Maryland
DEPARTMENT OF HEALTH

Developmental Disabilities Administration

Utilization and Qualified Provider Review

Standard Operating Procedure Guidance

Issue Date: 3/30/2023

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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
- Maryland licensed and certified service providers

Purpose

This guidance outlines the Liberty Healthcare Corporation process to conduct documentation and targeted onsite reviews to evaluate DDA performance measures related to:

- Billing and service documentation (review of paid claims for proper payment)
- Staff qualifications
- Provider licensing/certification process

The purpose of this guidance is to set forth applicable procedures for oversight and verification of provision of DDA funded services and obtain insight into overall claim management, service documentation and provider qualifications by service category.

The DDA is committed to fiscal integrity and responding proactively to identify and address systemic deficiencies and therefore ensure a stable, transparent, and accountable billing, utilization and Qualified Provider process.

Definitions

A. "Claim" means a paid amount for a day of service on a particular date of service, for a particular participant and particular service (i.e., a claim covers all units paid for the date of service)

B. "DDA Provider" means an individual or entity, licensed or certified/approved by the Maryland Department of Health, that furnishes DDA-funded services to applicant(s) or participant(s) in accordance with the DDA's requirements and, if furnishing Waiver program services, enrolled as a provider in the Medicaid Program.

C. "Documentation Requirements Checklist" means a document listing all necessary information required by service type from a DDA Provider to complete a Utilization Review/Qualified Provider Review.

D. “Financial Accountability” means the assurance that DDA payments are made only for eligible participants, for authorized services on a date of service and follow all billing documentation requirements.

E. “Findings Report” means the resulting summary of findings and determinations rendered during the review. There are two types of findings reports, (1) Initial findings reports – give providers an opportunity to submit appropriate supplemental or corrected documentation to substantiate proper payments for claims reviewed (based on Billing and Service Documentation only, not staff qualifications (2) Finalized findings reports will provide the final determinations on if standards were met for each indicator question in the reviews and if any claims were found to be improper payments and subject to recoupment.

F. “Improper Payment”. If at final review, provider billings are determined to have unmet standards (e.g., improper payment), the DDA will recoup the amount of the claim.

G. “LTSS*Maryland*” means an 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, the participant’s person-centered plan, and services and funding authorized by the DDA.

H. “Liberty Reviewer” means a qualified professional trained in conducting utilization and qualified provider reviews both remotely and on site on behalf of Liberty Healthcare Corporation.

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. “Participant” means an individual enrolled in, and receiving, DDA-funded services.

K. “Pending” means that an Unmet finding can be remediated with supplemental/corrective documentation.

L. “Person-Centered Plan” or “PCP” means a written plan that is developed by a planning process driven by the individual with a developmental disability to:

    a. Identify the goals and preferences of the individual Identify services to support the individual in pursuing the individual’s personally defined outcomes in the most integrated community setting.

b. Direct the delivery of services that reflect the individual's personal preferences and choice; and
c. Identify the individual's specific needs that must be addressed to ensure the individual's health and welfare.

M. "Qualified Provider" means a provider that completes the licensing/certification process as specified by the DDA and ensures only qualified staff/vendors provide services.

N. "Remote Review" means a desk review of randomly selected claims and when applicable the provider's most recent licensing/certification process based on documentation submitted by a DDA provider, DDA regional licensing/certification tracking and information found within LTSS*Maryland* and/or PCIS2. The Remote Review will determine if sufficient documentation is present to support paid claims, staff qualifications and provider qualifications and will assess the accuracy of paid claims vs published rates for the service.

O. "Onsite Review" means conducting onsite visits to DDA providers that include interviews with the participant and/or representatives from their team, staff and administrators. The purpose of the onsite review is to evaluate the root causes of improper paid claims and unmet staff and provider qualification standards identified as part of the Remote Reviews to support the provider in developing a corrective action plan to reduce the recurrence of future unmet standards. Onsite Reviews will be determined by the DDA's prioritization of unmet findings (see below criteria in the Onsite Review Process). DDA providers will be notified if an onsite review is required.

P. "Utilization Review" refers to the claims review component of the Utilization/Qualified Provider review and includes the review of claims for the purpose of ensuring Financial Accountability performance measures and determining if the claim was paid properly.

Overview

The Maryland Department of Health (MDH) is the single state agency for Medicaid. The MDH's Office of Long-Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations related to the operation of the Waivers. The MDH's Developmental Disabilities Administration (DDA) is the Operating State Agency (OSA) and funds community-based services and supports for people with developmental disabilities. The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the

waiver programs and the state only funded programs as well as ensure all services are provided by qualified providers. AUTHORITY: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 4442.8; SMM 4442.10.

The Developmental Disabilities Administration (DDA) has contracted with Liberty Healthcare Corporation to conduct a series of post-payment reviews (utilization reviews outlined below) to ensure the integrity of payments made across all Home and Community-Based Waiver and state only funded services (see Appendix I Financial Accountability in the approved Waiver applications). In addition, DDA also contracted with Liberty to ensure all DDA services are provided by Qualified Providers and staff. The Utilization/Qualified Provider reviews include the following:

- Review of randomly selected paid claims for financial accountability (*may include claim recoupment for improperly paid claims*)
- Review of staff qualifications for dates of service of the randomly selected paid claims for providers randomly selected to be reviewed in the Qualified Provider sample (unmet staff qualification standards will not be tied to recoupment of paid claims).
- Review of the provider's most recent licensing or certification process to ensure applications were submitted timely, were processed timely and contained complete documentation based on initial and renewal requirements.
- Onsite reviews conducted at DDA provider organizations when multiple unmet standards are identified (see criteria listed below in the Utilization/Qualified Provider Process section)

Utilization (Claims) Review

As stated in the Waivers, the claims review component of the reviews are designed to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for were provided to the participant. The reviews will consist of reviewing provider furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the participant's Person-Centered Plan (PCP), and Service Funding Plan (SFP) or Detailed Service Authorization (DSA) in LTSS*Maryland*.

The scope of the reviews is limited to a statistically valid sample of claims by service on a quarterly basis with a 95% +/-5% confidence interval.

Qualified Provider Review

Also stated in the Waivers, is the requirement for providers to gain and maintain licensure or certification and ensure staff meet all qualifications listed in Appendix C. of the Waivers.

The Qualified Provider Review will consist of two components.

- Staff/vendor training and qualification review based on dates of service of the claims reviewed in the claim sample for those providers also selected in the Qualified Provider review
- Review of the provider's most recent licensing or certification process to ensure applications were submitted timely, were processed timely and contained complete documentation based on initial and renewal licensing/certification requirements.

A statistically valid sample (with a 95% +/- 5% confidence interval) of providers for the Qualified Provider component of the review will be based on those providers with randomly selected claims in the sample that had licensure/certification renewal dates during the quarter the claims sample is pulled.

Liberty Healthcare reviewers will be requesting and reviewing information from DDA providers as part of the combined Utilization/Qualified Provider Reviews. The documentation requirements include the following:

- Required documentation listed for the specific service in DDA's Guidelines for Service Authorization and Provider Billing Documentation
- When applicable, **Employee Timesheet** for the employee that provided the service for the claim
- When applicable, **Employee Training Records** for DDA Required Trainings not found in the most recent licensing/certification materials submitted to DDA/OHCQ including Employee Date of Hire, original training completion dates, and updated training dates (when applicable)
- When applicable for providers selected in the qualified provider sample, verification documentation for required staff qualifications as listed in Appendix C of the Waivers for the service (e.g., applicable background check) not found in the most recent licensing/certification materials submitted to DDA/OHCQ
- When applicable for providers selected in the qualified provider sample, provider licensing/certification documents not found in the most recent licensing/certification materials submitted to DDA/OHCQ

Liberty reviewers will follow a detailed process outlined below in the section titled **Utilization/Qualified Provider Review Process**. The process includes information related to provider notifications, documentation requests, findings reports and the process for onsite visits if applicable.

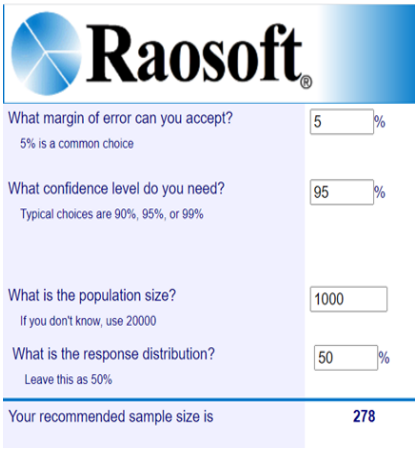
APPLICABILITY

This guidance applies to all information documented and uploaded into the participant's record in LTSS*Maryland* related to their person-centered plan and service authorization as well as billing documentation in LTSS*Maryland* or PCIS2. It also pertains to the service documentation submitted by the DDA provider organization for the selected claims under review. Each claim is reviewed using a detailed step by step instructional guide by Liberty Healthcare Corporation reviewers. The guide includes the review of the claim for financial accountability (proper payments) and for the verification of staff qualifications as outlined in Appendix C of the Waivers (unmet staff qualification standards will not be tied to recoupment of paid claims). In addition, a detailed step by step guide will be followed in reviewing the timeliness and completeness of the most recent provider licensure/certification process.

SAMPLE SELECTION PROCESS

Claims Sampling:

The claims component of the review will be conducted on a random sample of claims proportional to Waiver, region and service types as a discovery method for the financial accountability sub-assurance performance measures.



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). It will generate the total number of claims that must be randomly selected annually and then divided by 4 for the quarterly review for each Waiver and State Only Funded program and then proportionately distributed by service type. The minimum sample size will be generated when the total number of claims for the chosen review is entered into the population field.

Special Sampling Notes –

1. **Baseline**: the minimum quarterly sample size of claims will be reviewed from April-June 2023. The claims will be selected from an 18-month lookback period based on service date of the claim. An estimated 450 randomly selected claims will be reviewed from the selection period July 1, 2021 through December 31, 2022.

2. **Full Implementation/Regular Quarterly Reviews**: Annual Sample Size/4 of paid claims must be reviewed quarterly and will be pulled from two quarters prior from the time of review. An estimated 450 randomly selected claims per quarter will be reviewed beginning FY24Q1 (Paid claims from FY23 Q3 – January-March 2023).

The table below provides the Dates of Service for the claims that will be reviewed by Liberty and the time period they will be reviewed over the first year of Utilization Reviews.

Paid Claims Pulled From [Date of Service Time period]	**Claims Reviewed During [Review Time Period]**
July 1, 2021 - December 31, 2022 (**Baseline -*18 month look back review***)	March 15, 2023 - June 30, 2023
January 1, 2023 - March 30, 2023 (***begin regular quarterly reviews***)	July 1, 2023 - September 30, 2023
April 1, 2023- June 30, 2023	October 1, 2023 - December 31, 2023
July 1, 2023 - September 30, 2023	January 1, 2023 - March 31, 2024
October 1, 2023 - December 31, 2023	April 1, 2024 - June 30, 2024

An estimated 450 claims per quarter will be reviewed (see example quarterly sample below).

Service Type	**CP**	**CS**	**State** Funded	**FS**	**Total**
Assistive Technology and Services	1	1	0	1	3
BSS - Behavioral Assessment	1	1	0	1	3
BSS - Behavioral Consultation	1	1	0	1	3
BSS - Behavioral Plan	1	1	0	1	3

Service Type	CP	CS	State Funded	FS	Total
BSS - Brief Support Implementation	1	1	0	1	3
Career Exploration Services	1	1	1	0	3
Community Development Services	9	25	6	0	40
Community Living	43	0	28	0	71
Day Habilitation	20	19	13	0	52
Employment Discovery and Customization	1	1	0	0	2
Employment Services	8	15	36	0	59
Environmental Assessments	1	1	0	1	3
Environmental Modification	1	1	0	1	3
Family and Peer Mentoring Supports	1	1	0	0	2
Family Caregiver Training and Empowerment	1	0	0	1	2
Housing Support Services	1	1	1	0	3
Individual and Family Directed Goods & Services	1	1	0	1	3
IFDG&S - Staff Recruitment & Advertising	1	1	0	1	3
Live In Caregiver Supports	1	0	0	0	1
Nursing	1	1	1	1	4
Other	0	0	1	0	1
Participant Ed, Training, and Advocacy	1	0	0	0	1
Personal Supports	14	35	12	82	143
Remote Support Services	1	0	0	0	1
Rent - Individual Support	0	0	1	0	1
Respite Care Services	1	2	0	8	11
Respite Care Services - Camp	1	1	0	1	3
Respite Care Services - Day	1	1	0	1	3
Respite Care Services - Hour	1	1	0	1	3
Shared Living	1	0	1	0	2
Support Broker	1	1	0	3	5
Supported Living	3	0	3	0	6
Transition Services	1	0	0	0	1
Transportation	1	1	1	1	4
Vehicle Modification	1	0	0	1	2
Grand Total	**124**	**115**	**105**	**109**	**453**

Qualified Provider Sampling:

The qualified provider component of the review will be conducted on a random sample of licensed and certified providers whose initial licensing/certification or renewal fell within the review period.

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). It will generate the total number of licensed and certified providers that must be randomly selected annually and then divided by 4 for the quarterly review. The minimum sample size will be generated when the total number of licensed and certified providers for the chosen review is entered into the population field.

Calculation of Newly Enrolled and Currently Enrolled Samples:

Total Provider Population

Certified/Licensed	Newly Enrolled (Waiver Start Date < 1 year)	Currently Enrolled (Waiver Start Date >= 1 year)	Grand Total
Certified	19	74	**93**
Licensed	2	223	**225**
Grand Total	**21**	**297**	**318**
Sample Size	**21**	**168**	

Quarterly Sample Size

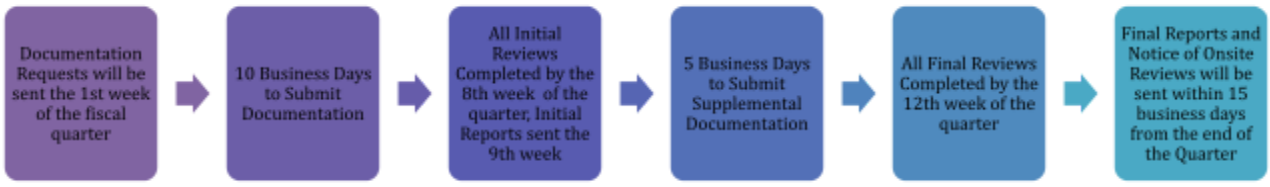
Certified/Licensed	Newly Enrolled (Waiver Start Date < 1 year)	Currently Enrolled (Waiver Start Date >= 1 year)	Grand Total
Certified	5	11	**16**
Licensed	1	32	**33**
Grand Total	**6**	**43**	**49**

Sampling will be proportionate to providers that “are” and “are not” classified as OHCDS providers. Below is the breakdown of the number of OHCDS providers.

Cert/Licensed	Number of OHCDS	Number of Non-OHCDS
Certified	9	2
Licensed	26	6
Grand Total	**35**	**8**

Staff training and qualifications on dates of service of selected claims will be reviewed for providers selected in the Qualified Provider sample.

UTILIZATION/QUALIFIED PROVIDER REVIEW PROCESS



PRE-REVIEW ACTIVITIES:

Step 1: Quarterly claim sample will be pulled and uploaded into LibertyTraks.

Step 2: Claims associated with providers selected in the qualified provider sample will include review of staff training and qualifications. Claims associated with providers not selected in the qualified provider sample will only be reviewed for financial accountability (e.g., Proper payment).

For newly licensed/certified providers during the review period, only the licensure/certification component of the reviews will be conducted.

Step 3: A lead reviewer will be assigned to each provider included in the claims and qualified provider samples. The lead reviewer will communicate and coordinate with the provider for both types of reviews as applicable (*claims and qualified provider reviews*). Lead reviewers also will be the reviewer that conducts onsite reviews when applicable.

Step 4: Claims will be evenly assigned across Liberty reviewers in LibertyTraks to enable them to begin building 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 5: During the first week of each quarterly review period, the Lead reviewer will send an email notification to the primary contact at the DDA Provider organization informing them of the review of the specified claim(s), which will include the date of service, service type and participant who received the service. They also will inform the provider if they were selected as part of the Qualified Provider review. The Lead reviewer will request required service documentation in relation to the claim using the DDA's Guidance for Service Authorization and Provider Billing Documentation as well as staff training and qualification documentation if applicable. The email notification will request confirmation of receipt. If confirmation is not received within three (3) business days, the Lead reviewer will call the provider organization to verify primary contact information.

Documents needed to complete the reviews include:

A. Required documentation listed for the specific service in **DDA's Guidelines for Service Authorization and Provider Billing Documentation**
B. When applicable, **Employee Timesheet** for the employee that provided the service for the claim
C. When applicable for providers selected in the qualified provider sample, **Employee Training Records** for DDA Required Trainings not found in the most recent licensing/certification materials submitted to DDA/OHCQ including Employee Date of Hire, original training completion dates, and updated training dates (when applicable) to confirm the employee was qualified to provide services on the date of service of the paid claim
D. When applicable for providers selected in the qualified provider sample, verification documentation for required staff qualifications as listed in Appendix C of the Waivers for the service (e.g., applicable background check) not found in the most recent licensing/certification materials submitted to DDA/OHCQ.

E. When applicable for providers selected in the qualified provider sample, provider licensing/certification documents not found in the most recent licensing/certification materials submitted to DDA/OHCQ

Step 6: DDA Providers have ten (10) business days to respond to documentation requests. LibertyTraks will provide reviewers with alerts of when documentation is due. If a provider fails to submit requested documentation, the review will be initiated with the documentation that is available in LTSS*Maryland*.

Step 7: The Lead Reviewer will upload the documentation submitted by the DDA provider to LibertyTraks within three (3) business days of receiving it. Reviewers will begin reviews in the order they receive requested documentation and will complete reviews within three (3) business days of starting a review. All initial reviews will be completed by week eight (8) of the quarter.

REMOTE REVIEW ACTIVITIES:

Step 8: Reviewers will complete remote claims and qualified provider reviews to determine if the services outlined in the individual's Person-Centered Plan have been delivered, documented, billed, and paid as required, as well as provided by qualified providers and staff when applicable. (**See attached Appendix B, Indicator Questions/Authority Table**).

Step 9: Quality control checks on at least 10% of reviews will be conducted by Liberty supervisors 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 training will be provided to reviewers not meeting the 85% or higher accuracy threshold. Findings will be adjusted accordingly to accurately reflect the correct finding and evidence.

Step 10: **Initial Findings Reports will be generated from LibertyTraks for financial accountability indicators only**. Met and Unmet findings will be included in the **Initial Findings Report**.

A. Unmet Findings consist of:
    a. Less services provided than billed.
    b. Services provided did not match the definition of the services billed.
    c. Payments cannot be substantiated by appropriate service record documentation.

B. Findings for financial accountability will be sent in an Initial Review summary report for each provider in the sample by week nine (9) of the quarter.
C. If unmet findings are identified in the initial reviews, the provider Initial Review summary report will highlight each unmet finding, indicating which claims are "pending remediation" and request supplemental/corrective documentation to remediate the unmet finding.

Step 11: The provider will have five (5) business days to provide supplemental documentation for the purposes of remediating any unmet findings for financial accountability indicators highlighted in the Initial Findings summary report.

Step 12: Upon receipt of supplemental documentation from the provider, the reviewer will determine if additional documentation is acceptable. If allowable, a remediation determination will be included in the Finalized Findings Report.

Step 13: Finalized reviews will be completed by the end of the quarterly review period (week 12 of the quarter) and results of the reviews will be sent to providers within 15 business days after the end of the quarter. Supplemental documentation will not be accepted after Finalized Findings reports are completed.

Step 14: Based on the extent of unmet findings, it will be determined if any of the following actions will occur and they will be communicated to the provider with the Finalized Findings Report:

- an onsite review by Liberty Healthcare staff to be conducted at the DDA Provider organization; (details outlined in Steps 15-17 below)
- submission of a corrective action plan to Liberty Healthcare (details are outlined in Step 18 below) ; and/or
- recoupment of payment for improperly paid claims by DDA (details are outlined in Step 19 below)

ONSITE REVIEW ACTIVITIES:

Step 15:

The following criteria will be utilized to determine if an onsite review is required:

- No service documentation submitted for any of the claims reviewed
- More than one claim reviewed with the same discrepancy (related to service documentation, or un-resolved timesheet discrepancies)
- More than one staff with training and/or qualification discrepancies

In the communication to the DDA provider regarding the Onsite Review, Liberty will provide a list of participants, staff and administrators that will be asked to participate in an Onsite interview with a Lead reviewer. Providers will assist Lead reviewers to schedule the Onsite interviews within five (5) business days of being notified of the Onsite Review.

Step 16: The Lead Reviewer will conduct the onsite review by interviewing the participant and/or representative, the staff person who was listed on the service documentation and/or a provider administrator. Interviews and onsite observation are for the purpose of ensuring services are being delivered in the type, scope, amount, duration and frequency specified in the PCP and to better understand the potential causes of unmet findings. The information from the Onsite Reviews will be used to support the DDA provider in correcting any systemic issues causing unmet findings.

The Lead Reviewer shall obtain verbal consent from participants or their legal guardian to conduct the interview. If desired by the participant, family members, guardians, and important others will be included in the interview.

Step 17: A summary of the interviews will be completed by the Lead Reviewer and will be used with the Finalized Findings report and request for Corrective Action Plan to provide technical assistance to the DDA provider administrative team during an exit conference. The Exit Conference will be scheduled within five (5) business days of the completion of the Onsite Review and will be conducted virtually.

Corrective Action Plans:

Step 18: CAP Criteria and Process

Liberty will request the submission of a Corrective Action Plan (CAP) at the time Finalized Findings reports are sent to providers if unmet findings remain for the following:

- Documentation did not verify proper payment of the service, and/or
- Staff providing the service did not meet qualifications on the date of service

If a CAP is required, the provider agency will submit the CAP to the Liberty reviewer for approval within thirty (30) business days of the request and will have thirty (30) business days from approval to submit evidence the CAP was initiated and/or fully implemented.

Liberty will continue to monitor the implementation of the CAP until completion. At the time of completion, Liberty will provide the finalized CAP and evidence of implementation to the DDA QIO contract monitor. Liberty will then send an acceptance letter for the implemented CAP within five (5) business days to the provider agency contact.

DDA Recoupment of Improperly Paid Claims

Step 19: Recoupment Criteria and Process

DDA will request recoupment (repayment by the provider) for any claims that proper payment could not 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**;
- 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

Recoupment notification will be sent by DDA directly to the provider.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 process for appeal and repayment of claims will be outlined in DDA's recoupment communication.

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

Step 20: Special Reviews

The DDA contract monitor may request a Special Review of a provider to be conducted based on situations external to the Remote and Onsite review process. If requested, a Special Review will be conducted adhering to the process outlined above.

Findings Reports

Findings Reports will be created based on each Utilization/Qualified Provider review conducted by the Liberty reviewer.

For each compliance indicator question of 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 will be noted in LibertyTraks. 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
- The DDA will follow up with provider agencies regarding recoupment of improper payments included in the Finalized Findings Report.

Medicaid Fraud

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

Appendix A. PROVIDER COMMUNICATION

Communication with providers is an essential component of a successful utilization/qualified provider review. Below is a list of communications that will be used to ensure provider engagement in the utilization process.

Provider Outreach			
Document	Definition/Purpose	Timing	Audience
Initial Checklist of Requested Documents	List of documents sent to provider by Lead reviewer notifying provider of required documents needed to complete the review.	Emailed to the provider at the start of the remote reviews. Provides a specific list of documents that are required from the provider to begin the reviews.	Service Provider
Initial Findings Report (*for financial accountability only*)	Communication sent to the provider, notifying them of potential discrepant findings. May include a request for correction or additional documentation.	Sent upon the completion of the Initial Remote Review(s) by the 9th week of the quarterly review period.	Service Provider
Finalized Findings Report	Communication sent to the provider with finalized	Completion of the Final Review(s) by the end of the quarterly	

	results of the Remote Review(s)	review period (12th week).	
Onsite Review Notification	Communication sent to the provider (when applicable) that an onsite review is required.	Sent with the finalized reports within fifteen (15) days of the end of the quarterly review period.	Service provider
Exit Conference Notification	Notification of date and time of exit conference to review findings and provide technical assistance.	Sent within five (5) business days of completion of the Onsite review.	Service Provider

Appendix B: Indicator Question/Authority Table

Indicator Question	Sub-Question	Categories	Authority
Is the claim supported by documentation that services were delivered? **(Financial Accountability)**	***All four sub questions must be "1=Met" for the response for this performance measure to be met.***		Guidance on Service and Authorization and Provider Billing Documentation HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery

Indicator Question	Sub-Question	Categories	Authority
(Financial Accountability)	If applicable, was the date of service with start and end times included in service documentation?	Met=applicable service documentation includes start and end times of service delivery. Unmet= documentation does not include start and end times.	Guidance on Service and Authorization and Provider Billing Documentation HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
(Financial Accountability)	Do all service documents identify the correct participant for the claim?	Met= all pieces of provider submitted documentation are clearly marked to indicate the name of the participant who received the service. Unmet= Name doesn't match claim or absence of a name.	Guidance on Service and Authorization and Provider Billing Documentation HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
(Financial Accountability)	Was service documentation consistent with the Guidelines for Service	Met= service documentation was consistent with requirements outlined in the	Guidance on Service and Authorization and Provider Billing Documentation

Indicator Question	Sub-Question	Categories	Authority
	Authorization and Provider Billing Documentation?	Guidelines for Service Authorization and Provider Billing Documentation; Unmet= service documentation was not consistent with the requirements listed in the Guidelines for Service Authorization and Provider Billing Documentation.	
(Financial Accountability)	Does the timesheet confirm the staff worked on the date of service and during the time-of-service delivery (if applicable)?	Met= employee timesheet clock in and clock out times correspond with the date and time of service delivery. Unmet= employee timesheet doesn't confirm the employees' clock in and clock out times on the date of service or no timesheet for the date of service was submitted.	Guidance on Service and Authorization and Provider Billing Documentation (Only some services indicate a timesheet is required)

Indicator Question	Sub-Question	Categories	Authority
Was the person eligible on the date of service and was the service authorized in the PCP? **(Financial Accountability)**	*** Both responses to the two sub questions below must be 1=Met in order for the response to this indicator question to be 1=Met.***		HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
(Financial Accountability)	Was the person eligible on the date of service?	Met= participant was eligible on the date of service. Unmet= date of service falls outside of the eligibility span.	HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
(Financial Accountability)	Was the service authorized in the PCP?	Met = service was authorized on the date of service; Unmet= service was not authorized on the date of service	HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery

Indicator Question	Sub-Question	Categories	Authority
Was the claim coded and paid for in accordance with the reimbursement methodology specified in the approved waiver? **(Financial Accountability)**		Met= claim was coded and paid for accurately as evidenced by use of an accurate waiver code, billing rate, and billing unit. Unmet= claim was not coded and/or paid correctly	HCBS 1915 (C) Waiver Appendix I: Financial Accountability; Quality Improvement: Financial Accountability
Did the employee (s) who delivered services meet all required training and qualifications on the date of service? **(Qualified Provider)**	*** Both responses to the two sub questions below must be 1=Met in order for the response to this indicator question to be 1=Met.***		HCBS 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service DDA Training Matrix
(Qualified Provider)	Did the employees providing service for the claim meet all training requirements?	Met= submitted documentation indicates services were delivered by trained staff on the date of service. Unmet=	

Indicator Question	Sub-Question	Categories	Authority
		submitted documentation does not verify that services were delivered by trained staff on the date of service.	
(Qualified Provider)	Did the employees/vendors providing the service for the claim meet all qualification requirements?	Met= submitted documentation indicates services were delivered by qualified staff on the date of service. Unmet= submitted documentation does not verify that services were delivered by qualified staff on the date of service.	
Did the (Licensed/ Certified) provider meet required regulatory and applicable Waiver standards?	*** ALL responses to the sub questions below must be 1=Met in order for the response to this indicator question to be 1=Met.***		HCBS 1915 (C) Appendix C: Participant Services, C-1/C-6: Provider Specifications for Service

Indicator Question	Sub-Question	Categories	Authority
(Qualified Provider)			
(Qualified Provider)	If applicable, the provider submitted the renewal application for licensure/certification at least 60 days prior to the renewal date	Met = evidence from DDA and/or provider that the application was submitted on time Unmet = no evidence that the application was submitted on time	
(Qualified Provider)	Evidence provider is an eligible Medicaid Provider?	Met = evidence from DDA and/or provider that there is a signed medical assistance provider agreement Unmet = no evidence of the signed agreement	
(Qualified Provider)	Provider is in good standing with the IRS?	Met = evidence from DDA and/or provider that the provider is in good standing Unmet = no evidence that the	

Indicator Question	Sub-Question	Categories	Authority
		providing is in good standing	
(Qualified Provider)	Provider has a governing body?	Met = evidence from DDA and/or provider that they have a governing body Unmet = no evidence of a governing body	
(Qualified Provider)	Provider has an approved Program Services Plan?	Met = evidence from DDA and/or provider that the current program services plan was approved by DDA Unmet = no evidence program services plan is current or approved	
(Qualified Provider)	The provider has documentation of Commercial General Liability Insurance?	Met = evidence from DDA and/or provider has Commercial General Liability Insurance Unmet = no	

Indicator Question	Sub-Question	Categories	Authority
		evidence that the provider has Commercial General Liability Insurance	
(Qualified Provider)	The provider has documentation that all vehicles used in the provision of services have automobile insurance?	Met = evidence from DDA and/or provider that vehicles have automobile insurance Unmet = no evidence that all vehicles have automobile insurance	
If applicable, the OHCDS provider has current DDA approval to function as an OHCDS? **(Qualified Provider)**		Met = evidence from DDA and/or provider that the provider meets all OHCDS standards and has an approval from DDA to operate as an OHCDS Unmet = no evidence that the provider is approved to be an OHCDS and meets	HCBS 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service

Indicator Question	Sub-Question	Categories	Authority
		the requirements	

Appendix C: 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

Appendix D: REFERENCES

RELEVANT DOCUMENTATION:

Authorized HCBS 1915 (C) Waivers (Appendix C, D and I)

Guidance on Service Authorization and Provider Billing Documentation _7_1_23

DDA Training Matrix

REFERENCE MATERIALS

COMAR Title 10 Subtitle 22 Developmental Disabilities