Innovative Resource Group d/b/a
APS Healthcare

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

TBI Waiver Provider On-Site Review Process

TBI Waiver Providers will be required to participate in an on-site review every year. Any provider who enrolls at least one member during a calendar year will be queued for on-site retrospective review the subsequent year and each year thereafter.

All providers without an enrolled member will be required to participate in an on-site certification validation review.

Notification to Providers

Notice of On-Site Review Assigned Quarter – Providers will be informed via email of their assigned on-site review quarter. Typically this will fall two quarters after a successful submission of the agency's continuing certification application and after a full certification review determination has been made by the ASO.

Provider agencies who receive a Provisional Certification will be required to have an on-site review by APS Healthcare prior to full re-certification. This will likely occur outside the assigned review quarter.

2-Week Notice – Agency Executive Director(s) and Waiver Contact person(s) will receive an email at least 2 weeks (14 calendar days) prior to the start date of the agency's review. This email will inform the agency of the dates of review, tentative names of reviewers, the members selected for the Participant Experience Survey (Brain Injury), available appointment times for the survey, and general instructions.

Review Samples

Choosing Member Sample - Each review will be assigned a Provider Educator responsible to send the necessary notifications, prepare the sample to be reviewed, and compile final reports. The Bureau for Medical Services (BMS) has determined that initially 100% of enrolled members will receive a member record review.

Choosing Staff (Qualified Provider) Sample – Provider Educators will review a representative sample of personnel files in order to verify information submitted by the agency during their continuing certification.

Provider Preparation

Prior to the arrival of APS Healthcare Provider Educator(s), providers should prepare by:

- Ensuring there is available space for Provider Educator(s) for the duration of the review;
- Having two years of personnel files organized and available for the reviewers;
    - First year of provider reviews will yield one year of personnel records to review;
- Having a copy of the Participant Experience Survey (Brain Injury) schedule for reviewers;
- Ensuring that members/representatives selected for the Participant Experience Surveys have been notified, have agreed to the time of their appointment, a location has been secured for the face-to-face interview with the member and that he/she is expecting to meet with an APS Healthcare staff;
- Having member and qualified provider files accessible and organized, with all the necessary information filed appropriately.

On-Site Reviews: During the Review

Qualified Provider/Member Files - At the beginning of the review, a short introduction meeting will be conducted. At that time, providers will be given their member and qualified provider representative samples so that records can be made available to the reviewers.

Length of Review - Review lengths will vary based upon the size of the agency and the amount of documentation being reviewed. With current TBI enrollment numbers most reviews will last no longer than two or three days.

Provider Interaction and Technical Assistance - It is requested that the provider have someone available to the reviewers consistently throughout the review process (every hour or so). Providers are offered a daily exit interview, in which the reviewers explain review results for the day on a case-specific level. On the final day of the review, a final exit interview occurs. Typically, the reviewers explain the systemic issues and any remaining case-specific issues. Any additional provider questions are answered, and providers are offered an opportunity to request training specific to their needs.

Validation of Site-monitoring Review Tool - Provider Educators will validate the information from the most recent completed site-monitoring tool with a review of the agency policy and procedures, the agency Quality Management Plan, Personal Attendant direct care staff competency based training curriculum, and a walk through of the agency office setting to monitor office criteria compliance. The walk through will include digital verification (digital photos) that the physical office meets policy requirements**.**

Choosing Which Notes to Review - The Office of Program Integrity (OPI) provides claims data for a 6-month review period. APS Healthcare will review all notes for all services billed during that 6-month period for the enrolled members. Please note that the review period **only** pertains to service notes. Provider Educators will review documentation for qualified providers

as well as for services provided **outside** the review period, such as the Member Assessments and Service Plans in order to verify that they were completed as required.

On-Site Reviews: Certification Validation Only

All providers without an enrolled member will be required to participate in an on-site certification validation review using the Site-monitoring Review Tool.

APS Healthcare staff will validate the information from the most recent completed certification with a review of the agency policy and procedures, the agency Quality Management Plan, Personal Attendant direct care staff competency based training curriculum, and a walk through of the agency office setting to monitor office criteria compliance**.** The walk through will include digital verification (digital photos) that the physical office meets policy requirements**.**

Within 10 business days of the conclusion of the exit interview, APS Healthcare will email a Provider Review Report and Plan of Correction, if needed to the provider and to BMS (see descriptions in Review Reports section).

Participant Experience Survey (Brain Injury)

To assist providers in monitoring member/family satisfaction, APS Healthcare will conduct a face-to-face survey with the enrolled member as part of the review process. Survey results can serve as a tool to identify member satisfaction and potential areas for improvement.

The Participant Experience Survey (PES) (Brain Injury) solicits feedback from enrolled members with brain injury about the services and supports they receive under the TBI Waiver program.

When the provider is notified of the upcoming review, they will be given a list of members for whom survey appointments should be scheduled and a list of available appointment times. Whether the member will participate in the survey will be at the discretion of the member and those who know him/her well. However, as an explicit participant survey with no proxy version, the goal of the instrument is to allow program participants to comment directly on their experiences whenever possible. Legal representatives, family members, and providers cannot be the ***primary*** respondent for the survey. Agencies should schedule the selected members in the time slots provided and notify the member that they have been selected to participate in the survey as part of their agency's review. The agency should indicate the date, time and location that an APS Healthcare staff will be meeting with them. Possible locations include the member's home or place of work, a local library or mall. The length of time needed to conduct the interview with the member can vary, but at a minimum two (2) hours will be set aside for each survey.

Review Reports

If there are no recommended disallowances – Within 10 business days of the conclusion of the review APS Healthcare will email the reports to BMS. BMS TBI Waiver Program Manager will forward the following reports to the provider via Certified Mail:

- Provider Review Report
- Final Disallowance Report –This report will indicate that there are no disallowances.
- Plan of Correction – If any quality items were found to be deficient during a providers review, a plan of correction must be submitted within 30 calendar days to APS Healthcare**.** If applicable, the provider must request an electronic Plan of Correction from the APS Healthcare. If not submitted in the specified time frame, BMS may place a hold on claims until an approved Plan of Correction is in place**.** The Plan of Correction must be submitted in the electronic format provided. Any corrections/additions requested will be communicated to the provider. APS Healthcare will begin the Plan of Correction by outlining all areas found to be deficient during the review. The provider will be expected to complete the Plan of Correction by describing:
    - How the deficient practice(s) will be corrected;
    - What system will be put into place to prevent recurrence of the deficient practice(s);
    - How service delivery will be monitored in the future to ensure compliance and who will be responsible;
    - When the Plan of Correction will be implemented and completed, including notifying APS Healthcare when the POC steps are completed

If there are recommended disallowances – Within 10 business days of the conclusion of the exit interview, APS Healthcare will email the following draft reports to the provider and to BMS:

- Provider Review Report – Identifies issues found regarding a qualified provider (personnel), health and welfare, Member Assessment and Service Plans, and additional documentation associated with individual services provided.
- Plan of Correction —– If any quality items were found to be deficient during a providers review, a plan of correction must be submitted within 30 calendar days to APS Healthcare. If not submitted in the specified time frame, BMS may place a hold on claims until an approved Plan of Correction is in place. The Plan of Correction must be submitted in the electronic format provided. Any corrections/additions requested will be communicated to the provider. APS Healthcare will begin the Plan of Correction by outlining all areas found to be deficient during the review. The provider will be expected to complete the Plan of Correction by describing:
    - How the deficient practice(s) will be corrected;
    - What system will be put into place to prevent recurrence of the deficient practice(s);

- How service delivery will be monitored in the future to ensure compliance and who will be responsible;
- When the Plan of Correction will be implemented and completed.
- Send a notice of when the Plan of Correction has been completed.

Example:

Issue Found:	1. How will the deficient practice be corrected?	2. What system will be put into place to prevent recurrence of the deficient practice?	3. How will service delivery be monitored in the future to ensure compliance? Who will be responsible?	4. When will the Plan of Correction (POC) be implemented?
Current First Aid Certification: A copy of the actual certification card must be present, or a training signature list with date, pass/fail, and the instructor's signature.	This staff member was removed from providing services immediately and did not provide services until certification was completed on July 10, 2013.	An email notification system has been implemented. All staff training s-dates have been added to the system. Staff and staff supervisor will receive calendar notifications via email one month prior to certification expiration.	Staff supervisor will monitor certification due dates spreadsheet on a weekly basis, in addition to receiving calendar notification.	Spreadsheet, email notifications and monitoring will be fully implemented by August 1, 2013.

- Draft Disallowance Report – Identifies issues for which APS found the provider to be out of compliance that may result in potential disallowance. The draft report will not include dollar amounts related to potential disallowance. It will, however, indicate the claim information (including amount paid) from Molina for those items related to the specific members reviewed. The report will include only potential disallowance service units. If the provider wishes to make comments associated with the recommended potential disallowances, those must be placed on the draft report in the space provided and submitted along with the Plan of Correction. At this time, providers may submit additional information related to the review. **Please note: If additional claims data is requested, it is the responsibility of the provider to**

provide this information to APS Healthcare within 7 days of receipt of their draft disallowance reports.

The provider will have 30 days to submit the POC and Comments to the Draft Disallowance Report. Once received, APS will coordinate results and make final recommendations to be presented to the Review Committee (see description below). Following the review committee, APS will finalize the Disallowance report (per committee recommendations) and send to BMS. BMS will send the final disallowance report to provider with instructions for repayment.

Review Committee

Review Committee – BMS, OPI, APS, and any other entity deemed necessary by BMS will meet as a Review Committee in order to consider the provider's comments related to the Draft Disallowance Report and the provider's approved Plan of Correction. The group may make changes to the Draft Disallowance Report based on additional information submitted by the provider.

Additional Information

Office of Program Integrity (OPI) and Expanding Review Findings - If upon review, OPI finds a disallowance issue to be potentially systemic, they may issue a request for an additional self-review. Non-compliance with OPI's request for a self-review may result in removing a provider's ability to submit claims into Molina ("pay hold"). Depending on the severity and rate of occurrence of the issue, OPI may also conduct an on-site follow-up at the provider agency to ascertain the extent of the deficiency and to recommend additional disallowances.

Medicaid Fraud Reporting - If at any time APS suspects Medicaid fraud, a referral will be made to OPI.

Fiscal Employer Agent -

As a sub-contractor of the Bureau for Medical Services, Public Partnerships, LLC will not be subject to disallowances cited in their report. However, a portion of the Per Member Per Month fee may be sought for any deficits found in the performance of duties of the Resource Coordinators. In addition, any deficits related to a member that would have resulted in a disallowance must be addressed with the member in order for them to continue self-directing their services in the future.