Claims Reviews

Contents

Guidance

Update on saving spreadsheets

- During training, Reviewers were advised to save completed claims review forms in the review file, but we are changing this requirement. Completed spreadsheets should now be saved in the OneDrive File where reviewers access the spreadsheets.

Identification of Claims to be Reviewed

- DODD will pull 10 random claims for upcoming provider reviews and save in claims review excel document.
- Excel document will be saved in Claims Reviews OneDrive prior to date of review.

Citation Language

Citation Language for 5.017 (Independent Providers) and 5.022 (Agency Providers):

The service documentation does not validate payment for the following claims:

- Date for ID Number
- Date for ID Number
- Etc.

The claims were not validated because (select one or multiple):

- The documentation does not contain (list elements), which are required to validate payment for claims
- No documentation of claim provided; or
- Documentation did not match units billed.

Please note that because payments for claims unsupported by service documentation are recoverable by the Department, the Plan of Correction must indicate provider's intent to back out billing for these claims.

Sample Key

- If you are citing a provider for an individual not in the original sample, you will need to add the individual to the sample, but indicate "(Claims reviews only)" as you do

not need to complete the rest of the tool for that individual. If you cannot find the person in RDS to add to the sample, contact Antonleena Boykins for assistance.

Citing 5.017/ 5.022

Use this citation ONLY for the 10 claims reviews on the spreadsheet:

If missing:	5.017/5.022
Type of service	Do not cite.
Date of service	**Cite**
Place of service	Do not Cite.
Name of individual receiving service	**Cite** (if documentation also missing Medicaid Number)
Medicaid identification number of individual receiving service	**Cite** (if documentation also missing individual name)
Name of provider	Do not cite.
Provider identifier/contract number	Do not cite.
Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provide	Do not cite.
Group size in which the service was provided	Do not cite.
Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided	**Cite** (Documentation must indicate services were provided but you do not need to confirm services against ISP)
Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided	Do not cite.
Times the delivered service started and stopped	**Cite**
Documented units do not match units billed/ paid	**Cite**
All Documentation	**Cite** and Report to DODD review manager

No documentation for claims reviews on day of review

- Review "Documentation Acknowledgment" form with provider and ask them to initial then sign/ date
- If provider refuses to sign/ date, indicate on form and indicate that copy left with provider
- Scan or copy form prior to leaving review

Exit Conference

- Indicate whether claims review documentation was received or not. You do not need to discuss outcome of claims review

Plan of Correction

- If provider is cited under 5.017/5.022, the Plan of Correction can only be approved if it indicates intent to back out the billing for the claims unsupported by documentation.

Verifying the Plan of Correction

- DODD is currently working on a solution for reviewers to be able to easily verify if billing was backed out or not. However, at this time, if you issue a citation under 5.017/5.022, send an email to DODD review manager with the following information after you approve the plan of correction:
    - Provider Name
    - Specific Claims cited (i.e. Individual # on date)
    - Date by which provider agreed to back out billing
- Claims will be monitored and reviewers will be informed when/ if billing backed out.

Claims Review Q&A

General Questions

Question: Do you give providers the specific dates (for the 10 claims) if they do not have the service delivery on the day of the review, or just say they need 3 months for the specific individuals?

Answer: Give the provider enough specificity to identify documentation needed without revealing exact dates/ claims. For instance, if the provider keeps service documentation weekly, you can just request the documentation for the relevant person/ week.

Question: Are we still allowing multiple forms to meet the requirements?

Answer: Yes, rule still allows this as long as it is not "claims for payment a provider submits to the department for services delivered" (billing documentation). Please note that independent providers will soon be required to use Department-provided documentation templates.

Question: We have a review scheduled for August, but the review has already been started with the previous tool. So this change would be for any new reviews?

Answer: Review should be in "planning stage" in RDS and the tool will be updated.

Question: To confirm — is this only for 15-minute claims at this time? What about shared living providers who bill one unit — would this cover those billable claims with no supporting documentation?

Answer: Yes, only 15-minute HPC providers.

Question: Will DODD reviewers notify CBs if they are asking providers to back out billing?

Answer: County Boards can see this on the review reports once made public; there will not be specific reporting to the County.

Question: What about providers who have multiple billing errors in Tableau?

Answer: Claims will be selected only from claims paid to the provider.

Question: Are there any plans to time-study this process?

Answer: The focus at this point is on implementing the process. After the process is implemented/ reviewers are comfortable with it, we will be able to more accurately determine the amount of time this is adding to the review.

Claims Review Sample

Question: Will the billing review only be for the random sample or for both the random sample and the individuals in your sample?

Answer: It will be 10 randoms claims billed by the provider and could be for any individuals the provider was paid for, both those in the sample and not in the sample.

Question: Provider can submit claims within 350 days of service. If provider did not bill for last three months, are we checking their billing in last six months or so… will rule about 350 days' timeline also be adjusted? How far do we go back, if the reviewer cannot compare service delivery documentation and billing (provider can always go 350 days back and submit claims later). If provider decides to bill after review is over, reviewer would not be able to verify anymore, because this provider would not be under review anymore. Are we going to flag providers who do not bill?

Answer: Claims will be chosen from claims paid to the provider, so the provider has billed for the claims reviewed. If provider has not billed in the three months prior to the review, claims will be pulled from most recent three months provider billed.

Question: What if provider did not bill at all for the last three months?

Answer: Claims will be pulled from the most recent three months they billed.

Question 12: To clarify… the samples DODD is pulling are within the 3 months prior we are reviewing regularly?

Answer: Yes, but claims pulled may be for individuals not in the sample

Citing under 5.017/5.022 and backing out billing

Question: For 5.022, we are only citing if we cannot validate claims. If they are missing required details (e.g., group size), that will not be cited under 5.022 — it will be cited in the service delivery area?

Answer: Providers should be cited as normal for any issues with the documentation. An additional cite will be issued under 5.017/5.022 **only for the ten claims on the spreadsheet** if the service documentation does not validate payment for claims (no documentation/ units don't match/ 'crucial elements' missing.

Question: What do we do if we are citing them because documentation for people on the sample does not contain required elements, and they are elements we would have to pay back for under 5.022?

Answer: Providers should be cited as normal for any issues with the documentation. An additional cite will be issued under 5.017/5.022 **only for the ten claims on the spreadsheet** if the service documentation does not validate payment for claims (no documentation/ units don't match/ 'crucial elements' missing.

Question: What if individuals in the sample have no time-in/time-out for any of the three months?

Answer: Reviewers should cite under 5.017/ 5.022 **only** for the 10 claims on the spreadsheet. If provider is missing an element for service documentation that is not part of the claims review, cite as you normally would (i.e. 5.004 for time-in/time-out) and if the missing element is one that would result in a cite under 5.017/5.022 if you were doing claims reviews, please report to your DODD manager as this will be referred for further action.

Question: If the provider has no documentation but shows claims that support they billed the full three months (outside of the 10 claims), would they be required to back out all the claims?

Answer: This should be cited as normal and reported to the DODD review manager for further action.

Timelines and Exit Conference

Question: If provider gave claims documents during review, but reviewer is not able to review at that time: How long does reviewer have to review? Should the reviewer delay the exit or just mention that the claims info still needs reviewed and other citations could result?

Answer: The exit should not be delayed because of the claims reviews. At the exit, the reviewer should indicate whether they did/ did not receive the documentation and that it is under review. The reviewer would still need to issue the report in 10 days.

Question: What do they say at the exit if they have not filled out the spreadsheet while on site, are going to do it when they get back to their desk – leave as potential citation, not mention at all?

Answer: Just indicate whether you have/ do not have the documentation and will review it.

Question: If we are waiting for provider to verify that they unbilled as part of POC verification, will POCV timeline still be the same as currently?

Answer: The POCV timeline is the same. Contact your DODD review manager if you need an extension of timelines.

Question: If it was a no-cite review, are we now recording just to say we have or have not received the documentation for fraud?

Answer: Yes, unless you reviewed on site and determined there are no issues, then a recorded exit is not required.

Question: Does the 10 days to send the report start after 48 hours?

Answer: No, the 10-day timeline starts after the exit. This is to avoid confusion and conflicts with extending the timelines. During the biweekly check-in, we will assess if this is

allowing enough time to review claims documentation or if the process should be amended.

Question: Are we adjusting the exit date, or will we have two documents — the exit and the 48-hour documentation acknowledgment?

Answer: No, we are not adjusting the exit date. If the provider does not have documentation at the review and must complete the Documentation Acknowledgment ("48 hour") form, they will receive an exit conference record and a Documentation Acknowledgment Form.

Question: Do we need to adjust exit date to match 48-hour acknowledgement form (if we need to provide that form)? Or will exit be completed as we do it currently, and acknowledgment form separately?

Answer:

The exit form will be completed as it is done currently and the acknowledgment form will be done separately.

Question: Do we have to record exit if provider has no cites for review and reviewed the claims?

Answer:

The process is to not record the exit if no citations. If you review claims on site and they match billing, you won't be issuing a citation so you do not need to record the exit.

Question 11: Do we have to record exit if provider has no cites for review and the claims have yet to be reviewed? Would record exit as could potentially have cite after reviewing.

Answer: Yes, record the exit and indicate documentation was/ was not received and will be reviewed later.

Miscellaneous

Question: Will the PowerPoint be emailed?

Answer: This is located in the Resources folder in the OneDrive Claims Review File.

Question: How soon are we getting access?

Answer: Everyone who attended the training should now have access to the OneDrive Folder.

Question: Could this be added to the CB follow-up emails?

Answer: We don't understand the question, please email compliance.dodd.ohio.gov to provide additional information.

Question: What if provider does not follow the ISP as written? For example: 3 hrs. per day of HPC has been authorized for MON-FRID. However, provider maintains documentation and bills 2 hrs. MON-SUN. Provider does not follow the ISP, but their service delivery documentation and billing does match.

Answer:

At this time, we are ensuring service delivery documentation and billing match.

Question: If a provider only serves one person (therefore all claims associated with that one person in the sample) – where do reviewers cite for documentation issues?

Answer: See crosswalk above.

Question: Can DODD reviewers save the spreadsheet of claims in folder where provided or should it be saved in the OneDrive provider review file too (for DODD reviewers) and/or RDS too (for CB/SOCOG reviewer)?

Answer: Spreadsheets should be saved in folder where they are provided (clarified from training).

Question: Will there be a point person, who can get back to us in a timely fashion, that specifically works with county boards or COGs if there is a billing issue that is out of the normal routine. If so can we have their contact information as soon as possible.

Answer: Contact your DODD review manager with any questions/ issues.

Legal Authority

Ohio Administrative Code 5123-9-06 (IO/ Level 1 Waiver):

(J) Service documentation

(1) Providers will maintain service documentation in accordance with this rule and service-specific rules in Chapter 5123-9 of the Administrative Code.

(2) Claims for payment a provider submits to the department for services delivered will not be considered service documentation. Any information contained in the submitted claim for payment may not and will not be substituted for any required service documentation information that a provider is required to maintain to validate payment for home and community-based services.

(3) Each provider will maintain all service documentation in an accessible location. The service documentation will be made available upon request for review by the department, the Ohio department of medicaid, the centers for medicare and medicaid services, a county board or regional council of governments that submits to the department payment authorization for the service, and those designated or assigned authority by the department or the Ohio department of medicaid to review service documentation.

Ohio Administrative Code 5123-9-40(K) (Self-Waiver):

(1) Services under the self-empowered life funding waiver will not be considered delivered unless the provider maintains service documentation.

(2) A provider will maintain all service documentation in an accessible location. The service documentation will be available, upon request, for review by the centers for medicare and medicaid services, the Ohio department of medicaid, the department, a county board or regional council of governments that submits to the department payment authorization for the service, and those designated or assigned authority by the Ohio department of medicaid or the department to review service documentation.

(3) A provider will maintain all service documentation for a period of six years from the date of receipt of payment for the service or until an initiated audit is resolved, whichever is longer.

(4) If a provider discontinues operations, the provider will, within seven calendar days of discontinuance, notify the county boards for the counties in which individuals to whom the provider has provided services reside, of the location where the service documentation will be stored, and provide each such county board with the name and telephone number of the person responsible for maintaining the records.

(5) Claims for payment a provider submits for services delivered will not be considered service documentation. Any information contained on the submitted claim will not be substituted for any required service documentation information that the provider is required to maintain to validate payment for home and community-based services.

Ohio Administrative Code 5123-9-30(E):

(E) Documentation of services

Service documentation for homemaker/personal care will include each of the following to validate payment for medicaid services:

(1) Type of service.

(2) Date of service.

(3) Place of service.

(4) Name of individual receiving service.

(5) Medicaid identification number of individual receiving service.

(6) Name of provider.

(7) Provider identifier/contract number.

(8) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.

(9) Group size in which the service was provided.

(10) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.

(11) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.

(12) Times the delivered service started and stopped.