



September 2012

## **Operational Policies and Procedures Manual**

### **Florida Statewide Quality Assurance Program (FSQAP)**

**Mission:** Supporting people to live everyday lives through collaborative quality improvement strategies designed to promote a person directed service delivery system.

**Vision:** A globally recognized leader in advancing quality through enhancement of community support systems for people with disabilities.

This manual describes the policies and procedures used to implement the Florida State Quality Assurance Program. This process is owned by the Director of Florida Operations.

**Note: This is a controlled document. Master document is the on-line version.** It supersedes all previous updates. Users shall not make unauthorized alterations. Users must determine the current version and completeness prior to use. The user must discard obsolete documents.

**Table of Contents**

List of Acronyms..... 4

Qualifications of Delmarva Staff..... 6

Confidentiality..... 6

Customer Service..... 7

Grievances..... 7

Non-Compliance with the Discovery Review Process..... 8

Discovery Review Procedures..... 9

Quality Framework..... 9

Person Centered Reviews (PCRs)..... 9

Pre-Interview/Onsite Activities..... 11

Notification to WSC..... 11

Selecting the Sample for PCRs..... 11

Scheduling the face-to-face interview/a confirmation call.....11

Pre-Interview Information Gathering for the Interview..... 12

Review of Information from APD..... 12

Scheduling Support Coordinator/Consultant and Provider participation in the PCR..... 12

Confirmation call to the Support Coordinator and Provider(s)..... 13

Requesting Records..... 13

Claims Data Pull..... 13

Interview Activities..... 14

Face-to-Face Interviews (NCI, Health and Behavior Assessment, and Individual Interview Instrument)..... 14

Service Specific Record Reviews..... 16

Support Coordinator/Consultant Interview and Central Record Review..... 16

Service Provider--all services rendered as part of the person's service delivery System..... 17

Medicaid Claims Data Analysis..... 18

Data Entry..... 18

The Medical Peer Review (MPR) Process..... 18

Medical Record Request Criteria..... 20

Criteria for Forwarding a Focused Review for Medical Director Review..... 20

Report Distribution..... 21

NCI Interview Validation by HSRI..... 21

Provider Discovery Reviews..... 21

Types of Services to be Reviewed..... 21

Procedures and Methods for Reviews..... 22

Pre-Onsite Activities..... 22

    Scheduling the PDR..... 22

    Medicaid Claims..... 23

    Sample Selection for Record Reviews..... 23

    Gathering Information from APD..... 24

Onsite Activities..... 24

    Confirming Documents for Review..... 24

    Observation of Service Delivery Locations..... 25

    Administrative Record Review..... 25

    Individual Record Review..... 26

    Provider/Direct Care Staff Interviews..... 27

    Alert Reporting..... 28

    Preliminary Findings..... 28

Post Onsite Review Activity..... 28

    Report Development and Distribution..... 28

Other Reporting Activities..... 29

Reconsideration Procedures..... 30

## List of Acronyms

**AHCA** – Agency for Health Care Administration.

**Agency** – A business or organization enrolled to provide waiver services, that has one or more staff employed to carry out the services.

**Alert** – An alert is activated when the Quality Assurance Reviewer determines a person’s health, safety and /or rights are in jeopardy and immediate corrective action is needed.

**APD** – Agency for Persons with Disabilities.

**Area Office** – APD’s local office responsible for managing one of APD’s 14 service Areas.

**CDC+** – Consumer Directed Care Program is a Medicaid funded option that empowers individuals receiving home and community based services to employ their own workers and pay for services with a monthly budget they manage.

**Consultant** – A waiver support coordinator specifically trained to assist CDC+ participants with program administration and care management.

**DD Handbook** – Developmental Disabilities Waiver Services Coverage and Limitations Handbook.

**DFMC** – Delmarva Foundation for Medical Care is the current vendor for the Florida Statewide Quality Assurance Program (FSQAP) .

**Discovery Process** – Process of collecting data and direct participant experiences in order to assess the ongoing implementation of the service delivery program.

**Discovery Tool** – Instrument used to capture information gleaned from review processes.

**FSQAP** – The Florida Statewide Quality Assurance Program is the program under which providers rendering services and billing to the Developmental Disabilities HCBS waiver are reviewed for quality assurance purposes.

**HCBS** – Home and Community Based Services is a Centers for Medicare and Medicaid Services (CMS) Waiver to support delivery of services in a community setting.

**HSRI** – Human Services Research Institute is the organization that developed the National Core Indicators, together with the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

**iBudget** – iBudget Florida gives APD customers more control and flexibility to choose services that are important to them, while helping the agency to stay within its Medicaid waiver appropriation.

**QC** – Quality Council is a council of self advocates, families, AHCA, APD and service providers who provide direction for the Florida Statewide Quality Assurance Program.

**MPR** – Medical Peer Review process is designed to identify the physical, functional and behavioral health care status and needs of individuals currently receiving services on any tier of the Florida HCBS waiver or participating in the CDC+ program.

**NCI** – National Core Indicator - Assessment tool used to gather information from people receiving waiver services to be used at a state level for comparison of the quality of waiver services.

**ORC** – Observation Review Checklist used to gather information about specific locations (licensed residential homes and adult day training facilities).

**PCR** – Person Centered Review is a process of discovery beginning with the person and reviewing all of the services and supports specific to the person.

**PDR** – Provider Discovery Review is a process of discovery focusing on provider compliance and accountability in delivering appropriate supports and services to people and meeting their needs.

**Provider** - A provider is any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills for Medicaid services.

**QAR** – Quality Assurance Reviewers are employed and trained by Delmarva to conduct Discovery Reviews.

**Reconsideration** – Process allowing providers to request a change in scoring of recoupment elements.

**WSC** – Waiver Support Coordinator is the provider who acts as the case manager for people on the HCBS waiver.

## **Policies and Procedures**

### **Qualifications of Delmarva Staff**

The work we do requires a highly skilled and talented workforce. Thus Delmarva seeks to draw upon the largest pool of potential applicants practical for vacancies or new positions that arise. Selection of QARs for positions within Delmarva are based upon the individuals' relevant experience, training and/or education. The ability to perform the essential functions of the job with reasonable accommodation are the prime factor in any employment or placement decisions. Any changes to these requirements are only made with Agency for Health Care Administration (AHCA) approval.

Prior to conducting any review activities, Delmarva's full team attended a week-long training session on the new FSQAP activities, after approval of the Discovery Tool and procedures. All reviewers, QA Supervisors, and the customer service representative were oriented to a variety of activities including:

- The mission and goals of the discovery process;
- All components of the Discovery Tool;
- PCR and PDR procedures and the use of teams to complete reviews;
- Procedures for issuing alerts;
- Reporting protocols;
- Report formats;
- Interview techniques and protocols;
- Information pertaining to data collection and transmission.

Reviewers received training from the Human Services Research Institute (HSRI) or an HSRI approved trainer on the National Core Indicator (NCI) interview instrument, protocols and procedures. HSRI training on NCI surveys is thorough and includes the rationale behind person-centered planning and supports, and decision-making practices using the information gathered during the NCI interviews.

When new reviewers are hired, they receive the same rigorous training on discovery and interview activities from reviewer certified by HSRI as master trainers. Ongoing training occurs during biweekly conference calls.

### **Confidentiality**

All medical data and individual specific information are confidential and are only shared by Delmarva with agencies that have legal authority to receive such information. Delmarva complies with all federal and state laws governing confidentiality, including electronic treatment of records, facsimile mail, and electronic mail, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Discovery Process inputs are gathered via a customized, secure web-based application consisting of various modules. This application is continuously available to our Quality Assurance Review

staff (except for pre-determined and approved maintenance windows) via the Internet, protected by Extended Validation SSL (EVSSL) encryption. All modules are accessible from a single point-of-entry. Access to the modules will be role-based and limited to only those persons who require access.

All Delmarva staff are required to take a Security Awareness training session annually.

### **Customer Service**

A full time Customer Service Representative (CSR) is located in the Tampa office. The CSR serves as a liaison between Delmarva, Medicaid Waiver service providers and recipients, the APD Areas, and the business community. The person in this position is trained in all of the review processes in order to better communicate with all stakeholders. If unable to answer an inquiry or respond to a grievance, the CSR forwards the call to the person best able to address the issue. In addition, the representative is bi-lingual, fluent in English and Spanish. When the need for interpreter services for a quality assurance review arises, the CSR arranges for such services. Delmarva does not allow communication to be a barrier to providing excellence in services, including Customer Service. The CSR may be reached by fax (813-977-0027), or the toll free number (866-254-2075).

### **Grievances**

Delmarva strives to provide the best service possible in all aspects of business. We take every step possible to ensure customer expectations are met and exceeded when possible. Through our rigorous training and staffing processes, we make certain Delmarva associates understand what is expected of them when interacting with individuals receiving services, family members, providers, state of Florida personnel, and other community members. We set high standards for our employees, and expect them to maintain ethical business practices, i.e. honesty, integrity, respect, trust, responsibility and to be helpful and courteous to our customers at all times.

Delmarva consistently strives to exhibit the following key customer service qualities:

- Timeliness of response;
- Accuracy of information;
- Thoroughness of approach;
- Respectfulness of interactions.

If Delmarva falls short of meeting these requirements and a customer complains, we make every effort to resolve the complaint quickly and take the following steps to prevent the source of dissatisfaction from recurring. The following protocol can be followed when lodging a grievance:

- Contact our customer service representative at our toll free number 866-254-2075 and explain your concern;
- If you are not satisfied with the explanation/resolution ask to speak with a Quality Assurance Supervisor;
- If you are still not satisfied with the resolution please ask to speak with the Contract Manager;
- Calls are returned within 24 hours or by the next business day;

- Responses to written inquiries are within 30 days;

### **Non-Compliance with the Discovery Review Process**

According to 2009 Florida Statutes (409.907 and 409.913) and 1915j, the provider is required to participate in quality improvement activities conducted by the state of Florida. This includes the release of Medicaid patient information when requested. According to 1915j, "The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services".

#### **Non Compliant providers are those:**

- Who do not respond to at least two attempts to schedule reviews with them,
- Who do not make individual records available for review purposes,
- Who are a "no-show" after a review has been scheduled.

#### **Procedure for Providers who do not respond to scheduling efforts:**

Immediately after the second failed attempt to schedule the review, Delmarva reviewers notifies local APD area staff of the difficulty scheduling the review with the provider/representative. This is in the form of a phone call followed up with an email. The provider/representative is given three business days to respond to APD area staff. If local Area staff succeeds in getting the provider/representative to comply, the review continues according to schedule. If there continues to be non compliance from the provider/representative despite efforts from APD staff, the provider/representative is scored "Not Met" in all areas of the discovery tool. If the provider/representative is scored "Not Met" in all areas due to non-compliance, the Delmarva contract manager notifies the central APD office and AHCA by email.

#### **Procedure for Providers who do not make individual records available for the review process:**

During the scheduling phase of the Discovery Review Process providers/representatives are made aware of time frames for making records available. The reviewer informs each provider/representative involved in the Person Centered Review (PCR) and Provider Discovery Review (PDR) which records need to be available and when. If the provider/representative does not make all records available for review within the designated time frame, the provider/representative is scored "Not Met" for all elements pertaining to the record review. The reviewer notifies Local APD staff by phone and the Delmarva contract manager notifies central APD office staff and AHCA.

#### **Procedure for providers who are "no-show"**

Should a provider fail to appear at the scheduled time and location for a Discovery review, the provider/representative is scored "Not Met" for all elements pertaining to the record review. The QAR notifies local APD staff by phone, and the Delmarva contract manager notifies central APD office staff and AHCA.



## Discovery Review Procedures

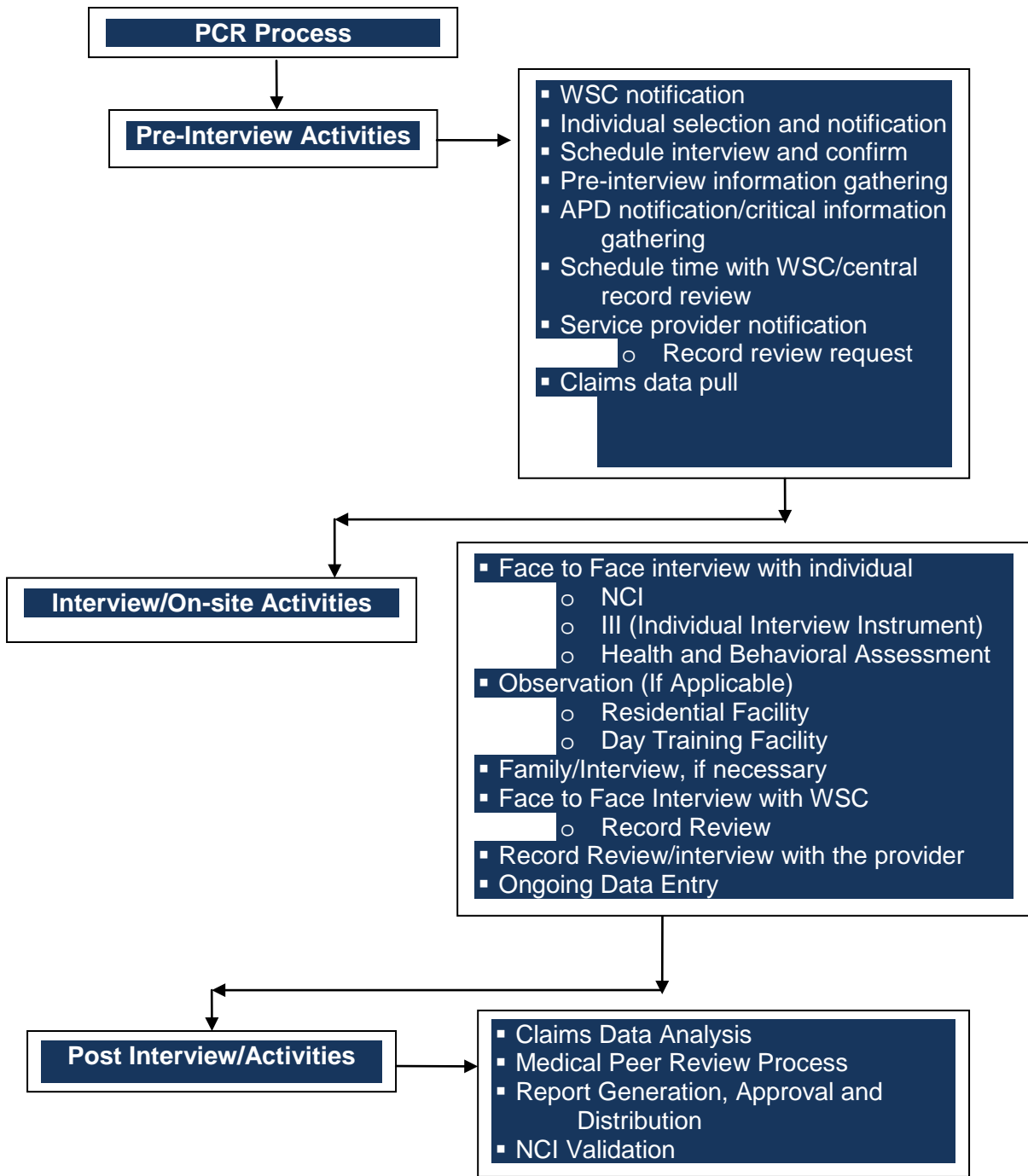
### Quality Framework

The Quality Assurance System developed by Delmarva, in collaboration with the Agency for Health Care Administration (AHCA) and the Agency for Persons with Disabilities (APD), is used to determine whether current systems to support individuals are efficient, effective, and rendered to their satisfaction. The Quality Assurance System [Discovery Process](#) has the goal of discovery, with two key processes being the Person Centered Review PCR and the Provider Discovery Review (PDR).

### **Person Centered Reviews (PCRs)**

The [Person Centered Review](#) process embodies the philosophy commonly characterized by many self-advocates of “Nothing About Me, Without Me”. It is designed to determine the effectiveness of the overall provider network systems in rendering services to individuals, as specified by the individual. Is there a consistent person centered approach used that allows individuals to direct their own lives, choose their own services and providers, participate in the development of their own support plans, and determine their own goals and objectives? Is the support plan deployed appropriately? The PCR sample is designed to allow results to be generalized to each APD Area and to the state system as a whole.

The Discovery Process begins with PCRs to assess the efficiency and quality of supports, services, planning and delivery—the support delivery system— from the individual’s perspective. PCRs begin with a face to face interview with individuals receiving services and include a review of supports and services specific to that individual, including a review of the support plan, cost plan, implementation plan and service records from each provider rendering services to the individual. The following flow chart describes the PCR process.



**\*\*Alert Identification and Reporting occurs in any phase if indicated\*\***

## **Pre-Interview/Onsite Activities**

### **Notification to WSC**

All WSC's and Consultants rendering services to individuals are included as part of the PCR process. A review schedule is submitted to AHCA and APD for approval. WSC's are sent a letter describing the PCR and PDR processes and the expectations of their participation in the process. The letter includes a web address for the FSQAP Web site where the PCR procedures can be accessed online. The support coordinator and consultant are directed to the [Delmarva website](#) to access the procedure manual explaining the PCR process. The letter also includes a list of potential documents the support coordinator must make available for the PCR process. These include but are not limited to: individual's central record, cost plans, service authorizations, progress notes, medical information, and provider information (implementation plans, monthly summaries etc).

### **Selecting the Sample for PCRs**

Support coordinators and consultants who rendered and billed for services over the previous 12 month period, as identified through claims data, are eligible for a PCR/PDR. On a quarterly basis support coordinators and consultants rendering services receive a letter notifying them they are scheduled for a review within the next 90 days. A random selection of two individuals receiving services are selected from each. For consultants serving people through the CDC+ program at least one individual receiving service through CDC+ may be selected for a PCR. The Delmarva QAR calls the WSC and/or CDC+ consultant and notify them regarding the selection of individuals for a PCR.

A list of individuals for each WSC and Consultant is generated from APD's Allocation, Budget and Control (ABC) database or provided by each WSC through the APD Area Offices. Claims data from FMMIS may also be used to further identify all individuals who receive services from the WSC/Consultant. The list is randomly ordered and stratified by DD Waiver and CDC+ participant. First, a 20 percent sample of CDC+ participants are chosen from Consultants, with no more than one per consultant, as possible. The first participant on the list is selected. Second, DD Wavier participants are selected, with a maximum of two per WSC/Consultant—two DD waiver participants or one Waiver and one CDC+ participant.

### **Scheduling the face-to-face interview/sending a confirmation letter**

The WSC and CDC+ consultant are tasked with contacting the person selected for a PCR. If the person agrees to participate in the PCR process the QAR calls the person, reiterate the purpose of the interview, and confirm if the person would like to participate. If the person chooses not to participate the PCR concludes; however for individuals participating in the CDC+ program a Provider Discovery Review (PDR) occurs for the person's Representative. (See page 30 for details) Demographic information such as social security number and residential setting, along with the reason for declining, is captured in the data for persons who decline.

The WSC or CDC + consultant is asked to contact the next person on the randomly ordered list. If the person chooses to participate, the WSC or consultant schedules the date, time and location for the interview based on the person's preferences. Reviewers maintain contact with support coordinators to gather information on interview locations, dates and times. Once the interview has been confirmed, the reviewer enters the information into the scheduling component of the web based system. This triggers the mailing of a confirmation letter to the person, outlining the purpose of a Person Centered review, tools used and examples of questions the Delmarva reviewer may ask.

### **Pre-Interview Information Gathering for the Interview**

Prior to conducting the NCI Adult Consumer survey, Individual Interview Instrument, and the Health and Behavioral Assessment it is important for the QAR to collect information that may be beneficial to the person and the QAR to help ensure the interview is successful. This information could include the person's communication style; if the person needs assistance from specific supports during the interview or uses a communication device; or if the person's primary language is different than spoken English. It is important for the QAR to have this information before the interview. If the person chooses, Delmarva obtains an interpreter to assist during the interview, e.g. sign language, Spanish, or Creole.

### **Review of information from APD**

Delmarva notifies APD of the upcoming PCR reviews for the month, including the name and contact information of the reviewer. A request is made for information pertaining to incidents, concerns, complaints or grievances regarding services to the individual. This information is discussed with the person, if willing, during the interview.

### **Scheduling Support Coordinator/Consultant and Provider participation in the PCR**

Close to the date of the actual PCR, the reviewer calls the support coordinator/consultant to discuss participation in the process and the date of the PCR. Once dates for the individual interviews have been confirmed, the reviewer establishes firm dates and times for the support coordinator interview, used to follow up on information gathered from the individual interview and complete the WSC central record review(s). The support coordinator's follow up, and central record review occurs only after the individual interview has been completed. The services targeted for the central record review for the individual include:

- **Residential Habilitation;**
- **Adult Day Training;**
- **Supported Living Coaching Services;**
- **Supported Employment;**
- **In-Home Support Services;**
- **Specialized Medical Home Care;**
- **Waiver Support Coordination/CDC+ Consultant;**
- **CDC+ Representative**
- **Behavior Assistant Services;**
- **Behavior Analysis Services;**
- **Companion services;**

- **Personal Care Assistance for adults;**
- **Respite Care.**

Other Medicaid waiver services received by the individual are documented in the PCR report.

### **Confirmation with Support Coordinator and Provider(s)**

Once the QAR and support coordinator have determined the actual dates of the support coordinator follow up and record review, this information is entered into the web based application. A phone call is made to the support coordinator to confirm date, location and time of review, and includes a list of documents that need to be available for review such as the cost plan, support plan, eligibility worksheet, and progress notes as noted in the notification letter. The reviewer details procedures related to the PCR process.

The QAR obtains from the support coordinator a list of providers, with contact information, for each person who agrees to be interviewed.

The same process occurs for the service provider(s) included in the PCR. QARs enters the record review(s) into the web based application which in turn will trigger a notification letter to providers informing them of the procedures related to their role in the PCR process. The letter also includes a list of potential documents that must be made available for review including but not limited to implementation plans, support plans, service authorizations, incident reports and other required documentation per service rendered. The reviewer contacts the service provider by phone to coordinate the date, time and location of the record review. The reviewer documents their calls to the provider and support coordinator. Notification letters to providers drawn into the PCR process are only sent out once the individual agrees to participate in the PCR process.

### **Requesting Records**

All service providers who are actively serving the person at the time of the interview are contacted, informed of the name of the person participating in a PCR, the twelve month period in review, and the documentation to bring to the record review portion of the PCR. At this time, the QAR schedules a time and location for the provider to meet with the QAR within the next 30 days. In the interest of saving time, providers may be requested to bring individual records to the support coordinator's office, if available, or another selected venue.

### **Claims Data Pull**

Reviewers access Medicaid claims data prior to the face-to-face interview. Claims data are used to compare the provider's documentation of services rendered to the person with actual billed claims to demonstrate whether the documentation matches what the provider billed with what was paid. The comparison will also show whether the provider billed according to the specific service(s) requirements and according to the approved rate on the approved cost plan. The comparison of claims data and service records will occur while meeting with the provider to review the individual's records.

## **Interview Activities**

### **Face-to-Face Interviews (NCI, Health and Behavioral Assessment, and Individual Interview Instrument)**

The interview with the individual takes place at a date, time and location of the person's choosing. During the initial face-to-face contact with the person the QAR confirms the person's willingness to participate in the interview, and confirms the person has approved the participation of any other people in attendance, including the support coordinator and family members (excluding the guardian). The QAR may gather additional information related to service delivery and satisfaction from family, guardian/legal representative, and/or support staff. These interviews may be needed to corroborate information or if there are significant gaps in information provided by the person. If the person no longer chooses to participate in the process, the PCR concludes; however for persons on the CDC+ program a Provider Discovery Review (PDR) occurs for the persons Representative (see page 30 for details). The QAR thanks the person and leaves. For those who choose to participate, the individual interviews consist of the National Core Indicators Adult Consumer Survey 2011-2012, Health and Behavioral Assessment (HBA), and the Individual Interview Instrument (III).

The QAR explains the two distinct components of the interview: 1) gathering information for the NCI; 2) gathering additional information using the III and HBA. Required NCI protocol is followed while administering the NCI survey to ensure the data are suitable for inclusion in the HSRI national database of information.

The NCI covers specific areas and consists primarily of choosing the most appropriate response from five possible responses. The purpose of the NCI is to identify and measure core indicators of performance of state developmental disabilities service systems, such as satisfaction with services, community integration, and choice. The survey consists of four parts:

- Pre-Survey Form which is used to gather information to be used during scheduling and conducting interviews
- Background Information which consists of:
  - demographic,
  - health,
  - residential,
  - employment,
  - behavior support needs, and
  - other support information.
- Direct interview with the person which covers:
  - employment/day activity,
  - home,
  - health and safety,
  - friends and family,
  - satisfaction with services, and
  - self-directed supports.
- Interview with the person or other respondents which includes:

- community inclusion,
- choices, and
- access to needed services.

The NCI is conducted face-to-face with the individual receiving services. Individuals may have someone present who knows them best, to assist during specific sections of the survey; however the first section must be answered by the individual independently. After the NCI is conducted, the QAR informs the person of the NCI's conclusion, the confidential nature of the interview, and then begin the III and HBA. The QAR also gives to the person a feedback survey and self-addressed/stamped envelope to complete at their leisure.

Data specific to the individual's desired goals, outcomes, and satisfaction with services are collected through the [Individual Interview Instrument](#). The III consists of open-ended questions relating to results/outcomes areas such as:

- The individual is educated/assisted to fully exercise rights
- The individual is treated with dignity and respect
- The individual's privacy is maintained
- The individual is supported to make informed choices
- The individual actively participates in decisions concerning his/her life
- The individuals is free from abuse, neglect and exploitation
- The individual is healthy and safe
- The individual is driving supports and services to achieve the outcomes he/she wants
- The individual directs changes of supports and services

The QAR ultimately determines if each numbered Element of the III is met for each person interviewed. The actual probes asked may vary from interview to interview depending on the needs of the person being interviewed and the person's communication style. Data specific to the individual's health and safety in all settings are collected using the [Health and Behavior Assessment](#) tool. The HBA consists of a series of questions related to medications taken, medical personnel involved in providing care, hospitalizations, adaptive equipment, environmental conditions, behavioral needs, and safety. The HBA is used to assist in identifying any health and behavioral issues/concerns which may be shared with the WSC and APD.

Should the face-to-face PCR interview occur at a location where the person receives Residential Habilitation or Adult Day Training services, the QAR may conduct an observation of that environment if the provider is projected to have a Provider Discovery Review between then and the end of the contract year. The observation is scheduled by the QAR with the individual and the provider with the intent that the information gathered during the observation is included in the provider's Provider Discovery Review results.



## Service Specific Record Reviews

### **Support Coordinator/Consultant Interview and Central Record Review**

Following the face to face interview with the person, the reviewer conducts a face to face interview with the person’s support coordinator to obtain follow up information related to the individual interview and observation (if conducted). This is the opportunity for the QAR to learn about processes used by the support coordinator for the following responsibilities:

- development of the person’s support plan;
- development of the cost plan to match the support plan;
- choices offered for service and provider selection;
- service planning;
- determining health and safety needs;
- safeguards used to prevent abuse, neglect and exploitation;
- ensuring appropriate preventative medical services and treatment are obtained;
- and, maintaining waiver specific documentation and billing requirements.

The QAR uses the information gleaned from the above processes to determine if the person is being supported with person centered planning as a cornerstone of service delivery. The focus of the interview and observation process is on several different levels and within each level, specific documentation will be reviewed, as identified in the following table

Level of Documentation	Documentation Reflect Compliance with:
Quality of the services and supports rendered	<ul style="list-style-type: none"> <li>▪ Services received are based upon the supports and services identified in the support plan</li> <li>▪ Services delivered are consistent with the plan of care</li> <li>▪ Services reflect measurable progress toward stated outcomes</li> <li>▪ Follow through to completion on any suspected abuse, neglect, and exploitation</li> <li>▪ Follow through to resolution on any health and safety concerns identified</li> <li>▪ Follow through to resolution on any financial issues</li> </ul>
Determination of whether services rendered met the required service limitations	<ul style="list-style-type: none"> <li>▪ Services provided match the scope of the service according to the coverage and limitations handbook</li> <li>▪ Services provided are in compliance with required service limits</li> </ul>
Compliance review of the billing documentation	<ul style="list-style-type: none"> <li>▪ Documentation is complete and contains all required components.</li> <li>▪ Documentation reflects the frequency and duration of claims billed</li> </ul>



An integral component of the PCR is a [review of the individual’s records maintained by the support coordinator and all other providers of services for the person](#). Review of these records covers the prior 12 month period and determines whether:

- Support plans are based on identified needs of the individual;
- The individual’s preferences were taken into consideration;
- The individuals health and safety needs were addressed;
- There is collaboration between service provider and the support coordinator;
- The person participated in at least one meeting with all relevant providers;
- The individual is making progress;
- There were incidents involving the individual, including the number of incidents.

The support coordinator is expected to be a part of and participate in conducting the record review, allowing the coordinator an opportunity to locate required documentation and explain anything that may be unclear.

The record review also helps to ensure the support coordinator is meeting the minimum standards listed below:

- Documentation verifying service delivery;
- The current support plan is in the central record;
- The cost plan is signed and in the record;
- Billing requirements are met;
- Fair hearings notifications requirements are met;
- Incident report requirements are met;
- Provider documentation is in the central record.

**Service Provider-- all services rendered as part of the person’s service delivery system**

Each provider who actively renders services to the person is included as part of the PCR discovery process. As identified above, the QAR meets with the provider(s) to review their records for the individual served. The last 12 month period is reviewed. The focus of the documentation review is on several different levels and within each level, specific documentation is reviewed, as identified in the following table.

Level of Documentation	Documentation Reflect Compliance with:
Quality of the services and supports rendered	<ul style="list-style-type: none"> <li>▪ Services received are based upon the supports and services identified in the support plan</li> <li>▪ Services delivered are consistent with the plan of care</li> <li>▪ Services reflect measurable progress toward stated outcomes</li> <li>▪ Follow through to completion on any suspected abuse, neglect, and exploitation</li> <li>▪ Follow through to resolution on any health and safety concerns identified</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Follow through to resolution on any financial issues</li> </ul>
Determination of whether services rendered met the required service limitations	<ul style="list-style-type: none"> <li>▪ Services provided match the scope of the service according to the coverage and limitations handbook</li> <li>▪ Services provided are in compliance with required service limits</li> </ul>
Compliance review of the billing documentation	<ul style="list-style-type: none"> <li>▪ Documentation is complete and contains all required components.</li> <li>▪ Documentation reflects the frequency and duration of claims billed</li> </ul>

The tool is designed to capture the information above for each service.

### **Medicaid Claims Data Analysis**

Documentation in the individual’s central record is compared with Medicaid claims data. The QAR determines if billing requirements and documentation specifications were met as identified in the Waiver services handbook. If documentation is determined to be Not Met this is entered into the report and is identified as potential recoupment to the State, if identified as such in the Waiver services handbook.

### **Data entry into the web based application**

QARs ensure data collected from the support coordinator interview and record reviews are entered into the web based application within 10 days of completion of the PCR process.

### **The Medical Peer Review (MPR) Process**

The Medical Peer Review (MPR) process is designed to identify the physical, functional and behavioral health care status and needs of individuals currently receiving services on the Florida HCBS waiver. The focus of the MPR process is on individuals’ safeguards as identified in the HCBS Quality Framework Focus IV. It captures health risk and safety concerns and will identify interventions designed to promote the health and safety of the individual. The process allows for the identification and reporting of critical incidents and potentially life threatening situations. It identifies environmental risks and recommendations, as needed, for modifications that promote safety and independence.

The process will identify:

- Use/misuse of chemical and/or physical restraints as defined in Florida Statute 65G-8.
- Medication management concerns and recommendations as defined in Florida Statute 65G-7;
- And, information on the current provision of healthcare services for each individual.

The MPR is conducted with established methods by the Delmarva Nurse Reviewer and includes:

1. Observation – real time, actual events/behaviors that occur in the individual’s natural context based upon real time observations conducted by the QAR.
2. Interview – targeted, direct questions that allow for the individual’s perspective based upon the NCI Adult Consumer Survey and the Individual Interview Instrument.
3. Documentation Review – stable and precise review of the individual’s Central File, Medical Information, Health and Behavioral Assessment, Medicaid Claims Data and Medical Record Review (as indicated)

The Medical Peer Review process begins at the time of the PCR interview with the availability of the Nurse Reviewer for real time consultation with the reviewers, individuals, families and providers as health and safety questions or concerns arise. Subsequent to the Person Centered Review on-site activity, the following activities occur for the MPR, for each individual interviewed:

1. Medicaid (FMMIS) Claims Data review of Institutional, Medical and Pharmacy claims by the Nurse Reviewer, for the 12 month period prior to the review
2. Review of the comprehensive Health and Behavioral Assessment data by the Nurse Reviewer
3. Review of the observational data collected through the PCR by the Nurse Reviewer
4. Review of information collected from the individual’s Central File and Medical File through the PCR on each individual by the Nurse Reviewer

This process will identify six possible categories of results:

- a. No health or safety concerns and no discoveries
- b. Health and/or safety concerns are noted and appropriate discoveries are made.
- c. Discrepancies are noted between the Health and Behavioral Assessment and the Institutional, Medical or Pharmacy claims data review and other document reviews that indicate the need for additional information. This would trigger a Focused Review. The intent of the focused review is to determine if individuals are receiving appropriate care and ensure appropriate discoveries are generated.
  - i. Components of the Focused Review may include a request for and review of the individual’s medical record, additional consultation with the individual, family and/or provider. If, after receipt and review of additional information, the discrepancies are found to be benign, the MPR is concluded.
  - ii. In the event that review of medical records does not solve the discrepancies the review is given to the Medical Director for input.
  - iii. In the event the Medical Director identifies the need for further review by a specialist in the area of concern the case is referred to a contract outside medical peer review organization.
- d. Critical intervention needed by either the Area Medical Case Manager or the Area Behavior Analyst. If during the time of the Person Centered Review, either based on information gathered from the provider or individual being

reviewed or observations of the QAR, any critical health or safety need or violation is noted, the QAR immediately notifies the Nurse Reviewer. The Nurse Reviewer notifies the Area Medical Case Manager or Area Behavior Analyst via phone. Notifications that do not contain PHI or ePHI are also sent via email. When PHI or ePHI are included, a hyperlink is created to allow users a direct link to the secure, web-based interface where they enter a username and password and collect the name of the individual and WSC, the date of the finding and a detailed report of the identified concerns.

### **MEDICAL RECORD REQUEST CRITERIA**

- 2 or more hospitalizations within 1 year
- 3 or more ER visits within 1 year
- 3 or more antiepileptic medications
- 3 or more psychotherapeutic medications
- 3 or more medications for chronic conditions
- 3 or more injuries requiring medical care within 6 months
- 2 or more Baker Acts
- Discrepancies are noted between interview results and claims data

#### **Criteria for forwarding a focused review for Medical Director Review includes:**

1. Any focused review that is initiated under the above medical criteria that, in the opinion of the reviewer, has not had appropriate interventions undertaken in response to the above criteria to prevent, when warranted:
  - Immediate physical harm or death, to self or others
  - Further preventable medical complications
  - Deterioration of clinical status, whether reversible or irreversible
  - Deterioration of quality of life, whether reversible or irreversible
2. Any focused review that is initiated under the above medical criteria that, in the opinion of the reviewer, the care provided lacked appropriate physician-directed oversight.
3. Any focused review that is initiated under the above medical criteria that, in the opinion of the reviewer, fails to comprehend, acknowledge, or address the underlying medical concerns sufficiently to allow for the most optimal outcome possible for the individual.
4. Any focused review that is initiated under the above medical criteria that the reviewer feels is outside the reviewer's scope of comprehension for offering a reliable opinion, but for which the reviewer continues to have concerns regarding the quality of care provided. **Criteria for requesting an expert specialist review:** When, after performing a Medical Director review, it is the opinion of the reviewer that the nature of the (medical) concern, and/or the level of complexity of the concern, warrants further in-depth review by a board-certified specialist (in the area of concern), in an effort to ensure that every available measure is/has been considered to allow for the most optimum outcome possible for that individual's unique medical circumstances, an expert specialist review is requested.

### **Report Approval and Distribution**

Delmarva Quality Assurance Supervisors approve 100% of reports. For QARs who complete data entry for a six month time period with 95% accuracy, managers review and approve a sample of reports each month. For those with less than 95% accuracy in report generation, managers approve 100% of their reports and provide coaching in the areas needing improvement.

Reports are distributed to individuals participating in the PCR process upon request, and made available to APD and AHCA for authorized users through the FSQAP reporting system within 30 days of completion of the review. Reports include specific information for each person sampled as part of the PCR process as well as information about the degree to which the person's support delivery system successfully meets the needs of the person.

### **NCI Interview Validation by HSRI**

After completing each interview, the QAR provides a feedback survey to the individual and/or guardian. The survey is designed to help ensure proper protocols were followed by the interviewer, and to protect the integrity and reliability of the data collected through the process. Surveys include an addressed and stamped envelope and are sent directly to HSRI for evaluations. Quarterly updates are provided to Delmarva and included in the quarterly reports to the Agency.

### **Provider Discovery Reviews**

The [Provider Discovery Review](#) (PDR) process is an integral component of the discovery process, used to evaluate the extent to which providers incorporate a person centered approach in their service delivery systems as well as their compliance and accountable to Medicaid, Medicaid Waiver, AHCA and APD standards. The PDR evaluates how providers assist people to meet their goals and needs. The process includes observation of the person's environment using an observation checklist for group homes and day training facilities, individual/staff interviews, administrative record reviews, individual records reviews, and Medicaid claims data analysis.

### **Types of Services to be Reviewed**

Provider Discovery Reviews (PDRs) are conducted annually with every provider rendering services to individuals who receive a PCR. In addition to the record reviews completed as part of the PCR process, a sample of individuals receiving services from the provider is selected as part of the provider PDR to ensure every service (listed below) rendered by the provider is monitored. The individuals who are selected have received services from the provider for at least six (6) months to be eligible for the sample. This limit is to ensure there is enough evidence to determine whether the provider is meeting the person's needs and goals. Six months is a reasonable timeframe for a provider to learn about the persons' needs, goals and what matters most to them. The services targeted for this type of on-site review are reflected in the [Discovery review tools approved by AHCA and APD](#) and available on the website [www.dfmc-florida.org](http://www.dfmc-florida.org).

Each provider identified as eligible for an on-site review receives a PDR once each contract year unless their results warrant ‘deemed’ status, thus making them ineligible for a review until the following contract year. The contract year is defined as the period from January to December. It should be noted the PDR schedule is driven by the annual PCR schedule and may not result in provider reviews that are exactly 12 months apart.

Once providers have received a PDR, they only need to comply with a record review if they are identified through any PCRs. The record review is only for the person selected for a PCR. Any provider not included in the discovery process via this method is contacted for a PDR prior to the end of the fiscal year. Providers who hold professional licenses for the service they render are not included in this process, with the exception of Behavior Analysis service providers.

### **Procedures and Methods for Reviews**

The PDR process is comprised of several activities including pre-onsite, onsite and post-review, all of which are completed by QARs. The following list outlines each activity and related responsibilities:

- **Pre-onsite Activities**
  1. Scheduling the PDR;
  2. Confirmation with provider including providing a link to this Operational and Procedure Manual and Discovery review tools posted;
  3. Sample selection for record reviews;
  4. Request information from APD related to complaints or any other issues about the provider;
  5. Medicaid claims data pull.
  
- **Onsite Activities**
  1. Confirming documents needed for review and staff who need to be available;
  2. Informal Individual Interviews, where possible;
  3. Observations of service delivery locations (Residential and Adult Day Training sites);
  4. Administrative Record Review;
  5. Individual Record Review(s);
  6. Provider/Direct Care staff interviews, where possible;
  7. Alert Reporting;
  8. Preliminary Findings.
  
- **Post-Review Activities**
  1. Report Development, Approval, and Distribution

### **Pre-Onsite Activities**

#### **Scheduling the PDR**

Every provider, including support coordinators, rendering services to a person selected for a PCR is scheduled for a PDR. All providers rendering an onsite service as described above receive an onsite visit. Prior to November 15<sup>th</sup> of a given year Delmarva QA Supervisors work

with QARs to set the PDR schedule for the entire year, identifying the quarter a provider will receive an onsite visit.

On a quarterly basis, Delmarva ensures providers scheduled for a PDR in the coming quarter receive a notification letter informing them they will be receiving a review within the next 90 days. The letter directs the provider to the website location to access the procedures manual and review tools. Providers who do not have internet access are directed to contact our customer service department. The relevant sections of the manual are mailed to providers at their request. The reviewer documents their calls to the provider in a contact log. Up to 30 days prior to the review the QAR contacts the provider by phone and sets a firm date/s for the review. The QAR also requests information on the types of services rendered, in which APD Areas services are provided, and confirms how many individuals receive each service. The QAR also collect information on the number of group homes and adult day training locations where services are rendered. This allows for planning on the part of the provider to ensure staff availability during the review timeframes.

A copy of all providers scheduled for a PDR is sent to APD by the 1<sup>st</sup> of each month or more often as dictated by APD’s needs.

**Medicaid Claims**

Quality Assurance Reviewers access and review Medicaid claims data prior to the review to confirm services rendered by the provider and select the sample of individuals for record reviews.

**Sample Selection for Record Reviews**

Based upon the claims data, individual records are selected to ensure all services rendered are represented in the sample. A service eligible for review must have been rendered and billed for in the previous six (6) month period. The individual’s records are chosen from the eligible services and the sample size is based on the total number of people receiving services.

PDR Records Sample Matrix Service Providers	
Individuals Served Per Provider	Number Individuals Sampled
1 - 29	At least 1 per eligible service, a minimum of 2 per provider
30 - 99	At least 1 per eligible service, a minimum of 3 per provider
100 - 199	At least 1 per eligible service, a minimum of 5 per provider
200+	At least 1 per eligible service, a minimum of 10 per provider



For Waiver Support Coordinators, two record reviews will be completed as part of the PCR. The coordinator knows in advance the names of individuals receiving a PCR and which records need to be provided. Therefore in addition to these, at least one record per coordinator is randomly selected for an “unannounced” record review, with up to a total of three record reviews per coordinator (treating provider) reviewed as part of the PDR. For example, support coordinator agencies with five treating providers have a total of 15 record reviews completed as part of the PDR, with at least five unannounced. A solo coordinator has at least three individual records reviewed, with at least one unannounced.

Note: there are circumstances in which a WSC could be pulled into more than 2 PCRs. Examples of these circumstances include:

- Support Coordinators who work in multiple Areas have 2 PCRs sampled for each Area in which they serve.
- Support Coordinators working for large agencies where caseloads shift around could result in one support coordinator serving more than 2 people who are in the PCR sample.
- Individual’s changing support coordinators due to personal choice, or a support coordinator discontinuing services results in a support coordinator who has already been drawn into 2 PCRs now serving another person in the PCR sample.

A stratified random sample of individuals is included in the record review component of the PDR. The record reviews for individuals already selected for the PCR are incorporated into the overall results for the provider. Because service providers have any number of record reviews completed in conjunction with a PCR, the proportion of additional records to be selected as part of the PDR process includes any other service not captured as part of the PCRs conducted.

### **Gathering Information from APD**

Notification to APD of upcoming reviews for the month includes the name and contact information of the lead reviewer and a request for information pertaining to complaints or grievances against the provider. This information is discussed with the provider during the onsite review to determine how the provider has addressed any complaints and grievances.

## **Onsite Activities**

### **Confirming Documents for Review**

The QAR meets briefly with the provider and staff once onsite. This initial meeting includes introductions and an opportunity to confirm documents to be made available and staff who may need to be present. Not until the QAR is onsite is the list of individuals selected for record review be shared with the provider.



**Observation of Service Delivery Locations**

Observations are conducted by the QAR at residential and day training service locations. The focus of these observations are used to determine if:

- there are health and safety concerns;
- there are rights restrictions/violations;
- the provider uses a person centered approach to service delivery;
- people are treated ethically and fairly;
- support plans and behavior plans are deployed appropriately;
- there are any abuse, neglect or exploitation issues; and
- there is appropriate staffing to meet required ratios.

During the observation component of the PDR, individuals who agree to participate are interviewed to determine how supports and services are being provided and their level of satisfaction with the provider.

An [observation checklist](#) is used as a guide and reporting mechanism for the QAR to document any concerns. Observations occur at all day program facilities. Observations completed as part of the PCR process are incorporated into the PDR and an additional site visit is not warranted. The same applies for group homes, assisted living facilities, and foster homes where Residential Habilitation service is provided. However, if the provider has more than 10 group home sites, a maximum of 10 sites are observed. The homes not seen are slotted to participate in an observation the next year until all home sites have been reviewed.

The number of residential locations are selected as follows:

Number of Group Homes	Number of Homes receiving an Observation
1 to 10	1 per home
11 or more	A maximum of 10 different homes observed

**Administrative Record Review**

Policy and procedures are the foundation of any organization. They are what guide and govern the systems and practices used by a provider organization to render services. If these policies are not in alignment with the expectations of the HCBS Focus Areas, then the provider is not providing services according to CMS standards or the Medicaid Developmental Disabilities Waivers Coverage and Limitations Handbook, since they mirror these standards. Therefore, the policy and procedures identified in the discovery tool to be reviewed as part of the [administrative review](#) are reflective of the CMS Focus Areas.

This section of the discovery process is the first phase of learning about how a provider renders services. Policies and procedures are key to begin to understand what the quality of the provider’s services may look like. They are reviewed to ensure they meet the required

standards. This includes a review of other pertinent documentation including but not limited to self assessments, incident tracking, and grievances.

All training requirements for all provider types and services are included as part of the review. Any service specific training required as part of the Medicaid Developmental Disabilities Waivers Coverage and Limitations Handbook are also included as part of this record review. Evidence of employee qualifications and completion of background screening requirements are included.

A sample of employee records is selected based upon the number of services the provider renders. At least one employee's record is selected per service provided. For support coordination agencies, a maximum of 3 staff records are reviewed since they are the same service.

### **Individual Record Review**

The [Discovery Tool](#) component used to collect data for individual record reviews during the PCR is also used for record review during the PDR, and determines compliance and accountability with all relevant Medicaid Developmental Disabilities Waivers Coverage and Limitations Handbook standards. Record reviews completed during the PCR are integrated into the PDR through Review and Provider ID numbers assigned in the database management system.

For support coordination, additional requirements such as caseload size, coordinator referrals, provider changes, and conflict resolution are included. Data captured provides a means to objectively measure the majority of the focus areas of the HCBS Quality Framework and compliance with handbook requirements, to include but not be limited to:

- information to support choice of community based services and supports in communities;
- person centered service planning and delivery and effective deployment of the support plan;
- provider capacity and capabilities including provider training and qualifications;
- participant safeguards to include health, safety and well being, and freedom from abuse, neglect and exploitation;
- education on rights and responsibilities, and opportunities for exercising rights;
- satisfaction with services and achievement of outcomes;
- system support as evidenced by provider collaboration;
- appropriate billing practices as evidenced by Medicaid claims; and
- required documentation.

Documentation for services rendered by the provider is reviewed for the 12 month period prior to the review. Medicaid claims data for the same 12 month period are compared to the provider's documentation for evidence of appropriate billing, and for identification of any recoupment of funds. At a minimum documentation review includes a review of Support Plans, Cost Plans, Implementation Plans, Behavior Plans, Service Authorizations, Agency Approved

Assessment, billing documentation, and other required documentation as specified per service. Documentation is used to determine the provider’s compliance with requirements per the Handbook and Florida and to make the determinations identified below.

Level of Documentation	Documentation Reflect Compliance with:
Quality of the services and supports rendered	<ul style="list-style-type: none"> <li>▪ Services received are based upon the supports and services identified in the support plan</li> <li>▪ Services delivered are consistent with the plan of care</li> <li>▪ Services reflect measurable progress toward stated outcomes</li> <li>▪ Follow through to completion on any suspected abuse, neglect, and exploitation</li> <li>▪ Follow through to resolution on any health and safety concerns identified</li> <li>▪ Follow through to resolution on any financial issues</li> </ul>
Determination of whether services rendered met the required service limitations	<ul style="list-style-type: none"> <li>▪ Services provided match the scope of the service according to the coverage and limitations handbook</li> <li>▪ Services provided are in compliance with required service limits</li> </ul>
Compliance review of the billing documentation	<ul style="list-style-type: none"> <li>▪ Documentation is complete and contains all required components.</li> <li>▪ Documentation reflects the frequency and duration of claims billed</li> </ul>

**Provider/Direct Care Staff Interviews**

Staff interviews take place when possible during record review and/or during observations of home and day activity locations. Questions may arise regarding the provider’s systems for rendering supports and services and it is important providers are given every opportunity to demonstrate compliance and innovative practices. This may also include subcontractors as is sometimes the case with Behavior services. Interviews afford the provider an opportunity to explain both formal and informal practices which support the provider’s implementation of policies and procedures that help support individuals in achieving their goals. Interviews with staff assist in gathering information related to staffing patterns, barriers to service delivery, best practices, inter-provider interaction, conflict resolution, and identification of areas that need improvement.

The provider is asked to give the QAR a list of staff and which service they provide. The QAR identifies the staff selected and the provider is responsible for setting up the interviews with staff

during the PDR time frames. When possible, staff are chosen who render different types of services to better determine if one type of service provides supports differently than another.

[Provider Discovery Reviews \(PDRs\) occur for all CDC+ Representatives](#) beginning October 1<sup>st</sup>, 2010. This occurs regardless of whether the individual participates or declines participation in the PCR process.

- Record review of Recipient/Representative files is conducted to verify:
  - Employee background screenings are current and maintained in individual's file.
  - Monthly spending procedures and corrective actions are followed.
  - Current Employee job descriptions are maintained in individual's file.

The Confirmation letter mailed to CDC+ participants scheduled for a PCR includes information regarding the Record Review of the Participant/Representatives files and a list of documents to be available for review such as the Purchasing Plan, time sheets, invoices and employee files.

### **Alert Reporting**

If at any point during the Discovery Process the QAR uncovers any indication of abuse, neglect, exploitation or has any concerns related to medical, behavioral, rights, health, safety, and/or mistreatment the appropriate entity is contacted – the abuse registry if needed – and local APD is notified by telephone immediately. Every effort is made to safeguard the person should such a situation arise. A written letter describing the circumstances leading to the alert is provided to the Agency, APD headquarters and Area APD within 2 business days of the incident. Delmarva QA Supervisors take the lead on reporting alerts.

### **Preliminary Findings**

The reviewer meets briefly with the provider and staff at the conclusion of the review and the provider is given a Preliminary Findings Worksheet which enables the provider to address areas requiring improvement in preparation for remediation activities with APD. The worksheet identifies the standards related to any potential recoupment items and alerts that are scored Not Met. Both the QAR and the provider sign a copy of the Preliminary Findings Worksheet to help ensure all participants have a clear understanding of noted deficiencies in these important areas. If the provider declines to sign the preliminary findings worksheet, the QAR documents this on the worksheet.

### **Post Onsite Review Activity**

#### **Report Development and Distribution**

PDR Reports are available within 30 days of the completion of the reviews via the FSQAP reporting system for authorized viewers. Hard copies are sent to providers.

The report presents findings of each component of the PDR, including the individual record review results, observations and the administrative records including policy and procedures and training and qualifications of staff. The results of the PCR(s) review are integrated into these findings as appropriate. The report identifies the following:

- Any services identified in the Support Plan but not in place for the individuals served;
- Any identified recoupment from individual records reviewed;
- Identification of any unmet needs, medical necessity or quality of care issues;
- Identification of significant health and/or safety issues;
- Any health, safety, abuse, neglect or exploitation alerts;
- Summary of findings addressing deficiencies;
- Physical environment;
- Interaction between staff and individuals;
- If people's rights are being observed;
- If people are healthy and safe, and free from abuse and neglect;
- If a person centered approach to service delivery is used,
- If there is appropriate staffing.

### **Other Reporting Activities**

Data are also captured to facilitate reporting on information specifically identified by the state in order to aid in its efforts toward remediation and improvement. This includes but is not limited to the following:

- Length of time the provider has been rendering services,
- Whether the Abuse Registry was contacted during the course of the review,
- Number of complaints or grievances against the provider.

Data from the PDR are collected using the Met/Not Met format based on the review procedures described above. Most elements result in a numeric point score, although some elements may be weighted due to their importance.

## Reconsideration Procedures

The Reconsideration Review is the process that allows a provider to request a change in scoring on the Provider Discovery Review (PDR). An example of when a provider may want to request a Reconsideration Review is when the provider believes required documentation was presented to the reviewer during the review, but the final report showed that the standard was still identified as "Not Met."

Reconsideration Requests are only applicable to standards of performance related to potential recoupment. These standards are identified on the Provider Discovery Review report under the heading **Potential Recoupment Reported to AHCA**. Additional clarification is under two other headings following results of each individual record review: **Detailed Issues from Record Reviews by Service and Individual** and **Recoupment Details**.

- \* **Important Note:** Documentation not made available at the time of the initial review will not be accepted for a Reconsideration Review.

If the provider disagrees with the findings related to potential recoupment in the Provider Discovery Review (PDR) report, the provider may request a Reconsideration Review. The Reconsideration Request must be made in writing and received within 30 days of receipt of the annual PDR report. If the request is not submitted in the 30 days, it is not accepted and the request is denied. The provider has the option of submitting the Reconsideration Request by hand delivery, mail or by fax to the Tampa or Tallahassee address/fax number located below. Upon receipt, the Reconsideration Request is entered into a tracking system to ensure Delmarva completes the Reconsideration Report within 30 days of receipt of the request.

To submit a Reconsideration Request the provider must fill out the Reconsideration Request form located on our website at [www.dfmc-florida.org](http://www.dfmc-florida.org) under Provider Resources.

Please carefully follow the procedures outlined below when requesting Reconsideration: All fields **must** be completed to be eligible for Reconsideration:

- Provider Number
- Provider Name
- Provider Street Address/City/State/Zip
- APD Area
- Provider Location (if applicable)
- Provider Discovery Review date
- Delmarva Reviewer Name
- Recoupment Standards (list service and standard number- example: Respite # 5) for which Reconsideration is requested. List service and standard # on each page submitted.

- Documentation to support Reconsideration (each document submitted must state which service and standard it applies to).
- Name of Person to Contact/Phone number

The completed Reconsideration Request form along with documentation to support the Reconsideration Request may be hand delivered, mailed or faxed to either the Tampa or Tallahassee office.

**Tampa Office**

12906 Tampa Oaks Blvd  
Suite 130  
Temple Terrace, FL 33637  
(866) 254-2075  
(813) 977-0027 Fax

**Tallahassee Office**

2039 Centre Pointe Blvd.  
Suite 202  
Tallahassee, FL 32308  
(850) 671-5096  
(850) 878-3958 Fax

A review of the Reconsideration Request is processed and a report generated within 30 days. If the provider does not receive the Reconsideration Report shortly after the 30 days, the provider should contact our Customer Service Representative at 1-866-254-2075.

**Final Note:** Reconsideration Request submissions should only include documentation related to the request. The provider should forward other documents related to remediation plans, corrective action plans or corrected documentation to the appropriate local Area APD office if and when requested.

Revision Date	Change Description/Purpose
2012_0905	<p>Revised manual to remove repetition, refer reader to documents posted on contract website, corrected 45 day notice to 30 day notice, replaced “will” statements to “is/are” statements; added hyperlinks to review tools</p>
2010_1001	<p>Non Compliance Procedures to include CDC+ representatives and 1915J language – page 8            Non Compliance procedures – changed 3 calendar days to 3 business days – page 8.</p> <p>Sample size for WSC – page 24            Note: there are circumstances in which a WSC could be pulled into more than 2 PCRs. Examples of these circumstances include:</p> <ul style="list-style-type: none"> <li>• Support Coordinators who work in multiple Areas will have 2 PCRs sampled for each Area they serve in.</li> <li>• Support Coordinators working for large agencies where caseloads shift around could result in one support coordinator serving more than 2 people who are in the PCR sample.</li> <li>• Individual’s changing support coordinators due to personal choice, or a support coordinator discontinuing services results in a support coordinator who has already been drawn into 2 PCRs now serving another person in the PCR sample.</li> </ul> <p><b>Removed Said Sanchez’s name – page 7</b></p>
2011_0601	<p>Revised - DD Handbook was added to Explanation of Terms, page 4            Corrected - ‘Centers for Medicaid &amp; Medicare Services’, page 4            Revised - letter notification to support coordinators and CDC+ consultants to say ‘the next 90 days’ for Selecting the Sample for PCRs, page 11            Revised - ‘Confirmation letter to the Support Coordinator and Provider(s)’ to Confirmation with Support Coordinator and Providers, page 12</p> <p>Revised- Observation of Interview Environment to Observation of the Service Delivery Locations, page 15</p> <p>Revised - Confirming the Review with the Provider – confirmation phone call to include a brief review of review procedures and required documents, pages 13 and 23            Corrected - Number of group homes selected for Observation, page 25            Corrected reconsideration procedures to include statement ‘Reconsideration will only be applicable to elements of performance related to recoupment’, pages 7 and 29.            Revision – description of confirmation letter to CDC+ participants, page 29.</p>
2010_0201	<p>New procedure</p>