**REHABILITATIVE CLAIMS SUBMISSION AND PROVIDER REVIEWS**

**OBF/GMD 13-001 S**

**RFP Questions and Answers Series 1**

1. **Question: I missed the pre Proposal Conference. Is there a transcript from this meeting I could have and is this a development project for a claims processing system or a complete management of electronic claims and management of the membership data such as providers and Subscribers.**

   Response: The transcript of the Pre-Proposal Conference may be found on *eMM* and DHR's Website. The successful Offeror will convert claims data currently submitted in an excel format into HIPAA 837-P format and submit the claims to the MMIS for processing and payment. The successful Offeror will also be responsible for developing an online claims data submission process to replace the current excel format for DHR claims.

2. **Question: I am working on developing a proposal for this RFP, and I have a request to see if it is possible to obtain examples of a few items (listed below). One document may answer more than one of these requests as we are not very familiar with the current process. Any assistance or explanations would be greatly appreciated.**

   a. **Is there a way that the State could provide an example of the excel spreadsheet for this project that is currently in use?**

   Response: A sample Attendance Sheet and instructions completed by the Providers is attached and identified as **Attachment J** to the RFP.

   b. **May we see an example of documentation** of how the "**provider review" of** claims **is currently conducted?**

   Response: A copy of the Provider Review Tool is attached and identified as **Attachment K** to the RFP. The tool contains specific elements that must be maintained in the child's case record.

3. **Would it be possible for the State to provide a redacted copy (HIPAA Privacy) of what is being used currently?**

   Response: The HIPAA law may be researched online using the links and citations provided in the RFP.

4. **Question: How is data submitted and received from MMIS? (through normal sftp or advanced B2B gateway)**

Response: The Department is not certain whether normal SFTP is used or whether the more advanced B2B gateway is used by MMIS.

5. **Question: In what "format" data is received (remittance) back from MMIS?**

Response: The remittance advice is received from MMIS in HIPAA 837-P format.

6. **Question: RFP mentions "online system for submission of rehabilitative services attendance data" (Section 1.1). What is Attendance Data submission by Providers? Is it submitting daily/monthly present/absent of the child OR is it simply submission of claims data? Can we get a sample file or format/attributes?**

Response: Please see response to question #2(a) and Attachment J.

7. **Question: Role of Contractor is misleading in section 3.5.2.3 of RFP. It's mentioned twice under section B, point 1 and point 3.**

B.1 says **Contractor and DHR Administrators/Project Managers shall:**
- **a. Create, update and read claims.**
- **b. Add, delete and modify the roles of users.**

**B. 3. says Contractor shall:**
- **a. Read and process claims from all Providers. Contractors shall not be permitted to load, update, or delete claims on the website.**

**Please clarify.**

Response: Please see Amendment #2, which revises the section to refer to DHR Administrators/Project managers only.

8. **Question: If the sign off process (of DJS) could be accommodated electronically, would DJS be open to using the electronic submission process?**

Response: Not at this time.

9. **Question: In the RFP its mentioned Audited financial statements for the past three years. Do you have any exception to this requirement especially for small sized MBE firms? Evidence of no less than six (6) months of working capital? Once again being a small MBE firm what figure are you looking for? Is it based on the proposal cost?**

Response: Section 4.2H identifies four examples of ways in which an Offeror may demonstrate that it is fiscally responsible and financially stable should it be awarded the

Contract. The list is not all inclusive. An Offeror may submit other information so long as the information is sufficient to demonstrate fiscal integrity.

State of Maryland
PURCHASE OF RESIDENTIAL CARE - ATTENDANCE SHEET
LOCAL DEPARTMENT OF SOCIAL SERVICES

SERVICE MONTH: July-12

NOTE: TFC = Therapeutic Foster Care
RGH = Residential Group Home

FACILITY NAME: XXXXX

COUNTY CODE: 02

PROVIDER ADDRESS: xxxx Green St

PROVIDER TELEPHONE #: xxx-xxx-xxxx

AGENCY: DHR

PROVIDER CITY STATE ZIP: Annapolis Maryland 21209

EMAIL ADDRESS:

ADDRESS: Anne Arundel County DSS

PROVIDER CONTACT PERSON: Xxxxxx Yyyyy

Provider Tax ID #: xxxxxxxxxx

CITY, STATE, ZIP:

| NAME | Client/Id # | Medicaid Client ID# | Date of Birth | SSN | TFC or RGH | PROGRAM NAME | Provider NMIS # | TOTAL DAYS IN PROGRAM THIS MONTH | | DAILY ATTENDANCE FOR THE INVOICE MONTH (Y OR N REQUIRED FOR EACH DATE FROM BEGIN TO END) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 |
| Aaaaaa Bbbbbb | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y |
| Cccccc Ddddd | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y N N |
| Eeeee Fffff | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y |
| Ggggg Hhhhh | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y |
| Iiiiii Jjjjjj | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y Y Y N N N Y Y Y Y Y Y Y Y Y Y Y Y |
| Kkkkkk Llllll | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y |
| Mmmm Nnnnn | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y Y N Y Y Y N Y Y Y Y Y Y N Y Y Y Y Y N Y |
| Ooooo Ppppp | xxxxxxx | xxxxxxxxxx | xx/xx/xx | xxx-xx-xxxx | TFC | XXXXX | xxxxxxxxx | 07/01/12 | 07/31/12 | Y Y Y Y Y Y Y Y Y Y Y N Y Y Y |

Sample Attendance
May 22, 2013
A. Abel-Tongue

# Attendance Invoice Instructions:

1. In the upper portion of the form, complete all of the "Required" items for your organization.

Note:A new addition to the Attendance Invoice is the "County Code". Please select the appropriate placement County that corresponds to your Agency provided in the drop down box located next to the DHR agency information.
In the "Provider ID " box, we request that you enter your Federal Tax Identification Number.

2.Complete all of the items in the yellow on the lower portion of the form.
This information is of vital importance to the completion of the claim, please review this data to ensure the accruacy of your entries.
Additional forms will be required if there are more than 65 children in the facility.

3. Enter the "Begin" and "End" dates that each child was in the program for the month being invoiced.
This will include overnight stays outside of the facility, as long as the child was not discharged.
(Ex: if a child was in placement for the entire month, enter the first and last dates of the month).

4. Complete the Daily Attendance section for each child. If the child was PHYSICALLY in the facility, enter "Y". If the child was absent overnight ((e.g., home visit), enter "N".
Data input is necessary in order to accurately transfer attendance information to the invoice.

5. Review for accuracy to include verifying that no error codes are noted.

6. Select the tab marked "Invoice". Information entered on the Attendance Sheet automatically entered on the Invoice form.

7. Save file in the following format: PROVIDER NAME-DSSMMYY (e.g., GroupHome-BDSS0308). Rename the file each month.

8. **E-mail th**e file by the 10th of each month to: MdRehab@dhr.state.md.us

9. **Please d**o not email attendance sheets to the program contact person

10.Please do not manipulate the attendance sheet in anyway this will complicate the way in which we tally our claims data from the attendance sheet.

*Revised: September 2012*

Rehabilitation Option Services
Review For Federal and State Requirements

Facility _____ Provider ID _____ **Review Date:** _____

Client Name: _____ Client MA ID _____

Facility Type: TFC ___ /RGH ___

**Client Information**

Claim Date From _____ Claim Date To _____

Admission Date _____ Discharge Date _____

Initial Assessment Date: _____

**Reviewer to verify documentation in support of the requirements listed below is maintained in the recipient's file and is effective for the claiming period.**

1. **Assessment identifying an eligible diagnosis and completed by a LHSP?** Y N

Date Completed _____
Name and credentials of LHSP _____
Document(s) maintained as evidence of Assessment _____

**Documentation the recipient received the prescribed services** Y N

Date Completed _____
Document(s) maintained as Service Documentation _____

2. **Written, dated & signed Individual Treatment Plan addressing the recipient's eligible diagnosis, completed within 30 days of admission & prescribed by a LHSP** Y N

Date Completed _____. New Admission Y N
Name and credentials of LHSP _____
Document(s) maintained as evidence of ITP _____

3. **Written, dated & signed Treatment Plan Updates assessing the resident's progress in response to treatment. Completed at least every 3 months & signed by the case manager** Y N

Date Completed _____. New Admission Y N
Name and credentials of Staff _____
Document(s) maintained as evidence of Treatment Plan Updates _____
***( Please note the last 6 Treatment Plan dates)*** _____, _____, _____, _____, _____, _____

4. Does the Plan of Care/TSP include a statement regarding the **client's functioning level?** Y N

5. **Does the Plan** of Care/TSP include a statement regarding the services necessary to meet the **client's needs?** Y N

6. Does the Plan of Care/TSP identify specific goals as related to the child's treatment or services?
Y N

7. Does the Plan of Care/TSP contain information regarding the amount, dura**tion, and scope** of services/ Y N

8. Does the Plan of Care/TSP identify who is responsible for providing the services? Y N

Comments

_____

_____

_____

_____ _____

**REVIEWER'S SIGNATURE** **DATE**

_____

Reviewer's Name **(please print)**