Maryland
DEPARTMENT OF HEALTH

**Developmental Disabilities Administration**

**Self-Direction Utilization and Qualified Provider Review**

**Standard Operating Procedure Guidance**

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Revised Date: 10/15/2025

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

## Contents

## Audience

- Liberty Healthcare Corporation staff
- Developmental Disabilities Administration (DDA) staff
- People who self-direct their services and their support teams including Support Brokers, Coordinators of Community Services, employees, providers, vendors, family members and natural supports
- Financial Management and Counseling Services providers

## Purpose

The purpose of this guidance is to set forth applicable procedures for oversight and verification of provision of DDA funded self-directed services by qualified staff. This guidance outlines the Liberty Healthcare Corporation process to conduct utilization and qualified provider reviews of the Self-Directed Service Delivery Model. The reviews support fiscal integrity and financial accountability by evaluating compliance with Department standards related to billing, service delivery, and qualifications. Reviews also help to obtain insight into overall claims management by service category of self-directed paid claims.

## Definitions

A. "Claim" is a paid amount for a service on a particular date of service, for a particular participant and particular service.

B. "Documentation requirements checklist" is a list from Liberty Healthcare Corporation. It shows what information is needed - based on the type of service - from the Financial Management and Counseling Services provider. This information is used to complete a review to make sure services were used correctly and providers are qualified.

C. "Employee" is a person who is hired and paid to provide direct support services to a participant.

D. "Financial accountability" makes sure that payments are made for people who are eligible and for services that were approved, provided on the right date, and have the correct paperwork.

E. "Findings reports" are summaries from Liberty Healthcare Corporation that explain what was found after reviewing how services were used and if providers were qualified. There are two types of findings reports:

a. Initial Findings Report – This gives the Financial Management and Counseling Services provider a chance to send in more paperwork to show the payment was correct.
b. Final Findings Report – This gives the final decision about whether the payment followed the rules and was approved properly.

F. "Financial Management and Counseling Services provider" or "FMCS" are services provided to support a participant in the Self-Directed Services delivery model in using their budget authority and, if applicable, employer authority. Financial Management and Counseling Services include, but are not limited to:
   a. Processing claims for payment for Medicaid waiver program services in accordance with the participant's self-directed budget; and
   b. Verifying that the DDA provider, vendor, or employees meet all qualifications to provide the Medicaid waiver program service.

G. "Liberty Healthcare Corporation reviewer" is a qualified professional trained in conducting utilization and qualified provider reviews remotely and on site on behalf of Liberty Healthcare Corporation.

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

I. "LTSS*Maryland*" is an electronic data management system, developed and supported by the Department. It is used to create, review, and maintain records about:
   a. Eligibility status for services; and
   b. The participant's Person-Centered Plan, services, and funding authorized by the DDA.

J. "Organized Healthcare Delivery System" are agencies approved by DDA and who have authorization to subcontract with qualified providers to provide approved waiver services for individuals served through DDA.

K. "Participant" is an individual who is eligible to receive or is receiving DDA-funded services.

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

M. “Person-Centered Plan” is a written plan made together with the person who has a developmental disability who participates in or will participate in a Medicaid waiver program. This plan helps to the extent possible:

   a. Identify any special needs they have to stay healthy and safe;

   b. Figure out what the person wants to achieve; and

   c. Find services and providers that can help them reach their goals while being part of the community.

N. “Provider Managed” is a model where a licensed or certified agency, not the individual, is responsible for coordinating and delivering services like residential care, day programs, and other support.

O. “Recoupment” is when DDA requests a provider pay back a claim because it was improperly paid. Improper payment occurs when documentation requirements are not met for the claim billed.

P. “Self-directed services” means that participants, or their representative(s) if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

Q. “Self-directed service providers” are support brokers, employees, vendors or DDA providers who render services to a self-directed participant for a claim.

R. “Support Broker services” are services that provide information and advice to help participants who self-direct their services to make informed decisions related to day-to-day management of employees providing services.

S. “Utilization and qualified provider reviews” are reviews done after services are paid for to make sure DDA funds were used properly and that the staff who provided the services were qualified and trained.

T. “Vendor” is an individual or entity contracted by the participant and paid through an Organized Health Care Delivery System to provide a service to a participant enrolled in the Self-Directed Services Model.

## Overview

The Maryland Department of Health (MDH) manages Medicaid for the state. Within MDH, the Office of Long-Term Services and Supports makes sure that Medicaid Waiver programs follow all state and federal rules. The Developmental Disabilities Administration (DDA) is part of MDH and is responsible for funding and overseeing community services for people with developmental disabilities.

Maryland must show that it has a strong system in place to make sure Medicaid and state-funded programs use money the right way and follow all rules. References: 42 Code of Federal Regulations 441.302; 42 Code of Federal Regulations 441.303; 42 Code of Federal Regulations 441.308; 45 Code of Federal Regulations 74; Service Management and Monitoring 4442.8; Service Management and Monitoring 4442.10.

The Developmental Disabilities Administration (DDA) has hired Liberty Healthcare Corporation to carry out reviews after services have been paid for. These reviews help make sure that Medicaid and state funds are being used correctly for DDA services. (see Appendix I Financial Accountability in the approved Waiver applications). The reviews include:

- Looking at a random sample of paid claims for self-directed services
- Checking that the people and providers who delivered services were qualified to do so

These reviews, called utilization and qualified provider reviews, are meant to confirm that:

- The hours of service were actually provided
- The type of service matches what was approved

To do this, Liberty reviews documentation provided by the Financial Management and Counseling Services agency which includes DDA provider documentation as applicable, LTSSMaryland participant information, and required DDA forms. The review checks to make sure:

- The service was actually provided;
- The support hours used match what's written in the participant's Person-Centered Plan and were approved in the LTSSMaryland system;
- The staff who provided the service were properly trained and qualified.

Documentation requirements include the following:

- Required documentation listed for the specific service in DDA's Guidelines for Service Authorization and Provider Billing Documentation.
- Service documentation and staff qualification and training requirements specified in DDA's Self-Directed Services Policy & Manual and federally approved Medicaid Waiver Programs.

Liberty Healthcare Corporation reviewers follow a detailed process outlined below in the section titled **Self-Direction Review Process**. The process includes information related to notifications, documentation requests, findings reports and the process for participant interviews if applicable.

## Applicability

This guidance applies to all information added to the participant's record in LTSSMaryland, including their Person-Centered Plan, service approvals, and billing details. It also applies to service records sent to the Financial Management and Counseling Services (FMCS) provider for the claims being reviewed. Each claim is checked carefully by Liberty Healthcare Corporation using a detailed, step-by-step instructional guide.

## Sample Selection Process

How participants are chosen: The annual sample is chosen using a random selection method that provides a 95% confidence level (meaning it gives very reliable results) with a 5% margin of error. This sample is for all claims. This means it includes claims from self-direction and provider managed claims.

When one service has more claims, more claims for that type of service are selected in the sample. When one service has less claims, less claims for that type of service are selected in the sample.

How the sample size is calculated: A tool called Raosoft is used to figure out how many claims should be reviewed. It calculates the total number of claims needed each year, and then that number is divided by 4 to create the number of quarterly reviews. Participants may be included in the review if their annual Person-Centered Plan date is within the review quarter.

Timing of reviews: The table below gives examples of when claims are reviewed. For example, if a service was paid for between July 1, 2025, and September 30, 2025, Liberty Healthcare reviews those claims between November 1, 2025, and January 31, 2026.

| Quarterly Sample Period: Dates of Paid Claims | Quarterly Review Period: Utilization & Qualified Provider Reviews |
|---|---|
| July 1, 2025 - September 30, 2025 | November 1, 2025 - January 31, 2026 |
| October 1, 2025 - December 31, 2025 | February 1, 2026 - April 30, 2026 |
| January 1, 2026 – March 31, 2026 | May 1, 2026 – July 1, 2026 |
| April 1, 2026 – June 30, 2026 | August 1, 2026 – October 31, 2026 |
| July 1, 2026 – September 30, 2026 | November 1, 2026 – January 31, 2027 |

## Self- Direction Review Process

**PRE-REVIEW ACTIVITIES:**

**Step 1:** Quarterly claim sample is pulled and uploaded into LibertyTraks.

**Step 2:** Claims are assigned to reviewers at Liberty Healthcare Corporation. The reviewer prepares for the review by gathering information about the participant. This includes basic details like the participant's name, and other background information, which come from LTSSMaryland. This helps the reviewer build the case file before starting the full review.

**Step 3:** During the first week of each quarterly review period, the Liberty Healthcare reviewer sends a secure email notification to the primary contact at the Financial Management and Counseling Services provider. The email informs them that certain claim(s) are being reviewed and includes:

- The date of service;
- The type of service; and
- The name of the participant who received the service.

The email also asks the Financial Management and Counseling Services provider to send:

- Service documentation;
- Staff training records; and
- Proof that the staff were qualified to provide the service.

The reviewer asks the Financial Management and Counseling Services provider to confirm they received the email. If there's no response within three business days, the reviewer calls to make sure they have the correct contact information.

The email has a list of all documents needed to complete the review. This includes:

- Required documentation listed for the specific service in DDA's Guidelines for Service Authorization and Provider Billing Documentation.
- Service documentation and staff qualification and training requirements specified in DDA's Self-Directed Services Policy & Manual and federally approved Medicaid Waiver Programs.

**UTILIZATION REVIEW ACTIVITIES:**

**Step 1:** The Financial Management and Counseling Services provider has 15 business days to send the requested documents. Liberty Healthcare reviewers get reminders from their system (LibertyTraks) about when the documents are due. If the Financial Management and Counseling Services provider doesn't send the documents on time, the review still moves forward using the information available in LTSSMaryland.

**Step 2**: When the Financial Management and Counseling Services provider sends the requested documents, the Lead Reviewer at Liberty Healthcare uploads them into the review system (LibertyTraks) within 3 business days. Reviews are started in the order the documents are received, and each review is finished within 3 business days of starting. All initial reviews are finished by week 8 of the quarterly review period. After all reviews are done, Liberty Healthcare shares the results with the Financial Management and Counseling Services providers.

**Step 3**: Reviewers complete initial reviews to determine if the services outlined in the participant's Person-Centered Plan have been delivered, documented, billed, and paid as required, as well as provided by qualified employees, vendors and/or providers. **See attached Appendix B: Indicator Questions/Authority Table**.

**Step 4**: Liberty Healthcare Corporation Supervisors check the quality of at least 10% of the reviews to make sure each step was done correctly, following the review guide. These reviews are randomly chosen when the cases are first added into the LibertyTraks system. If a reviewer's accuracy is below 85%, they receive coaching and training to improve. If any mistakes are found during the quality check, the review results are updated to show the correct information and evidence.

**Step 5**: Initial findings reports are created using LibertyTraks and sent by secure email to Financial Management and Counseling Services providers. These reports include both what was done correctly and what still needs more documentation.

A. Unmet findings include situations where:
    a. Fewer services were provided than what was billed;
    b. The services provided were not the same as what was billed for;
    c. There is no proper documentation to show that the services were actually provided;
    d. There is no proof that staff had the required training before giving services;
    e. There is no proof that staff met the required qualifications before giving services.
B. The initial finding report is sent during the ninth week of the quarterly review period.
C. If any issues are found in the initial review, the report lists each one and show which claims need more documentation. It asks the Financial Management and Counseling Services provider to send additional documents to address issues.
D. It's recommended that the Financial Management and Counseling Services provider schedule a meeting with Liberty Healthcare Corporation by week 9 of the review period to go over any issues found and the documents needed.

**Step 6**: The Financial Management and Counseling Services provider has five business days to send in additional documents to help address any issues listed in the initial findings report.

**Step 7:** Once Liberty Healthcare Corporation receives the additional documents from the Financial Management and Counseling Services provider, a reviewer decides if the documents meet the requirements. If they do, the issue is marked as resolved in the final findings report.

**Step 8:** Final findings reports are sent by secure email to the Financial Management and Counseling Service provider within 15 business days after the quarterly review period ends.

**Step 9**: Depending on how many issues are found, it is decided whether to request an interview with the participant or their representative. An interview may be recommended if:

- No service records were submitted for any of the claim(s) reviewed; or
- No proof of staff training or qualifications was submitted for any of the claim(s) reviewed.

The reviewer tries up to three times to contact the participant or their representative to schedule a remote or in-person interview. If the reviewer can't reach the participant directly, they contact the participant's Financial Management and Counseling Service provider at least once. They may also reach out to Coordinators of Community Services or other people listed in the participant's profile in LTSSMaryland to help set up the interview.

These short interviews (less than 30 minutes) are meant to make sure the services match what's written in the Person-Centered Plan in terms of type, amount, and how often they happen. The interviews also help understand why any issues (unmet findings) were found. The information gathered is used to confirm review results and to help improve support and fix common problems.

Reviewers from Liberty Healthcare Corporation are required to report any health or safety concerns they learn about during the interview, following DDA's rules on reportable incidents.

Before the interview, the reviewer asks the participant or their legal representative or guardian for verbal permission. Interviews can be in person or virtual, depending on what the participant prefers. Family members, supporters, guardians, or other important people can join if the participant wants. If the participant or their guardian does not agree, the interview will not happen.

The final findings report states whether a participant interview was requested. If no interview is needed, the review is considered complete.

**Step 10**: The final findings report is sent to the main contact at the Financial Management and Counseling Service provider within fifteen (15) business days after the end of the fiscal quarter. The report is also uploaded to the Google Drive for review by the DDA Statewide Coordinator of Self-Directed Services, Financial Management and Counseling Services contract monitor and Quality Improvement Organization contract monitor.

**Step 11:** The reviewer writes a summary of the interview(s) and includes it with the final findings report. This helps provide guidance to the Financial Management and Counseling Services (FMCS) administrative team. If the FMCS provider asks for it, a virtual exit conference can be scheduled to offer support and help create a plan to fix any issues. The exit conference is held within five business days after the participant interview(s) are completed.

**Step 12**: Liberty Healthcare Corporation asks for a Corrective Action Plan if any of the following issues are still not resolved:

- The documents did not prove that the service was paid for properly, and/or
- The staff who provided the service did not meet training or qualification requirements on the date the service was given; and
- The Financial Management and Counseling Services provider does not already have a Corrective Action Plan in progress for the same issue from a past quarter. A Corrective Action Plan is considered “in progress” if it or the required follow-up documents (called Evidence of Implementation) have not yet been submitted or approved within the required timeframe.

If a Corrective Action Plan is needed, Liberty Healthcare Corporation notifies the Financial Management and Counseling Service provider by email. The Quality Improvement Organization and Financial Management and Counseling Services contract monitors are also notified. This notice is sent with the final report within 15 business days after the review period ends.

If a Corrective Action Plan is required, the Financial Management and Counseling Service provider must submit it to the Liberty Healthcare Corporation reviewer for approval within 30 business days of the request. Liberty reviews the plan to make sure it’s complete and accurate. The Financial Management and Counseling Service provider receives notice within 15 business days to let them know if the plan is approved.

If the plan is not approved, the Financial Management and Counseling Services provider gets written feedback(edits) explaining what needs to be fixed. The provider then has 15 business days to send an updated Corrective Action Plan to Liberty Healthcare Corporation.

Once the plan is approved, the Financial Management and Counseling Services provider gets written confirmation. They then have 30 business days to send proof to Liberty Healthcare Corporation that the plan has been put into action.

If more than 30 business days are needed, the provider can request extra time in writing when they submit the plan. Liberty Healthcare Corporation decides whether to approve the request.

If the evidence is not approved, the Financial Management and Counseling Services provider gets written feedback within 15 business days explaining what needs to be corrected. The provider then has 15 business days to send updated evidence to Liberty Healthcare Corporation.

Liberty Healthcare Corporation continues to monitor until the Corrective Action Plan is fully carried out (implemented). Once the plan is complete, Liberty sends an acceptance letter by secure email to the Financial Management and Counseling Services provider within 5 business days. Copies of the letter are also sent to the DDA Quality Improvement Organization contract monitor, the FMCS contract monitor, and the DDA Statewide Coordinator for Self-Directed Services.

If Financial Management and Counseling Services providers do not respond to Liberty Healthcare Corporation's requests for a Corrective Action Plan or proof that it was completed after three attempts to contact them, Liberty reports this to the Quality Improvement Organization contract monitor. The monitor decides if the plan should be considered abandoned. Providers who don't respond may face penalties from the Maryland Department of Health.

If a Financial Management and Counseling Services provider already has a Corrective Action Plan in progress from a previous quarter for the same issue, they will not receive a new plan. The provider must keep working on the current Corrective Action Plan until it is finished.

When a Financial Management and Counseling Service provider has repeated unmet findings for the same deficiency, new strategies are required in the Corrective Action Plan.

The Quality Improvement Organization contract monitor keeps all documents in a DDA Shared Google Drive.

**Step 13:** DDA requests recoupment (repayment by the provider) for claims when proper payment cannot be verified. This includes:

- Claims with no service documentation submitted by the provider;
- Claims with service documentation that did not meet the requirements listed in DDA's Guidelines for Service Authorization and Provider Billing Documentation and/or Self-Directed Services Manual Self-Directed Services Manual when applicable;
- Claims where the participant was not eligible on the date of service;
- Claims where the service was not authorized on the date of service for the participant;
- Claims where the participant was not eligible on the date of service.

Recoupment notification is sent by DDA directly to the provider. The following steps are used:

- DDA's Quality Improvement Organization contract monitor provides the DDA Headquarter's fiscal department with the recoupment report which outlines the reasons why the claim is eligible for recoupment;
- 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 gives the provider 14 calendar days to appeal the unsupported payment and provide documentation that satisfies the DDA's request;
- If, by the end of the 14 calendar days, the provider was unable to provide documentation that qualifies the payment, an invoice and payment instructions are emailed to the provider.

The process for appeal and repayment of claims is outlined in DDA's recoupment communication.

# Corrective Action Templates

## Corrective Action Plan Request Summary

### Baltimore Provider

Quick View Information

Main

**Date:**
10/02/2023

**Organization Name:**
Baltimore Provider

**Liberty Reviewer:**
Jennifer Mettrick

**Reviewed Service(s):**
Community Development Services Group (1-4)

**Deficiencies:**
Category: Policies and Procedures; Area of Deficiency: Missing documentation

**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**
432397

**Corrective Action Category**
Policies and Procedures

**Area of Deficiency:**
Missing documentation

**Description:**
Documentation did not include start and end times for the service and timesheet documentation to verify staff worked on the date of service was not submitted.

**Indicator Questions Related to Deficiency:**
UR1a: If applicable, was the date of service with start and end times included in service documentation?

#### Factors:

**Possible Internal Contributing Factors:**
Quality oversight process not in place for reviewing service documentation prior to billing submissions.

**Possible External Contributing Factors:**
Provider not receiving regular communications from DDA and was not using the Service Authorization and Billing guidance issued by DDA.

#### Plan

**Recommended Corrective Actions:**
Develop and implement a quality oversight process to review service documentation prior to billing.

**Corrective Action Status**
In Progress

**Link to Documentation Evidence**

## Medicaid Fraud

If there are widespread or possibly intentional billing problems, the DDA may report the Financial Management and Counseling Services provider, employee, vendor, DDA provider, or team member to the Office of Internal Audit Controls, Audit Compliance & Information Security.

## Appendix A: Communication

Good communication is key to a successful review. The list below shows the types of messages used to keep Financial Management and Counseling Services providers and participants involved throughout the review process.

| Outreach | | | |
|---|---|---|---|
| Document | Definition/Purpose | Timing | Audience |
| Notification and Initial Checklist of Requested Documents | List of documents sent notifying of required documents needed to complete the review | Emailed at the start of the review. Provides a specific list of documents that are required from the Financial Management and Counseling Services provider to begin the review | Financial Management and Counseling Services |
| Initial Report | Communication sent with initial results of the self-directed review | Emailed mid-review if supplemental documentation is required | Financial Management and Counseling Services |
| Findings Report | Communication sent with finalized results of the Self-Directed Services Review(s) | Completion of the review period | Financial Management and Counseling Services |

## Appendix B: Indicator Question/Authority Table

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| **Is the claim supported by documentation that services were delivered?** | *** All responses to the sub questions below must be Met in order for the response to this indicator question to be Met.*** | | |
| | If applicable, was the date of service with start and end times included in service documentation? | Met = a **timesheet/invoice** with the service name, date, start and end times<br><br>Unmet= any missing documentation listed above | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services policy and manual |
| | Do all service documents identify the correct participant for the claim? | Met = timesheet/ invoice with the correct participants name<br><br>Unmet = documentation with missing or incorrect participants name, or no service documentation submitted | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services policy and manual |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| | Was service documentation consistent with the Guidelines for Service Authorization and Provider Billing Documentation and, if applicable, Self-Directed Policy/Manual? | Met = documentation including name of staff who provided service, and a list of tasks completed<br><br>OR invoice including vendor name, number of hours/units, name of staff who provided service, description of tasks completed, total amount charged<br><br>AND verified service specific documentation required as part of the DDA Guidelines for Service Authorization and Provider Billing Documentation<br><br>Unmet = 1 or more missing documentation requirements | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Guidelines for Service Authorization and Provider Billing Documentation<br><br>Self-directed services policy and manual |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| | Does the timesheet/invoice confirm the staff worked on the date of service and during the time-of-service delivery (if applicable)? | Met = Electronic Visit Verification confirmed the staff worked on the date of service and during the time-of-service delivery or an Electronic Visit Verification exemption form was approved for the date of service<br><br>Unmet = documentation was not submitted or did not verify date of service and time of service delivery | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services policy and manual |
| | Was the timesheet/invoice approved by the participant or their designated representative? | Met = verification timesheet/invoice of approval by the participant or designated representative as listed in the current participant agreement<br><br>Unmet = timesheet/invoice was not approved by anyone or was approved by someone other than the participant or designated | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services policy and manual |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| | | representative | |
| **Was the person eligible on the date of service and was the service authorized in the Person- Centered Plan?** | *** Both responses to the two sub questions below must be Met in order for the response to this indicator question to be Met.*** | | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery |
| | Was the person eligible on the date of service? | Met = participant was eligible on the date of service.<br><br>Unmet = date of service falls outside of the eligibility span | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery |
| | Was the service authorized in the Person-Centered Plan? | Met = the service was authorized in the Person-Centered Plan on the date of service.<br><br>Unmet = date of service falls outside of the service authorization or was not authorized in the budget sheet | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| | | | policy and manual |
| | Did the authorized service meet service authorization criteria? | Met: Documentation verifies service was authorized properly<br><br>Unmet: Documentation cannot verify service was authorized properly<br><br>*This question is not used to issue Corrective Action or recoup claims. | Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery<br><br>Self-directed services policy and manual<br><br>Guidelines for Service Authorization and Provider Billing Guidelines |
| **Was the claim coded and paid for in accordance with the reimbursement methodology specified in the approved waiver?** | | Met = claim was coded and paid for accurately as evidenced by use of an accurate waiver code, within the reasonable and customary rates, number of units match units of service provided, entire claim amount is within traditional service maximum rates, and if applicable, had an approved wage exception form. | Home and Community-Based Services 1915 (C) Waiver Appendix I: Financial Accountability; Quality Improvement: Financial Accountability<br><br>Self-directed services policy and manual |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| | | Unmet = claim was not coded and/or paid correctly | |
| **Did the staff who delivered services meet all required training qualifications on the date of service?** | | Met = submitted documentation indicates services were delivered by trained staff on the date of service.<br><br>Unmet = submitted documentation does not verify that services were delivered by trained staff on the date of service | Home and Community-Based Services 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service<br><br>Self-directed services policy and manual |
| **Did the staff who delivered services meet all qualifications on the date of service?** | | Met = submitted documentation indicates services were delivered by qualified staff, and if applicable, qualified provider, on the date of service<br><br>Unmet = submitted documentation does not verify that services were delivered by qualified staff, and if applicable, qualified provider, on the date of service | Home and Community-Based Services 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service<br><br>Self-directed services policy and manual |

| Indicator Question | Sub-Question | Justifications | Authority |
|---|---|---|---|
| **Verification of DDA approved provider application for the service delivered, if applicable** | | Met = submitted a DDA approved provider application including approval to provide the service delivered<br><br>Unmet = provider application with applicable service is not verified | Home and Community-Based Services 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service<br><br>Self-directed services policy and manual |

## Appendix C: References

**RELEVANT DOCUMENTATION:**

Authorized Home and Community-Based Services 1915 (C) Waivers (Appendix C, D, and I)

Self-Directed Services Comprehensive Policy

Self-Directed Services Manual

**REFERENCE MATERIALS**

Code of Maryland Regulations Title 10 Subtitle 22 Developmental Disabilities