Maryland
DEPARTMENT OF HEALTH

Quarterly Targeted Case Management Reviews
Standard Operating Procedure Guidance

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*All text in red indicates added/revised language since the prior release date

CONTENTS

AUDIENCE

- Liberty Healthcare staff
- Targeted Case Management Organizations - Coordination of Community Services Agencies
- Developmental Disabilities Administration (DDA) staff

PURPOSE

This guidance outlines the Liberty Healthcare Corporation process to conduct Targeted Case Management (TCM) reviews to evaluate compliance with Development Disabilities Administration (DDA) standards related to:

- Level of Care determinations,
- Person Centered Planning,
- Monitoring,
- and Billing.

The guidance also provides follow-up processes that will be followed by Liberty Healthcare Corporation and the DDA. TCM reviews will include verifying:

1. Level of Care assessments have been completed in accordance with state policies and regulations.
2. Person centered plans have been completed timely and in accordance with state policy and regulations and address the person's desired life outcomes, goals and needs, including the completion and use of the Health Risk Screening Tool results in the planning process.
3. Required monitoring visits are occurring timely and contain detailed comments regarding participant progress on achieving personal goals and outcomes and receiving services as outlined in their person-centered plan.
4. Billing claims documented in activity notes in LTSS*Maryland* and appropriately document only billable targeted case management activities.

DEFINITIONS

A. "Annual Plan" is the person-centered plan completed within 365 days of the agreed upon Annual Person-Centered Plan (PCP) date.

B. "Billable Activity" are those services provided by the CCS that involve assessment of a participant, development and facilitation of the PCP, monitoring and follow-up of that plan's implementation and the progress made by the participant.

Note: Billable Activities include those from the "Billing Documentation Verification Quality Review Guidance (released October 7, 2022 and effective November 1, 2022). Billing

that was submitted November 1, 2022 and forward will be held to this standard. The guidance in place prior to November 1, 2022 will be utilized for activity notes submitted in that time frame. See Appendix B. for a list of Billable/Non Billable Activities (*Activities in **Bold** represent activities that went into effect November 1, 2022*).

C. "Billing Claim" is the term used for the targeted case management service rendered by the CCS and documented as activity notes in LTSS*Maryland* and submitted to the DDA for payment.

D. "Coordinator of Community Services" or "CCS" means an individual who provides Coordination of Community Services either as an employee or contractor of a DDA provider licensed or certified/approved to provide Coordination of Community Services.

E. "Coordination of Community Services" means the provision of targeted case management services that assist participants in gaining access to the full range of medical assistance services, as well as access to any additional needed generic, medical, social, habilitative, employment, recreational, housing, financial, counseling, legal, educational, and other support services.

F. "Community Coordination Services" means targeted case management services rendered to individuals with intellectual/developmental disabilities and their families to support their learning and gaining access to resources in their community, planning for their future, and accessing needed services and support to live in their chosen community.

G. "Detailed Service Authorization" means the LTSS*Maryland-DDA Module* PCP section that lists the DDA-funded services including the specific service name, service provider, units per month, annual service cost, and provider status.

H. "Findings Report" means a report generated by Liberty Healthcare Corporation that summarizes the outcome of each indicator question included in the review and that includes recommendations for improvement or suggested remediation actions to address Unmet standards related to each indicator question.

I. LibertyTraks - is a web-based software application developed by Liberty Healthcare Corporation that will be used to track the initiation, completion and results of each review conducted by Liberty Healthcare reviewers.

J. "LTSS*Maryland*" means a shared electronic information system, developed and supported by the Maryland Department of Health, used by DDA, the CCS, and DDA Providers to create, review, and maintain records regarding an individual's eligibility status for DDA-funded services, and the participant's person-centered plan.

K. "Participant" refers to a person enrolled in and receiving DDA-funded services.

L. "Pending" means that an Unmet finding can be remediated with supplemental/corrective documentation.

M. "Person-centered plan" is the written plan that is developed through a planning process driven by the individual with a developmental disability in order to:

1. Identify the goals and preferences of the individual with a developmental disability.

2. Identify services to support the individual in pursuing the individual's personally defined outcomes in the most integrated community setting.

3. Direct the delivery of services that reflect the individual's personal preferences and choice.

4. Identify the individual's specific needs that must be addressed to ensure the individual's health and welfare.

N. "Targeted case management" means a service allowed under federal Medicaid rules which includes services to assist targeted populations of Medicaid participants to gain access to needed medical, social, educational, and other services.

1. "Targeted case management" includes:

a. Performance of a comprehensive assessment and periodic reassessment of participant needs, to determine the need for any medical, educational, social, or other services

b. Provision of a waiting list coordination services

c. Provision of community coordination services and

d. Provision of transition coordination services

O. “Unit” refers to the 15-minute time increment that a CCS bills for services rendered to participants.

P. “Waiting List Coordination” means targeted case management services rendered by Coordinators to children and adults who have met the DDA’s eligibility requirements to receive services and are placed on the DDA waitlist for those waiting for DDA funding.

OVERVIEW

The CCS scope of work includes one-time completion of the Comprehensive Assessment (CA) of the participant, which identifies the level of support needed. DDA makes a determination after the CCS submits the CA on the participant’s Level of Care (LOC). The DDA then funds three types of ongoing Coordination of Community Services to eligible participants, which includes Waiting List Coordination Services, Community Coordination Services, and Transition Coordination Services. Each of these services includes three activities:

1. Facilitation and periodic revision of the individual’s PCP (Reference: COMAR 10.09.48.06B);
2. Referral and related activities (Reference: COMAR 10.09.48.06C); and
3. Monitoring and follow-up (Reference: COMAR 10.09.48.06D).

The DDA is responsible for monitoring Coordination of Community Services agencies to ensure that billing activities reflect billable services rendered and follows the Centers for Medicare and Medicaid Services (CMS) Waiver Assurances and Sub Assurances. This monitoring will be conducted quarterly through the TCM review conducted by Liberty Healthcare Corporation staff through the process outlined within this guidance.

As part of the TCM reviews, Liberty will examine all documentation in the selected participant’s *LTSSMaryland* record, as well as billing of TCM services to ensure that Coordinators of Community Services (CCS) assisted participants through eligibility determination, developing their person- centered plan and conducting monitoring and follow-up visits to assess the quality of the service implementation for each person to whom they are assigned to support. These reviews will ensure CCSs are delivering coordination services in the most efficient and effective manner to meet the needs of participants and billing is appropriate and supported.

Three types of TCM reviews will be conducted by Liberty Healthcare Corporation.

1. **Initial Level of Care Determination review** will be conducted quarterly to determine if LOC determination standards were met, and LOC determinations occurred prior to the participant receiving services for 100% of newly enrolled waiver participants from the review period.
2. **TCM Case File Review** is a comprehensive examination of the accuracy and quality of level of care re-determinations, the development of the participant's person-centered plan as well as monitoring and follow up visits conducted during the review period. The quarterly review will be conducted for a statistically significant random sample of waiver and state only funded participants with a PCP date during the review period.
3. **Billing Claims Review** will examine the completeness and accuracy of TCM billing activity notes during the review period. The quarterly review will be conducted for a statistically valid random sample of TCM paid claims from the previous fiscal quarter.

APPLICABILITY

This guidance applies to all information documented and uploaded into the participant's record in LTSS related to level of care determination, person centered planning, monitoring and follow-up and billing claims submitted by each Coordination of Community Services/ Targeted Case Management agency for all billable services rendered during the annual plan year. Each billable activity is documented and recorded in the LTSS*Maryland* system as they are performed.

TCM REVIEW SAMPLE SELECTION PROCESS

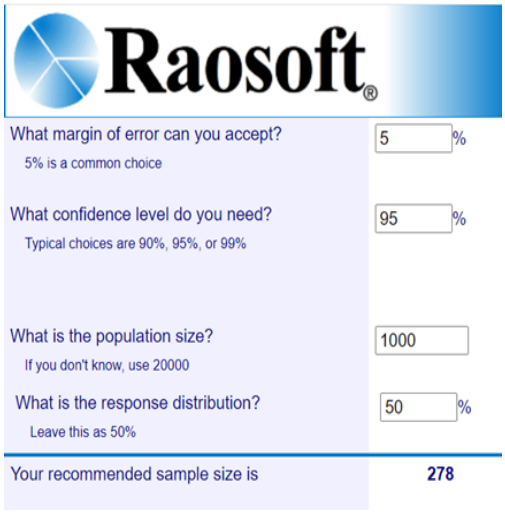
1. **Initial Level of Care Sample** - The sample for initial level of care determinations will be 100% of newly enrolled waiver participants from the previous fiscal quarter. A report will be run quarterly from LTSS*Maryland* on newly enrolled participants from the previous quarter.

2. **TCM Case File Sample -** The TCM Case File Review sample will be selected quarterly on a statistically valid random sample of participants within each of the three approved DDA Waivers (Community Pathways, Community Supports and Family Supports Waivers) and State Only Funded participants.

The following steps will be taken to determine the statistically valid random sample:

- Liberty's data analyst will utilize LTSS*Maryland* data imports on participants to determine the total number of participants for each Waiver and State Only Funded program each fiscal year.

- A sampling methodology of 95% confidence interval (+/- 5% error margin), using the following automatic sampler, will be used to determine the final sample size (Raosoft software, http://www.raosoft.com/samplesize.html). The sample size calculator will generate the total number of participants that must be randomly selected annually. The annual number will be divided by 4 to determine the quarterly TCM review sample for each Waiver and State Only Funded program. The minimum sample size will be generated when the total number of participants for the chosen review is entered into the population field.



- Quarterly samples will be selected based on the adequate sample size and will include participants with an annual person-centered plan date in the previous quarter (e.g. Sample pulled in fiscal quarter three for participants with an annual person-centered plan date in fiscal quarter two (October, November, December).

- A proportionate number of participants, receiving services through both the traditional and self-directed service delivery models, will be selected by region and by size of CCS organizations within each Waiver/State Funded program sample from those whose annual person-centered planning date fell within the previous quarter.

- To determine the percentage of the total participants within each region and by size of CCS agency during the quality review period, LTSS*Maryland* reports allow you to sort by region and by CCS organization to calculate the proportion of the total sample that should be included for each region and CCS organization. (See examples below)

	Minimum Quarterly Sample Size				
Region	**CP**	**CS**	**FS**	**State Funded**	**Total**
Central	45	34	7	32	**118**
Eastern	9	7	5	6	**27**
Southern	30	31	10	30	**101**
Western	12	10	6	3	**31**
Sample Size	**95**	**82**	**27**	**71**	**275**

3. **TCM Billing Claims Sample** -

- A statistically valid random sample of TCM billed claims will be reviewed as part of the billing verification process of the TCM review.
- The total number statewide claims submitted during the previous quarter for each of the Waiver/State Only programs will be determined using the Activity Claims Report in LTSS*Maryland*.
- The same sample size calculator will be used to determine the adequate number of claims to review from the universe of claims associated with the selected participants for the review period.

Quarterly Claims Sample	CP	CS	FS	State Funded	Grand Total
Total	**104**	**106**	**95**	**104**	**409**

TCM REVIEW PROCESS

The TCM Review process is outlined below for each of the three TCM reviews.

Step 1: Samples uploaded into LibertyTraks

(Initial LOC): To complete Initial LOC reviews, Liberty will capture 100% of newly enrolled participants for the quarter review and assign reviewers to a proportionate number of cases in Liberty's web-based data collection and tracking system (LibertyTraks).

(TCM Case File Review): To complete TCM Case File reviews, Liberty will draw the required sample of participants and assign reviewers to a proportionate number of cases in Liberty's web-based data collection and tracking system (LibertyTraks).

(Billing Claims Review): To complete Billing Claims reviews, Liberty will randomly select TCM billing claims from the universe of claims from the previous quarter from LTSS*Maryland*, then upload them in LibertyTraks and assign to reviewers.

Step 2: Assignments will be made within LibertyTraks, flagging the case for the assigned reviewer. The reviewer will then be able to access the case and build the record in preparation for the review. For all cases, this will include demographics of the participant and provider(s) that we have captured from data imports (e.g., imports from PCIS2 or LTSS*Maryland*) or from previous reviews.

Step 3: The assigned reviewer will then continue to build the record by completing the following three steps: (1) capture additional information from LTSS*Maryland* records needed for the review; (2) upload required documentation into LibertyTraks (as applicable); and (3) review available information in preparation for completing the review.

Step 4: Reviewers will then complete the reviews using a detailed instructional guide (*see Appendix A. TCM Review Indicator Questions Guide*) and will enter findings, evidence for each finding and applicable recommendations and/or remediation actions into LibertyTraks. Reviewers will complete reviews within three (3) business days of initiating the review.

Step 5: Supervisors of the reviewers will conduct quality control checks on at least 10% of reviews to ensure each step of the review was conducted as outlined in the instructional guide. Assignment of cases for quality control checks will be randomly selected at the time the sample is loaded into LibertyTraks. Follow-up coaching and re-training will be provided to reviewers not meeting an 85% or higher accuracy threshold. Findings will be adjusted accordingly to accurately reflect the correct finding and evidence.

Step 6: Findings Reports for Initial Level of Care Reviews and TCM Case File Reviews

- CCS agencies will receive an aggregate Findings Report (i.e., summary of findings by indicator question and participant) within 15 business days of the end of each review period. The summary will be sent to the CCS agency lead contact(s), the applicable DDA Regional Director and the DDA QIO Contract Monitor.

- If specific indicator questions have "unmet" findings present, Liberty will follow-up with the CCS agency within 15 business days of the end of the review period to request the development of a corrective action plan (*see step 9 for details on Corrective Action Plans*).

Step 7: Findings Reports for Billing Claim Reviews Only

- CCS agencies will receive the Initial Billing Findings Report forty-five (45) business days prior to the end of the review period. For Billing Claims, there will be an opportunity to submit supplemental documentation.

- The CCS agency will have up to twenty (20) business days from the time of receipt of the Initial Findings Report to review the report, submit clarifying questions to Liberty Healthcare as needed and submit supplemental documentation that supports an "unmet" indicator question being changed to "met" (or remediated).

Step 8: Final Review of Billing Claims

- After twenty (20) business days, supplemental documentation received from CCS agencies will be uploaded into LibertyTraks and the reviewers will update findings as applicable. The Liberty reviewer will then close the file and generate a finalized Findings Report.

- CCS agencies lead contact(s) will receive an aggregate Finalized Findings report (i.e. summary findings by indicator question and by claim). The summary and individual reports will be sent to the CCS agency, the applicable DDA Regional Director and the DDA QIO Contract Monitor within 15 days after the end of the review period.
- If Unmet findings for billing claims are indicated in the Finalized Billing Report, Liberty will follow-up within 15 business days after the end of the review period requesting the CCS agency to submit a corrective action plan (*see step 9 for details on Corrective Action Plans*). DDA also will follow-up with the provider regarding recoupment of billing claims with unmet findings. The following outlines the steps:
    - The contract monitor will provide the DDA HQ fiscal department with the recoupment report which will outline the reasons why recoupment is suggested.
    - The DDA Fiscal Director, or other designated member of DDA staff, will email the provider informing them that sufficient documentation was not supplied for the corresponding payment.
    - The DDA will give the provider 2 weeks to appeal the unsupported payment and provide documentation that satisfies the DDA's request
    - If, by the end of the two-week period, the provider was unable to provide documentation that qualifies the payment, an invoice and payment instructions will be emailed to the provider
    - The provider will have 30 days within receipt of the invoice to send payment to the DDA

Step 9: Corrective Action Plans

- Liberty will request a CCS agency to submit a corrective action plan (CAP) with remediation strategies if one or more of the cases/claims reviewed during the review period included unmet findings for the following:
    - PCPs not approved before the annual plan date.
    - PCPs where the Person's identified risks listed in the HRST were not documented in the Risk section of the PCP.
    - Not all required monitoring forms were submitted for the review period.
    - Required monitoring visits could not be verified because they occurred in person.
    - Monitoring forms did not include adequate description of participant progress towards outcomes.
    - Billing claims where:

- Activity notes did not provide a description of only billable activities.
- Activity notes did not provide adequate detail to determine scope and duration of services provided.
- Required supporting documentation (if applicable) was not found in LTSS*Maryland* associated with the activity note for the date of service.

- If a CAP is required, Liberty will notify the CCS agency within fifteen (15) business days of the end of the review period along with the quarterly summary report and individual review reports.
- The CCS agency will submit the CAP to Liberty designee per the CAP request (see Appendix C. CAP Request Template) for approval within thirty (30) business days of email receipt.
- Within five (5) business days, Liberty will review the CAP and will send a letter to the CCS Agency and DDA Contract Monitor if the CAP is approved. If not, recommendations to improve the CAP will be provided and can be resubmitted within five (5) business days.
- The CCS agency will have thirty (30) business days from approval to submit evidence the CAP was initiated and/or completed. Liberty will continue to follow-up until the CAP is fully implemented.
- Upon determination the CAP has been fully implemented, Liberty will send a notification letter stating the CAP has been closed to the CCS agency and DDA Contract Monitor.
- The DDA Contract Monitor will keep all documents in a DDA shared google drive.

Findings Reports

Findings Reports will be created for each CCS agency by type of TCM review. Findings reports will be exported from LibertyTraks, the data management system utilized by Liberty Healthcare Corporation, into Excel files that will provide a summary of findings by indicator question and details of each review conducted during the review period. Reviews with unmet findings will be sorted at the top of the Excel file.

For each compliance indicator question for the review, a findings category will be selected, evidence related to the findings category selected will be documented and an appropriate remediation action (if applicable) or quality improvement recommendation (if applicable) will be noted. Any indicator questions that address future standards, not yet in effect, will also include a findings determination, evidence, and recommended actions in order to meet standards by the effective date.

Findings can be reported definitively as

- Met standards (Yes) or
- Unmet standards (No)
- If an indicator question is not applicable, the finding of Met standards will be selected

Example indicator question – The most recent person-centered plan was approved on or prior to the person's annual plan date?

Met – the most recent person-centered plan was approved on or prior to the person's annual plan date

Unmet – the most recent person-centered plan was not approved on or prior to the person's annual plan date

MEDICAID FRAUD

If there are systemic or alleged **intentional** billing issues, the DDA may refer the CCS Agency to the Department's Office of the Inspector General. A referral may also be made to the Maryland Department of Health Medicaid Fraud Control Unit, which may take additional action.

APPENDIX A: INDICATOR QUESTIONS/AUTHORITY TABLE

Initial Level of Care Review:

Indicator Question	Justifications	Authority
LOC PM1: Was the initial LOC assessment completed prior to the enrollee receiving waiver services?	Met= The initial LOC assessment was completed prior to Waiver enrollment date; Unmet= The initial LOC was not completed prior to the Waiver enrollment date or not uploaded in LTSS*Maryland*	HCBS 1915 (C) Community Pathways Waiver- Appendix B-6. Level of Care Criteria

LOC PM2: Was the initial LOC determination completed according to State policies and procedures?	Met= The initial LOC was completed according to State policies/procedures. CCS: Comprehensive Assessment completed and uploaded in LTSS*Maryland* by the CA Due date, a face-to-face meeting including in person or virtual) is documented as part of the CA or corresponding meeting minutes and there is CA supporting documentation uploaded. Unmet= If the CA is completed after the due date, or no face-to-face documentation or no uploaded supporting documentation for the CA. DDA RO: Met if the following are complete. Review of CA, Recommendation to RO Director, RO Director determination and letter sent within 60 days.	HCBS 1915 (C) Community Pathways Waiver- Appendix B-6. Level of Care Criteria -

Participant Case File Review:

Indicator Questions	Justification Categories	Authority
Was an annual LOC redetermination assessment completed by the annual recertification date?	Met = LOC recertification date was within a year of the previous LOC recertification date; Unmet = LOC recertification was not completed within a year of the previous LOC recertification date	HCBS 1915 (C) Community Pathways Waiver- Appendix B-6. Level of Care Criteria - "The CCS verifies annually that the participant continues to meet the developmental disability eligibility determination."
Was the plan updated within 365 days of the previous person-centered plan?	Met=The PCP was updated within 365 days of the previous PCP; Unmet=The PCP was not updated	Person Centered Planning Policy (Policy Stat 10361724); COMAR 10.09.48.06B

Indicator Questions	Justification Categories	Authority
	within 365 days of the previous PCP	
Did the person-centered plan reflect that participant's individually chosen assessed needs were addressed through waiver funded services or other funding sources or natural supports?	Met="Important FOR Me" items were supported by services or natural supports as documented in the Outcomes section; Unmet= "Important FOR Me" items were not supported by services or natural supports as documented in the Outcomes section	Person Centered Planning Policy (Policy Stat 10361724); COMAR 10.09.48.06
Did the person-centered plan reflect that participants have their personal goals addressed through waiver funded services or other funding sources or natural supports?	Met= "Important TO Me" items were supported by services or natural supports as documented in the Outcomes section; Unmet= "Important TO Me" items were not supported by services or natural supports as documented in the Outcomes section	Person Centered Planning Policy (Policy Stat 10361724); COMAR 10.09.48.06
Are the identified risks listed in the HRST documented in the Risk section of the PCP?	Met=All identified health care and behavioral risks identified in the HRST are addressed in the Risk section of the PCP; Unmet= not all identified health care and behavioral risks were documented in the risk section of the PCP	Person Centered Planning Policy (Policy Stat 10361724); COMAR 10.09.48.06
Was the HRST rated by the CCS within 90 days of the PCP expiration date and based on IntellectAbility Standards?	Met=All HRST sections were updated with Ratings notes as applicable within 90 days before the Annual PCP date; Unmet=Not all sections were updated within 90 days before the Annual PCP date	Person Centered Planning Policy (Policy Stat 10361724); COMAR 10.09.48.06

Indicator Questions	Justification Categories	Authority
Was an HRST with a level score of 3 or higher completed by a HRST Reviewer (RN) within 90 days of the PCP expiration date and within the IntellectAbility Standards?	Met=Not applicable if scores less than 3; or all sections of the Reviewer notes were updated within 90 days before the Annual PCP date for HRST level scores of 3 or higher with applicable notes; Unmet=Not all reviewer notes were updated within 90 days before the Annual PCP date for HRST level scores of 3 or higher	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06
Is there an updated Nursing Care Plan if the person is authorized for applicable nursing services?	Met=Not applicable; or the participant is authorized for nursing services and has an updated Nursing Care Plan; Unmet=The participant is authorized for Nursing services and does not have an updated Nursing Care Plan	Person Centered Planning Policy (Policy Stat 10361724) LTSS – DDA CCS Coordinator User Manual
Is there an updated Behavior plan if the person is authorized for behavioral support services?	Met=Not applicable; or the participant is authorized for behavior support services and has an updated Behavior Plan; Unmet=The participant is authorized for Behavior support services and does not have an updated Behavior Plan	Person Centered Planning Policy (Policy Stat 10361724) LTSS – DDA CCS Coordinator User Manual
Did the participant receive information about reporting abuse, neglect and exploitation?	Met = Individual Signature Page is signed by the participant with the attestation they received information on abuse, neglect and exploitation and uploaded in the Active PCP; Unmet = If the participant did not sign the Individual Signature Page or it is no uploaded in the Active PCP	LTSS – DDA CCS Coordinator User Manual
Did the person-centered plan have a completed CSQ?	Met = The PCP had a completed CSQ; Unmet=The PCP did not have a completed CSQ	LTSS – DDA CCS Coordinator User Manual

Indicator Questions	Justification Categories	Authority
Did monitoring occur at the required frequency during the year?	Met=Number of required monitoring forms were completed during the year; Unmet= Less than the required number of monitoring forms were completed during the year	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06
Did monitoring visits occur in person?	Met= At least one monitoring visit occurred face-to-face (during Appendix K) otherwise visits required to be completed in a variety of settings/services, either through teleconference or in person; Unmet= No monitoring visits were conducted face-to-face, either through teleconference or in person	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06
Is there documentation that verifies whether or not services were being delivered as specified in the PCP included in the person's LTSS*Maryland* record for each monitoring visit?	Met= At least one type of documentation was included in activity notes or client attachments to support that the CCS reviewed the PCP and Service Implementation Plan (SIP) with the person to see if services were being delivered based on their preferences, communication needs and SIP; Unmet= No supporting documentation for the monitoring of services was found	COMAR 10.09.48.06
Does Section 3, Progress Toward Outcomes, adequately describe progress on the participant's outcomes?	Met= All monitoring forms adequately describe progress on the participant's outcomes; Unmet= Not all monitoring forms adequately describe progress on the participant's outcomes	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06
If concerns related to possible abuse, neglect or exploitation were raised in monitoring visits, was	Met= No concerns raised; or concerns were raised and a corresponding incident report was submitted in PCIS2; Unmet= Concerns were raised and a	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06

Indicator Questions	Justification Categories	Authority
an incident report submitted?	corresponding incident report was not submitted in PCIS2	
Do monitoring forms include follow-up on all critical incidents that were submitted in PCIS2?	Met=All critical incidents that were filed in PCIS2 for the date range were followed-up on in the monitoring visits; Unmet= Not all critical incidents that were filed in PCIS2 were followed up on in the monitoring visits	LTSS – DDA CCS Coordinator User Manual; COMAR 10.09.48.06

Billing Claims Review:

Indicator Questions	Justification Categories	Authority
Does the activity note provide a description of only billable activities?	Met= The activity note only includes billable activities; Unmet= The activity note includes non-billable activities. Include the list of non-billable activities the note included using the proper code (Q/R/Z/etc.).	Coordination of Community Services Billing Documentation Verification Quality Review Guidance (Linked in the Billing Quality Review Memo)
Does the description in the activity note provide adequate detail to determine scope and duration of services provided?	Met=The description in the activity note provides adequate detail to determine the scope and duration of services provided; Unmet= The description in the activity note does not provide adequate detail to determine the scope and duration of services provided	Coordination of Community Services Billing Documentation Verification Quality Review Guidance (Linked in the Billing Quality Review Memo)

Indicator Questions	Justification Categories	Authority
Is there supporting documentation listed in LTSS*Maryland* associated with the activity note for the date of service?	Met= No supporting documentation is needed for this billing activity or there is supporting documentation listed in LTSS*Maryland* associated with the activity note for the date of service; Unmet = There is no supporting documentation listed in LTSS*Maryland* associated with the activity note for the date of service	Coordination of Community Services Billing Documentation Verification Quality Review Guidance (Linked in the Billing Quality Review Memo)

Appendix B: Billable/Non-Billable Activities List

CCS Billable vs Non Billable Timeline

2021 Billable vs Non Billable List for CCS Billing

2022 Billable vs Non Billable List for CCS Billing

Billable Activities include:

1. Services that assist eligible participants in gaining access to needed medical, social, educational and other services [Social Security Act 1905(a)(19), 1915(g); 42 CFR440.180 (c)

2. Periodic ongoing reassessment of individual needs, to determine the need for any medical, educational, social, or other services. (42 CFR 440.169(d)(1));

This includes:

(i) Taking client history.

(ii) Identifying the needs of the individual and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual."

3. Annual Person-Centered Plan planning, development and facilitation and necessary revisions (42 CFR 440.169(d)(2));

(i)Includes the discovery and exploration planning process to identify the personal outcomes and service providers who will establish goals to address the medical, social, educational, and other services needed by the individual.

(ii)Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized representative and others to identify their trajectory goals to their good life).

(iii) Identifies a course of action to respond to the assessed needs of eligible individuals.

(iv) includes successful entry of the plan into LTSS and submission to the DDA up to approval".

4. Referrals to services (42 CFR 440.169(d)(3));

Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the PCP".

5. Monitoring and Follow-Up activities (42 CFR 440.169(d)(4))

(i)Periodic reassessment of the individual's needs and progress on goals and outcomes are conducted minimally quarterly or more frequently based on the needs of the person.

(ii)Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family member, service providers, or other entities or individuals and conducted as frequently as necessary, and including monitoring, to determine whether the following conditions are met.

• Services are being provided in accordance with the individual's approved PCP;

• Services approved in the PCP are adequate; and

• Changes in the needs or status of the individual are reflected in the PCP. Monitoring and follow up activities include making necessary adjustments in the PCP and requesting Service Implementation Plan revisions from providers.

6. Successful contact with eligible people/family members with the express purpose of helping a Medicaid-eligible person access services. Contacts may be made through face-to-face, telephone, mail, email, and virtual contacts (telemedicine/virtual call platforms).

7. Contact with an ineligible person/family member with the express purpose of helping this person access services. Contacts may be made through face-to-face, telephone, mail, email, and virtual contacts (telemedicine/virtual call platforms). Also includes documentation of unsuccessful attempts to contact the person/family members via any of these methods. ("Ineligible is defined as individuals who may have lost eligibility or have challenges to becoming eligible)

8. Contact with non-eligible individuals or non-targeted individuals when directly related to eligible person's care ("non-targeted individuals" is defined as a person's chosen team members or others who are not receiving Medicaid services).

9. Case management activities provided in the last 180 consecutive days of a Medicaid eligible person's institutional stay if for the purpose of community transition (regardless of whether the person successfully transitions). In the unique situations where more than 180 days are required for transition, consult with the DDA to confirm billing.

Non-Billable Activities:

1. Activities performed that are an integral part of another covered Medicaid service.
2. Activities which constitute the direct delivery of underlying medical, education, social or other services to which an eligible person has been referred.
3. Services which constitute the administration of another non-medical program such as guardianship, child welfare or child protective services, parole and

probation functions, legal services, and special education (except case management included in IEP and individualized family services plan).

4. Contact with non-eligible or non-targeted individuals that are related to the identification and management of a non-eligible/non-targeted person's care unless the status is due to disenrollment or the person's need for emergency service planning.

5. Transportation of any participant.

6. Time receiving support/guidance from the DDA, LTSS Helpdesk, or internal CCS agency supervisory staff.

7. Coordinator training. This includes training received internally to the CCS agency, and through other entities including the DDA. Billing for training has been built into the administrative rate.

8. [**Non-Billable after Nov 1, 2022 only**] Billing documentation or associated billing activities (e.g., Time to enter activity noted in LTSSMaryland, Submission of state payment invoices)

9. [**Non-Billable after Nov 1, 2022 only**] Unsuccessful attempts to contact participants. This includes leaving telephone messages

Appendix C: Corrective Action Plan Request Template

Each deficiency requiring corrective action will be listed under the Corrective Action Plan Request Summary. See below an example of the Corrective Action Plan Request summary and the individual deficiency summary templates.

Corrective Action Plan Request Summary

Baltimore Provider

Quick View Information

Main

Date:
10/03/2023

Organization Name:
Baltimore Provider

Liberty Reviewer:
Jennifer Mettrick

Deficiencies:
Category: Service Planning; Area of Deficiency: Timing of Person Centered Plan Submission

Category: Staff Training; Area of Deficiency: Non-Billable services were included in the Activity Note

Corrective Action Plan Requirements:

For each area of deficiency, create a corrective action plan that addresses the following:

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Who, by job title, and how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Acceptance of Liberty's Corrective Action Plan or submittal of a Corrective Action Plan must be returned to Liberty Healthcare by (30 business days of the exit conference)

Evidence the Corrective Action Plan has been implemented within your organization must be submitted 30 business days after approval ***an official due date will be sent once Corrective Action Plan has been approved**

Deficiency Requiring Corrective Action

Baltimore Provider

Quick View Information

Deficiency Details:

Record ID
432392

Corrective Action Category
Service Planning

TCM Review Type:
Case File Review

Area of Deficiency:
Timing of Person Centered Plan Submission

Description:
The PCP was submitted 5 days before the Annual PCP date which does not meet the submission requirement of 20 business days prior to the Annual Plan Date

Indicator Questions Related to Deficiency:
CFR2 Was the plan updated within 365 days of the previous person-centered plan?

Factors:

Possible Internal Contributing Factors:
New CCS transitioned to the case during the PCP development process.

Possible External Contributing Factors:
CCS turnover

Plan

Recommended Corrective Actions:
Update case transition process to build in additional support and guidance for new CCSs to meet PCP submission requirements.

Corrective Action Status
In Progress

Link to Documentation Evidence

APPENDIX D: RESOURCES

RELEVANT DOCUMENTATION:

COMAR 10.09.48.06
Community Pathways Waiver- Appendix B-6
CCS Billable Activities Example List 2022
Person Centered Planning Policy (Policy Stat 10361724)
Case Note Documentation Training Module _7.22Finalpptx.pptx

LEGAL REFERENCES

Md. Code, Health Gen. Art § 7, Subtitle 10, 42 § CFR 441.715, 42 § CFR 441.720,

REFERENCE MATERIALS

COMAR Title 10 Subtitle 22 Developmental Disabilities
COMAR Title 10 Subtitle 9 Medical Care Programs (Medicaid)§ CFR 441.725, COMAR 10.22.05
COMAR 10.22.07
COMAR 10.09.48.06