101.
  - **After you receive a quick refer for a client**, contact Therap to get started with their onboarding process https://help.therapservices.net/s/article/6945

- **Agency QSPs – Therap process once enrolled**
  - After you receive a notice that you are approved as a new QSP, the QSP Enrollment team will send you an email notifying you that a Therap account has been created for you. Please allow 5-7 business days to receive this information.
  - If you have not received this email after 5 – 7 business days, email QSPresetpw@nd.gov for assistance.
  - Once your account is created, you may request training from Therap; however, **you cannot log in to your account until you have a specific client/individual assigned to your case.**
  - **After you have a client/individual assigned to you**, a CM will quick refer at least one individual to your newly created Therap account. **This must be done before you can move to the next step.**
  - Once you receive a quick refer, complete the onboarding form to start training with Therap.
  - Therap will create a Super Admin role in your Therap account to verify a client/individual is assigned to your Agency.
  - Therap will meet with you to train you on current modules used by ND Therap.

Client Liability / Cost Share

- Some individuals (clients) are responsible for a portion of their service costs.
- This amount is deducted from the QSPs payment before payment is issued. The QSP must collect payment due from the individual.
- The HCBS CM, QSP Enrollment and the Claims Department are not responsible to collect the client liability/cost share from eligible individuals or assist the QSP in collecting this amount.

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.
- **NOTE**: The delay of filing claims or filing many months of claims at one time negatively affects members. When large amounts of claims are filed at the same time, members who are responsible for paying Client Liability or Cost Share receive one larger bill, instead of many bills spread over several months, making it harder for them to pay.
- For more information regarding this policy, visit this link.

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 (CM).

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 CM will generate Service Authorization(s) (SA), often called a Pre-Auth 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 SA for each member before providing services and be eligible for payment.
- You must review and acknowledge SAs within Therap.
  - You may receive/acknowledge more than one SA for each member (one for each service you are authorized to provide).
  - The tasks you are authorized to provide are listed on the SA. Task descriptions are defined on the form beside the authorized task.
    - Directions to acknowledge SA within Therap are online.
  - It is your responsibility to notify the CM if you are approved for a service you are not enrolled to provide.
    - Log in to your account in the Enrollment Portal 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 SA 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 may 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 Rate/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
  - Therap Overview for ND Aging Agency QSPs
  - Therap Training Academy
- **Therap Support request** – https://help.therapservices.net/s/article/6939
- **Follow these steps to generate billing from EVV data:**
  - **Before you bill**
    - Acknowledge SAs 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)

- **Before sending claims**
  - Check Sandata visits to ensure all are 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**
- **ND MMIS Professional Claim Form Submission Instructions**
- **MMIS Training:** Computer-based training is available online.
  - 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 https://www.ndqsphub.org/

Billing Tips

- **Before you provide care:**
  - QSPs cannot provide services if the individual you provide care to (the client) is not home. Services can only be provided to individual in their home when they are present.
  - Competency standards, CNA certificates or LPN/RN licenses must be current. Your enrollment may be suspended or closed if your competency is not updated. QSPs cannot bill or receive payment if competency standards are not current.
  - Do not provide or bill for more than one service or more than one individual at a time.
    - Example 1: If you are authorized for homemaker and personal care services, you may only be clocked in and bill for one service at a time. You cannot be clocked in to provide homemaker and personal cares and bill for both services at the same time.
    - Example 2: If you are authorized to provide care to two different household members on a unit rate, you may only bill for one individual during the same time period.

- **Before** you submit your claim:
  - Read through your claim carefully and correct any errors before submitting.
  - Use the right 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 didn't provide.
  - Don't bill for more units than you actually provided.
  - Don't bill for more units that you were authorized on the service authorization.
  - Payment can be made only for the days the client is receiving care in his or her own residence.
  - Information specific to each billing code is available online.
- **After** you submit your claim:
  - Call the right place with your questions (See page 2).
  - If a claim is denied, it means that a payment wasn't issued.
  - Claims denied because of an error must be rebilled. Correct the billing error before you resubmit the claim.

Automated Payment Line

Use to check on your payment status. This automated system allows QSPs to check on the status of their claims. You'll need your QSP Medicaid ID number to use this system.

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

Instructions:

- 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.
- If you have called this number and still have questions, press "0" to speak to a live person. If asked for a PIN, press "0".

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

Audits, Adjustments, Appeals, Denials and Exclusions

- **Audits**

  HHS is required to complete audits of QSPs to ensure individuals receive the services they need and services provided meet standards set by HHS. When you enrolled as a QSP, you agreed to assist the HHS in completing these reviews and to submit documentation upon request. If a QSP does not keep service records, they may be subject legal and monetary penalties.

  HHS must recover funds paid for services not delivered according to policies and procedures per ND Administrative Code 75-03-23-10. Examples for recovery reasons (not a complete list):

  - Failure to keep appropriate records
  - If you did not provide the service
  - Inappropriate billing
  - Billing over the authorized amount or billing the wrong code
  - Photocopied records indicate 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

- **Adjustments**

  If HHS finds payments were inappropriately made, we will request a refund or process adjustments to take back these funds. Some examples include (this list is not all-inclusive):

  - Audit findings
  - Inappropriate services
  - Services not provided
  - Provider self-disclosure of inappropriate payments received
  - Inappropriate billing, billing over authorization or wrong procedure code
  - Inappropriate documentation / records

- **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 HHS within thirty days of the date of HHS'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 HHS 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.

    HHS 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
State Capital – Judicial Wing
600 E Boulevard Ave, Bismarck, ND 58505

- **Enrollment Denial and State or Federal Exclusion**
  If denied enrollment or terminated as a QSP and/or placed on the State Exclusion list for any of the findings listed under the audit or adjustment sections (the lists are not all-inclusive), you will receive a written denial/termination reason with a citation. You may also be referred to the OIG (Office of Inspector General) for possible exclusion in any capacity in the Medicare, Medicaid, and all Federal health care programs as defined in section 1128(b)(5) of the Social Security Act.

  If excluded, you will not be eligible to provide services to individuals whose care is reimbursed by federal health care programs such as Medicaid or by ND state funds. This does not impact your eligibility to receive Medicaid or Medicare benefits.

  After exclusion, if an individual wishes to again participate as a provider in the Medicare, Medicaid and all Federal health care programs, they must apply for reinstatement and receive an authorized notice from OIG of reinstatement.

  Denial or terminations may be appealed within 10 days of receiving the notice from HHS.

  Requests for appeal of denial or termination decision must be sent to:
  Health and Human Services – Appeals Supervisor
  State Capital – Judicial Wing
  600 E Boulevard Ave, Bismarck, ND 58505

Fraud, Waste & Abuse

The mission of HHS is to provide quality, efficient, and effective human services, which improve the lives of people. HCBS and Medicaid provide healthcare coverage to qualifying low-income, disabled individuals, children, and families. Fraud can be committed by Medicaid providers (including QSPs) or clients. HHS does not tolerate misspent or wasted resources.

By enforcing fraud and abuse efforts:

- Providers receive the best possible rates for the services they provide to Medicaid recipients.
- Recipients are assured their out-of-pocket costs are as low as possible.
- Tax dollars are properly spent.
- Recipients receive necessary healthcare services (including HCBS).

What is Fraud?

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person.

How do I report Medicaid fraud or abuse?

- **Phone 1.800.755.2604 or 701.328.4024**
- **Email medicaidfraud@nd.gov**
- **Fax 701.328.1544**
- **Mail:**
  Fraud Waste & Abuse Administrator
  Medical Services Division
  600 E Boulevard Ave Dept 325
  Bismarck ND 58505 0250
- **Or complete the Suspected Fraud Referral (SFN 20)**

To learn more about fraud and abuse, visit us online.

What is Abuse?

Abuse is when provider practices are inconsistent 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.
Abuse may also include recipient practices that result in unnecessary costs to the Medicaid programs.

What is my role in helping prevent Medicaid fraud and abuse?

REPORT any instance of suspected fraud or abuse.

Report Medicaid Fraud and Other Fraud

Anyone suspecting Medicaid fraud, waste, or abuse is encouraged to report it.
Examples of Fraud can include:

- Billing for services not performed
- Billing duplicate times for one service
- Billing outside the allowable limits
- Billing without an authorization to provide the service

To report suspected Medicaid Fraud, call 1-800-755-2604 and ask to speak with an attendant, or email: medicaidfraud@nd.gov. To report other program fraud, call the Fraud Hotline: 1-800-472-2622 or email dhseo@nd.gov.

QUALIFIED SERVICE PROVIDER (QSP) COMPLAINTS

A Qualified Service Provider (QSP) complaint is information about an issue involving a QSP that affects an individual's quality of care, health/welfare/safety, inappropriate billing, potential fraud/waste/abuse or failure to meet or maintain enrollment standards.

- *Absenteeism*
- *Abuse/neglect/exploitation*
- *Breach of confidentiality*
- *Criminal History/Activity*
- *Disrespectful*
- *Inappropriate Billing*
- *Care Unacceptable to the HHS*
- *Property Damage*
- *Self-Neglect*
- *Providing care under the influence of drugs/alcohol*
- *Medication errors that result in adverse effects*
- *Not submitting a critical incident report*

HOW TO SUBMIT A COMPLAINT

A complaint can be made by any person with information who suspects wrongdoing by an individual QSP, agency QSP or agency employee.

A complaint can be made by:

Email: carechoice@nd.gov

Phone:
ADRL 1-855-GO2LINK
(1-855-462-5465)

Mail:
Adult and Aging Services
QSP Complaint
1237 W Divide Ave; Suite 6;
Bismarck ND 58501

What to do if you are notified of a QSP complaint against you…

All QSP complaints are reviewed and processed by Adult and Aging Services. If we receive a complaint about you or your agency, you will be notified by phone or receive a letter by email.

Complaint letters are emailed to the email address on file with QSP Enrollment. (Check your email regularly for correspondence from HHS.)

Follow the instructions in the letter and return phone calls promptly.

Promptly provide any additional information and documentation requested by the Complaint Administrator.