TBI Waiver Provider Quality Desk Review Process-2024

TBI Waiver Providers are required to participate in a quality review every year. Any provider who enrolls at least one program member during a calendar year will be queued for a quality desk review the subsequent year and each year thereafter.

Provider agencies who receive a Provisional Certification will be required to have an on-site review by Acentra Health prior to full re-certification.

Notification to Providers

Agency Executive Director(s) and/or Waiver Contact person(s) will receive a **2-week notice** email that will be sent prior to the start date of the agency's review. This email will inform the agency of the dates of their review, tentative names of the provider educator(s) conducting the review, a list of the members that will be reviewed, lists of required documents (personnel and member) that must be scanned and emailed to the provider educator and general instructions for the review.

Review Samples

Choosing Member Sample – The Bureau for Medical Services (BMS) has determined that 100% of enrolled program members will receive a quality and utilization record review.

Choosing Staff (Qualified Provider) Sample – The provider educator will review the personnel files associated to the member(s) to verify information submitted by the agency during their continuing certification application review. Staff that provided services to the member(s) in the preceding year will have their personnel file reviewed.

Provider Preparation

For the annual Provider Quality Review providers should prepare by:

- Having the requested program member and qualified personnel files scanned in an organized manner, labeled as instructed in the notification letter and emailed to the provider educator by the date specified.

- Having copies of written policies and procedures; Competency-based curriculum, Trainer personnel file and Incident Management reports for the past year available. If needed the Provider Educator will request them at that time.

During the Review

At the beginning of the review, a brief introduction meeting will be conducted. At that time, Acentra Health staff will have already received and reviewed the requested review documents the provider previously sent so they (Acentra Health) will inform the provider of any documentation that is missing and required for the review. Acentra Health will send the provider a listing of the missing documentation that is still needed at the conclusion of the meeting. This meeting will also give the provider and/or Acentra Health the opportunity to ask any questions pertaining to the review.

Length of Review -Review lengths will vary based upon the amount of member and personnel files being reviewed for your agency and the amount of documentation being reviewed. With the current TBI enrollment number, 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 Acentra Health Provider Educator(s) reviewers via email or phone consistently throughout the review process. On the final day of the review, an exit interview occurs. Typically, the Acentra Health Provider Educator(s) 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 Educator(s) will validate the information from the most recent completed site-monitoring tool with a review of the agencies policy and procedures, Quality Management Plan, Personal Attendant and Case Management competency-based training curriculum.

Choosing Which Documents to Review – The BMS Office of Program Integrity (OPI) provides claims data for a 3-month review period. Acentra Health Provider Educator(s) will review all documents for G9002 U2 -Case Management, S5125 UB-Personal Attendant and A0160 UB-Non-Medical Transportation services billed during the 3-month period for the enrolled program members.
Please note that the review period is established for a review of paid claims only.
The Provider Educator will also review documentation that supports evidence of policy implementation and compliance by the provider.

Review Reports

Within 10 business days from the conclusion of the annual quality review, the review reports will be sent to the provider. Whether a provider has any recommended disallowances or not determines what review reports and from whom they will receive the review reports.

If there are no recommended disallowances – Acentra Health will email the final review reports to BMS. BMS TBI Waiver Program Manager will review and forward the final reports to the provider via secure email.

If there are recommended disallowances – Acentra Health will email the draft reports to the provider and to BMS and OPI via secure email.

The following are the types of review reports that will be sent to the provider (if applicable), based on your review findings:

- Provider Quality Review Report – Indicates if there were any deficient practices or issues found during the provider review regarding the areas of Qualified Personnel, Health and Welfare, Incident Management, Assessment and Service Plans, Case Management, PA Worksheets, and additional documentation associated with individual services provided.

- Draft or Final Disallowance Report –This report will indicate if there are paid claims subjected to disallowances from the review or if the review resulted in no recommendation for disallowances. The draft disallowance report *will not* include dollar amounts related to potential disallowance. It will, however, indicate the claim information (including amount paid) 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.

- Draft Plan of Correction (POC) – If any quality items were found to be deficient during a provider's review, a draft plan of correction will be generated. The provider must submit their responses to the draft POC within 30 calendar days to Acentra Health. The POC must be submitted in the electronic format provided.

NOTE: If the provider's response to the draft POC is not submitted in the specified period, BMS may place a hold on claims until an approved POC is in place.

Draft POC Example:

Issue Found:	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.
1. How will the deficient practice be corrected?	
This staff was removed from providing services immediately and did not provide services until certification was completed on July 10, 2023.	
2. What system will be put into place to prevent recurrence of the deficient practice?	
An email notification system has been implemented. All staff training dates have been added to the system. Staff and staff supervisor will receive calendar notifications via email one month prior.	
3. How will service delivery be monitored in the future to ensure compliance? Who will be responsible?	
Staff supervisor will monitor certification due date's spreadsheet on a weekly basis, in addition to receiving calendar notification.	
4. When will the Plan of Correction (POC) be implemented?	
Spreadsheet, email notifications and monitoring will be fully implemented by August 1, 2023.	

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

Review Committee
The Review Committee consists of the Bureau for Medical Services (BMS), Office of Program Integrity (OPI), Acentra Health, and any other entity deemed necessary by BMS. Those listed will meet as the Review Committee to consider the provider's comments related to the Draft Disallowance Report and the provider's approved

Plan of Correction. The group may or may not amend the Draft Disallowance Report based on additional information submitted by the provider.

6 Month Plan of Correction Follow up Review

BMS requires that Acentra Health conduct a six (6) month POC follow-up review for all providers who submitted a POC on quality items found to be deficient during a provider's annual review. The six-month POC follow-up review will be performed through a desk review of requested evidence.

Acentra Health will notify providers via secure email forty-eight (48) hours prior to the review. This email notification will serve as the request for specified evidence. The provider will have 48 hours to submit the requested evidence via secure email.

Office criteria deficiencies noted in Chapter 512 will result in a request for current photographs of the provider agency in relation to what deficiencies were sited.

During the review, the Acentra Health Provider Educator will verify that the provider's Approved Plan of Correction has been implemented as stated and that the provider addressed the deficiencies as identified on their Approved Plan of Correction.

Within 10 business days from the conclusion of the 6-month POC follow up review, Acentra Health will email the following report/letter to the provider and to BMS:

- 6-month POC Follow-up Review Letter: This letter notifies the provider of the outcome of their 6-month POC Follow-up Review. Additional documentation may or may not be requested in this letter.
- 6-month POC Follow-up Report: After reviewing the provider's submitted evidence, the Acentra Health Provider Educator will complete the 6-month POC Follow-up Report which identifies compliance and/or noncompliance with the corrective actions and strategies outlined in the provider's Approved Plan of Correction and their recommendations for improvement.

In addition to the 6-month POC Follow-up Review report, the agency will be provided with Technical Assistance as necessary and requested during and after the review.

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 Gainwell ("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 Acentra Health suspects Medicaid Fraud, a referral will be made to OPI.

Fiscal Employer Agent (FE/A) Personal Options - As a sub-contractor of the Bureau for Medical Services, the FE/A 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 program member that would have resulted in a disallowance must be addressed with the program member for them to continue self-directing their services in the future.